Gathering claim information

Gathering claim information

Gathering information is an important part of the effective and efficient management of a claim. We need to gather information to support appropriate liability determination and decision making and to support return to health and, where possible, work.

What information do we gather?

Comcare gathers sufficient information to make decisions. Comcare's requests for information must:

- be specific
- be relevant to the decision at hand
- be realistic in their timeframes
- clearly state when information is due
- clearly communicate why we have asked for the information, and
- seek only information we don't already have.

Employees

These pages explain how we can request information from an employee, including using section 58 of the SRC Act.

Requesting information from employees

Employers

These pages explain how we can request information from an employer, including using section 71 of the SRC Act.

Requesting information from employers

Medical and allied health practitioners

Medical and allied health practitioners can provide relevant and appropriate medical evidence and information about the employee.

These pages provide information about obtaining a medical certificate, medical reports, clinical notes and medical imaging, as well as home, or Activities of Daily Living (ADL), assessments and labour market assessments.

Obtaining a medical certifiate

Obtaining a medical report or clinical notes

Obtaining medical imaging reports

Undertaking a home-based assessment

Undertaking a labour market assessment

Independent medical examinations overview

Comcare can engage and use an independent legally quality medical practitioner to conduct an examination of the employee. There are legislated requirements for when Comcare is considering this, which are outlined in this section.

Independent medical examinations

Clinical Panel

The Clinical Panel is a resource to help you gather and assess medical evidence. These pages provide guidance and instruction on the use of the Clinical Panel.

Undertaking a clinical panel review

Employees

Requesting information from employees

A Claims Manager may need to request information or documents from an employee in relation to their workers' compensation claim. Examples of the type of information include current medical certificates, clinical notes/reports, payslips and financial statements.

Comcare has a power under section 58 of the SRC Act to formally request information. However, we can also request the information informally from the employee.

In this section

Requesting information from employees

Comcare can request information directly from an employee without using any legislative power, or we can use section 58 of the SRC Act to request information. This page contains information about:

- how stop clock provisions work with requests for information
- the procedure to action a stop clock in Pracsys when an employee advises they will submit information or documents
- informally requesting information from an employee
- formally requesting information
- the procedure to formally request information
- following up a formal request
- the procedure to extend time for an employee to respond to a section 58 request, and
- non-compliance with a formal request for information.

Requesting information from employees

Introduction

You may need to request additional information or documents from the employee to support their workers compensation claim. This can be done informally and formally, under section 58.

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

- current medical certificates
- clinical notes and reports
- records of earnings, including payslips
- financial statements including BAS statements and ATO group certificates
- incident statements.

Only factual and specific information or documents which are relevant to a claim made by, or in relation to, an employee may be requested. You should not make general or broad requests for information from an employee.

Employees can access the Guide to submitting employee statements, which includes the employee statement template, on the Comcare website.

When communicating with employees, please be mindful of the Claims Communication Principles and refer to the guidance in Communicating with an employee.

Vulnerabilities: If during your communications with an employee you believe that the employee has specific vulnerabilities, consider the appropriateness of adding a Commitment Claim flag. This is to ensure that Comcare's communications with the employee are productive and positive. See Commitment claims for more information.

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When to request information informally versus formally

Whether we request information informally versus formally depends on the circumstances of the claim. Our normal approach is to request the information informally in the first instance following a conversation with the employee. However, there will be instances following that conversation where a formal section 58 request is required to gather the information.

For **initial claims for liability**, requesting information informally does not 'stop the clock' on prescribed determination timeframes, which may impact the time you have available to determine the claim. However, requesting information formally will 'stop the clock' on the timeframe to determine the claim until the requested information is received, potentially delaying the employee's claim determination. You should take these considerations into account when deciding whether to request information informally or formally. See the section Stop Clock Provisions below for more information.

If you are unsure, please discuss with your Assistant Director and Injury Manager, and bring to a triage meeting where relevant. For further guidance, refer to the Triage page.

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Stop Clock provisions for requesting information

There are prescribed timeframes for determining claims under the *Safety, Rehabilitation and Compensation Amendment (Period for Decision-making) Regulations 2023*. The prescribed timeframes start on the day that Comcare receives a claim for compensation that meets the requirements set out under section 54 and is being determined under section 14 of the SRC Act.

However, the prescribed timeframes do not apply to certain periods in which Comcare seeks further information or material in relation to the claim. These stop clock provisions include where Comcare:

- requests information or a copy of a document from the employee under section 58 of the SRC Act, or
- is advised by the employee that they will provide further evidence in relation to their claim.

In these instances, the 'stop clock' request applies on the date that:

- Comcare provides the written section 58 request to the employee (i.e. the date that Comcare emails or sends the section 58 request to the employee), or
- the date that the employee advises Comcare that they will provide further evidence in relation to their claim.

Once the stop clock request has been created in the '*Manage Initial Liability Assessment*' (MILA) or '*Manage Initial Liability Task*' (MILT) dashboards, the calendar day countdown will stop.

To finalise the stop clock request, use the date that Comcare:

- receives the required information from the employee
- is advised by the employee that they will not be providing any further evidence, or
- reasonably believes that the employee is not going to provide the information or evidence.

Once the stop clock request has been finalised in the MILA or MILT dashboards, the calendar countdown will recommence the next day (unless there are other stop clock requests on the claim).

Please refer to the following guidance:

- Pracsys user guide - How to update MILA or MILT.
- Decision making under the SRC Act for full details about prescribed timeframes and stop clock actions.

Informal requests for information

The prescribed timeframes **do not apply to** instances where Comcare informally requests information from the employee. However, they do apply if the employee **advises** Comcare that they are going to provide further evidence in relation to the informal request. The date that the employee advises Comcare that they will provide further evidence is the date that the clock stops.

Other exceptions to prescribed timeframes

The prescribed timeframes also **do not apply** in instances where Comcare **formally** requests information from the employee under section 58 where:

- Comcare has already made a section 14 determination on the claim
- a new secondary condition is being determined against an existing claim
- there is a continuation of an employee's compensable condition against an existing claim.

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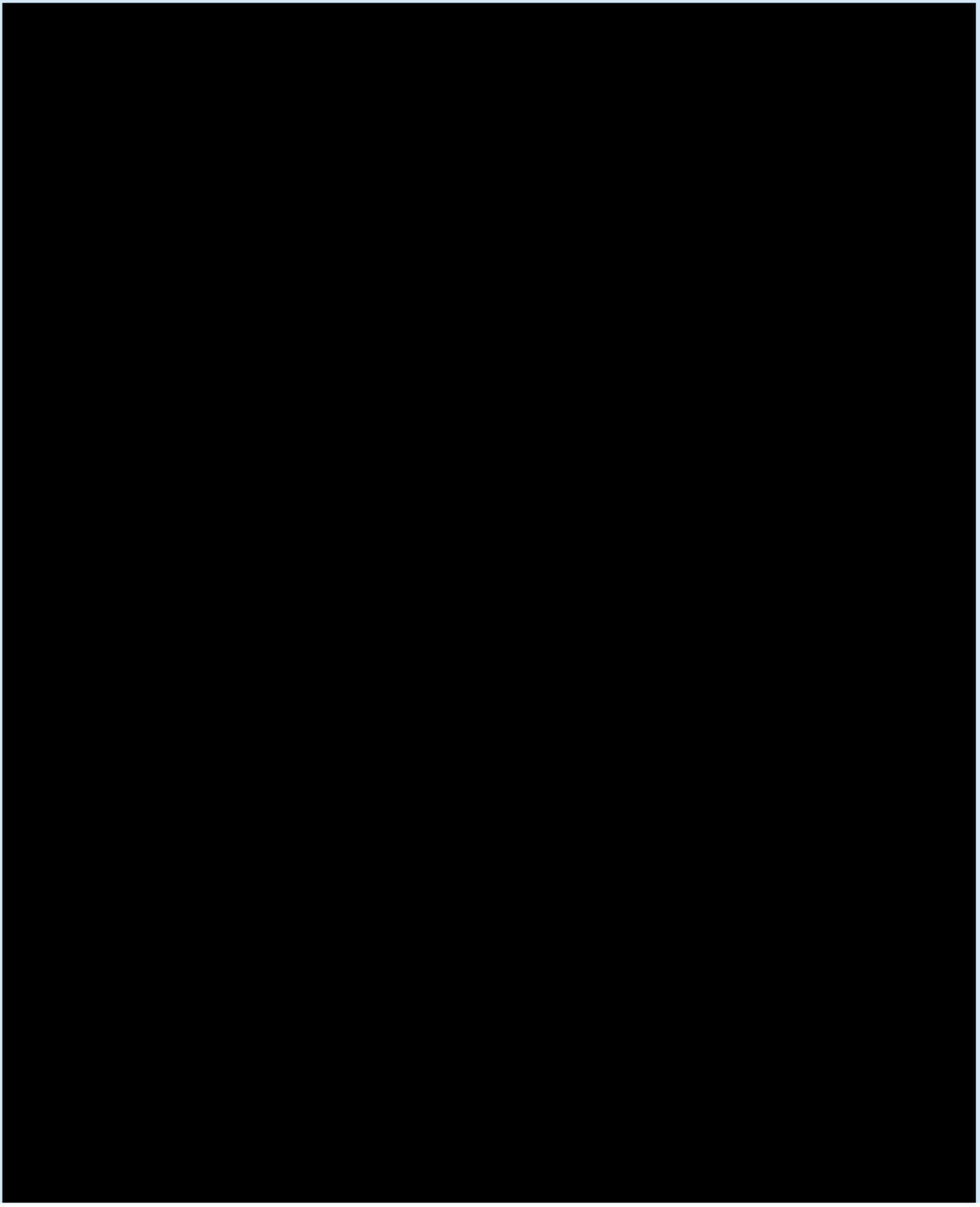

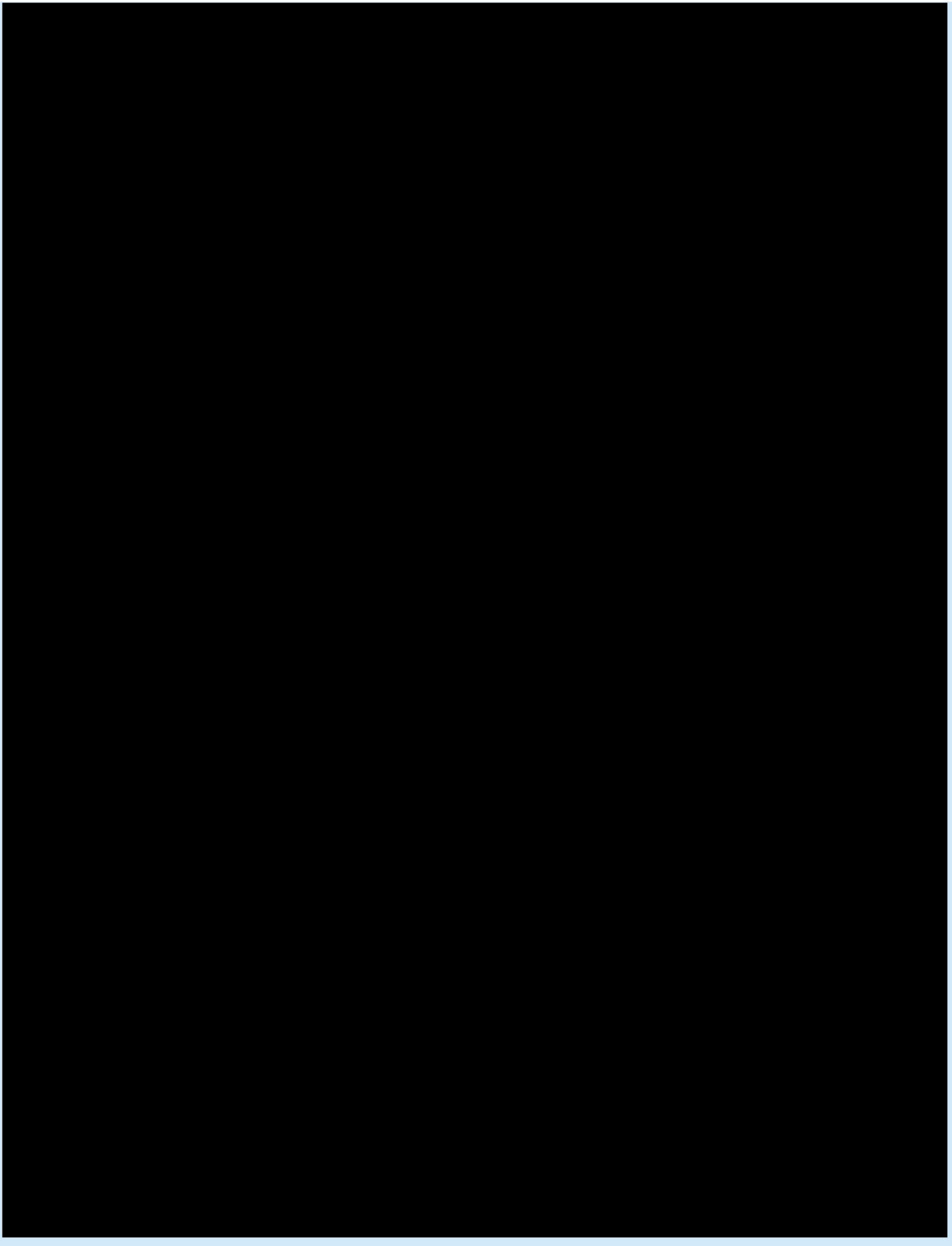

Informally requesting information from an employee

It is generally appropriate to request information informally first. This can be done by phoning the employee and then following up with an email detailing the conversation.

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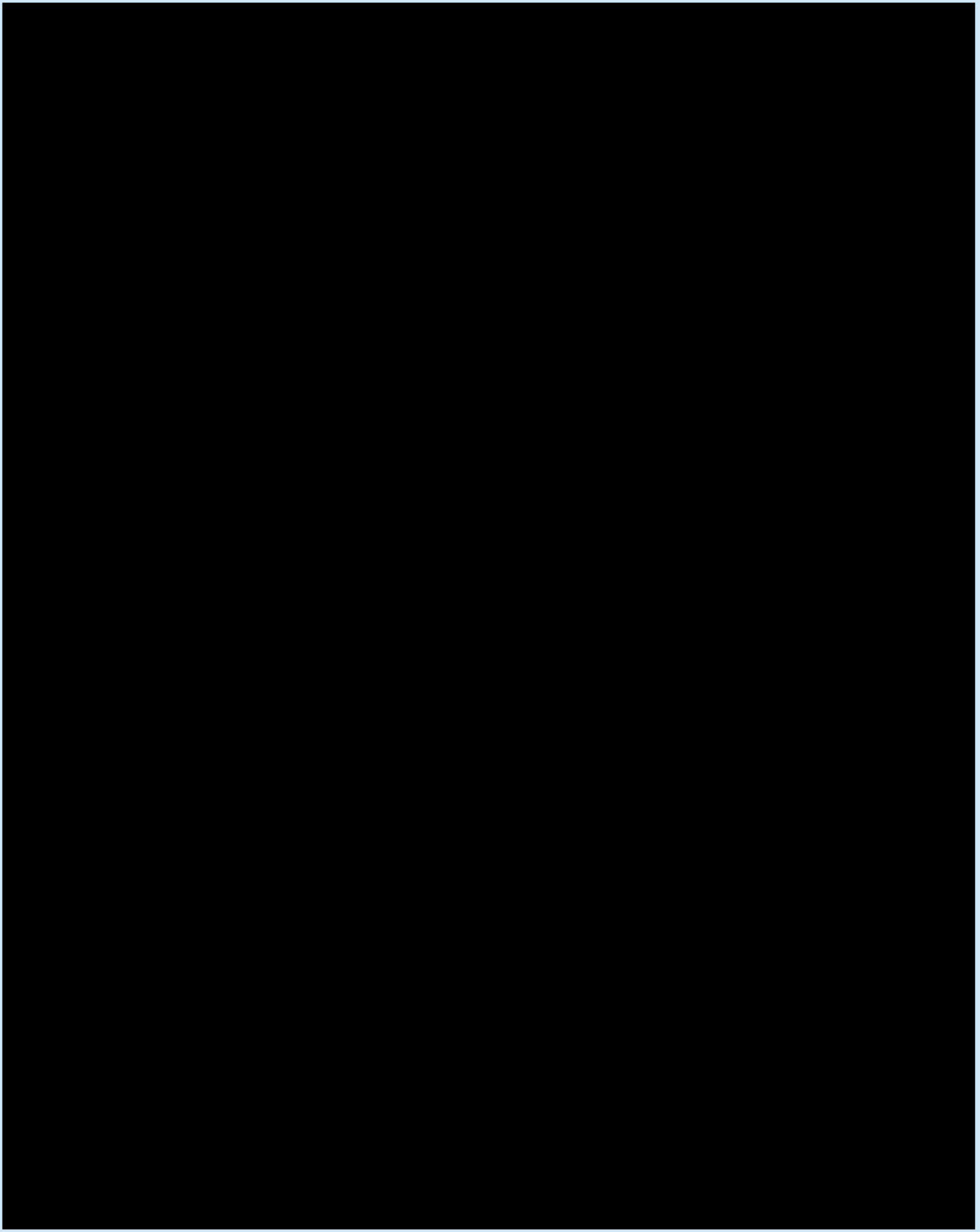

Formally requesting information from an employee under section 58

Section 58 of the SRC Act gives Comcare specific powers to request relevant information or documents from an employee in relation to their compensation claim.

You would usually only request information or documents under section 58 of the SRC Act where an employee has been provided with a prior, informal, opportunity to provide the information or documents.

Before making a request under section 58

When making a request under section 58 of the SRC Act, you must be sure:

- the employee has the information or document relevant to their claim
- the employee may obtain such information or a copy of the document without incurring unreasonable expense or inconvenience
- the Australian Privacy Principles are followed when requesting the information.

Response timeframe and extension of time requests

A notice issued under section 58 of the SRC Act asking the employee provide information or documents gives the employee 28 calendar days to respond.

You can consider providing an extension of time to the employee, at their request, if a reasonable excuse is provided and they are unable to provide the information or documents within this timeframe. Generally, extensions are given on request where the employee has demonstrated they are taking action to provide the information, and you are satisfied the reason for the delay is reasonable.

Acceptable reasons for an extension of time to provide a response may include the employee being unable to:

- obtain the information due to their medical condition
- obtain the information due to a third party not being able to provide the employee the documents within 28 calendar days of the section 58 notice being issued.

See online legislative training module: evidence collection under the SRC Act for further information.

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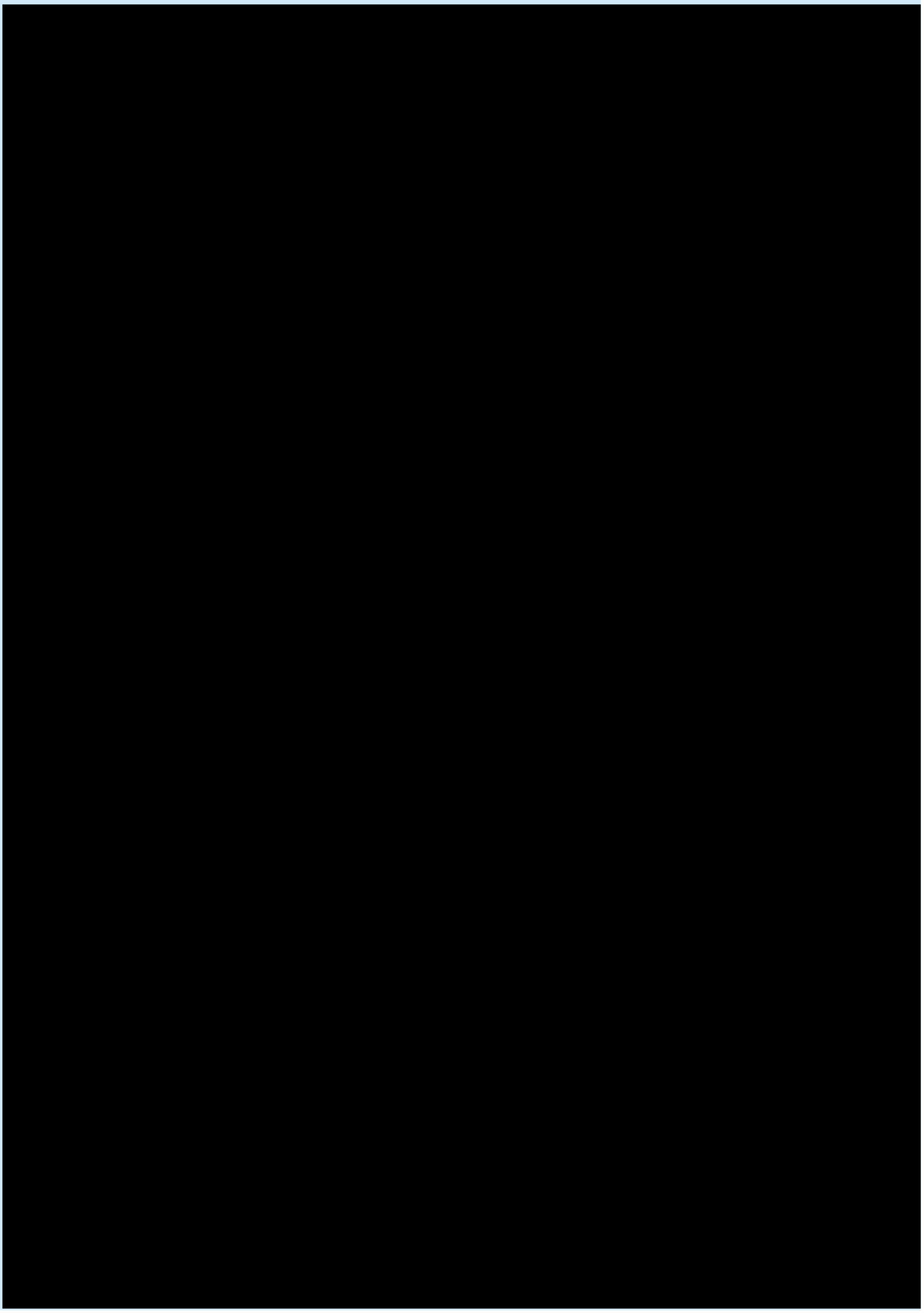

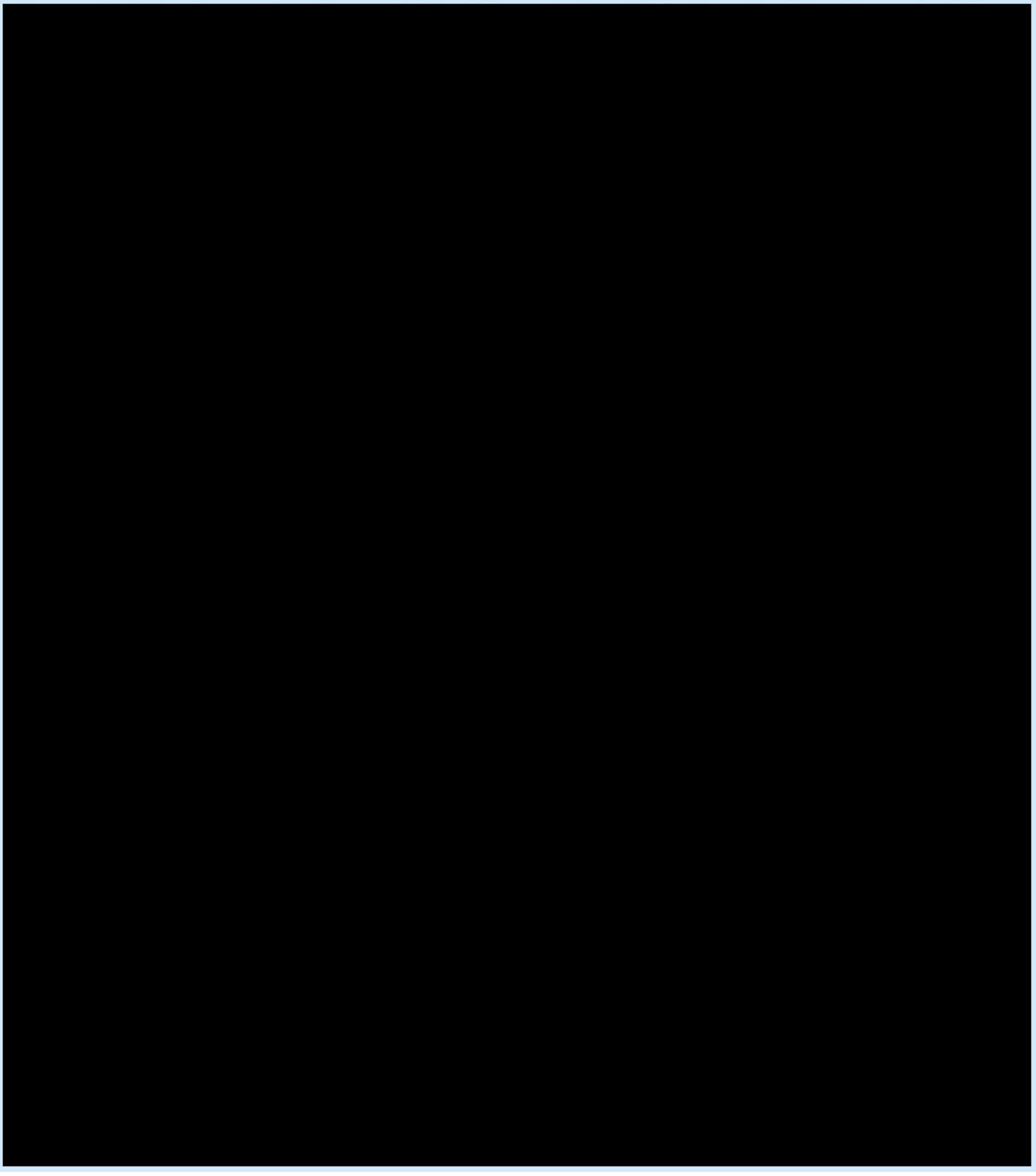

Follow up of a formal request

When you have requested information or documents from an employee under section 58 of the SRC Act and the employee has not responded within 28 days, or the received information or documents are not what you originally requested, you must follow up on your request.

Following a request for information or documents under section 58 of the SRC Act, the employee may ask for an extension of time to provide the requested information or documents. See Procedure to grant extension of time for a section 58 request.

On receipt of an employee's response to a request for information, it is important to ensure the documents provided are consistent with what was initially requested.

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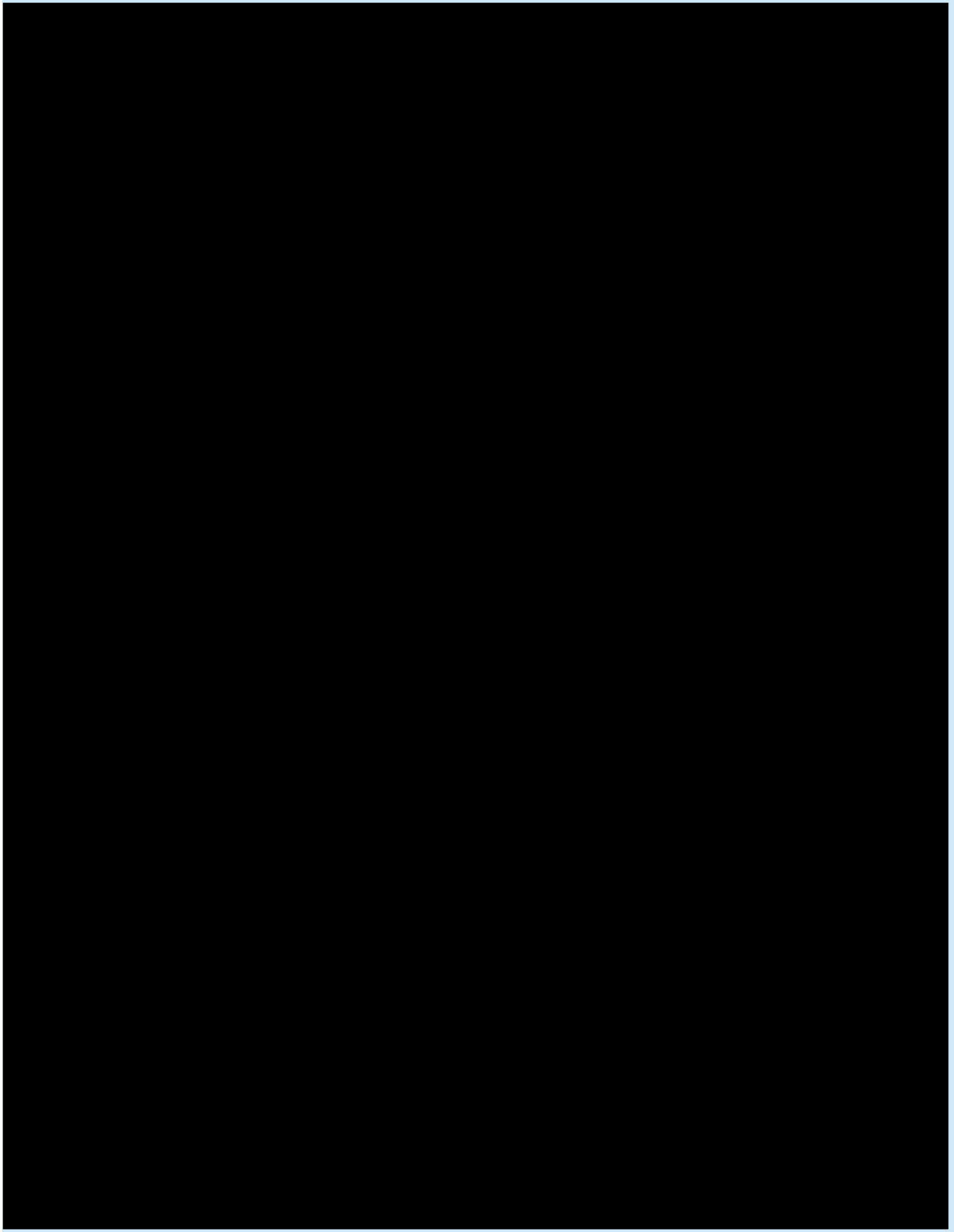

Non-compliance with a section 58 request

An employee must be given an opportunity to provide a reason for not complying with a section 58 notice. Where an employee has provided a reason for not complying with the section 58 notice, you must consider if the excuse is reasonable.

What constitutes a reasonable excuse depends on the facts of each case. The following are examples of what may be considered reasonable:

- The information or document which has been requested no longer exists.
- The employee is not able to obtain the information, for example if an employee's treating practitioner refuses to provide a report.
- The employee's medical condition precludes them from obtaining the required information.
- Costs associated with obtaining the information cannot be met by the employee.
- The employee disputes the relevance of the document to their compensation claim, and can provide reasons to justify this.
- The employee did not receive the notice in time to comply with the request.

Refusal to deal

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

Where a request under section 58 of the SRC Act resulted in a refusal to deal with a claim and the information supplied is satisfactory, it is essential the refusal to deal is promptly lifted.

For claims impacted by the prescribed timeframes, you will need to update the MILA/MILT dashboard to finalise the stop clock request as soon as the refusal to deal is lifted.

The date that Comcare received the requested information from the employee is the date that the stop clock request is finalised.

Please note: Once the MILA dashboard has been updated and the stop clock request has been finalised, the calendar day countdown will recommence the next day (unless there are other stop clock requests on the claim.

For further guidance refer to the Refusal to deal page.

Employers

Requesting information from employers

There may be times when a claims manager may need to request information or documents from an employer to assist in the management of a compensation claim. Examples of the types of information include current medical certification, information related to the employee's recovery, medical treatment and capacity for work, cessation of employment details, employment agreements and rehabilitation reports.

Comcare has a power under section 71 of the SRC Act to formally request information from an employer. However, we can also request the information informally from the employer.

In this section

Requesting information from employers

Comcare can request information directly from an employer without using any legislative power, or we can also use section 71 of the SRC Act to request information. This page contains information about:

- types of information and payment of costs
- information Comcare can receive, send and store
- how to decide whether to request information formally or informally
- stop clock provisions and how they are affected by information requests
- procedure to request information informally
- procedure to request information formally
- non-compliance with a section 71 request
- procedure to follow up a section 71 request
- extension of time for a section 71 request
- procedure to action an extension of time request
- procedure to action an employer response to an information request, and
- information on closed circuit television.

Fitness for duty reports (FFD)

Employers may request, under certain conditions, that an employee undertake a medical examination to identify if they are fit to return to work. The reports produced from such an examination are generally known as Fitness for Duty reports.

This page includes information about:

- requesting an existing fitness for duty report
- using a fitness for duty report, and
- consent to use a fitness for duty report.

Requesting information from employers

Introduction

We require information from employers to manage claims and make decisions.

We can only request factual and specific information or documents that an employer has in their possession, custody or control which are relevant to a management of a claim. We should not make general or broad requests for information from an employer. If we receive information that is not relevant to the claim, it must be redacted or removed entirely.

Examples of the types of information or documents that may be requested from an employer include, but are not limited to:

- information related to the employee's recovery, medical treatment and capacity for work
- leave records if required
- supervisor and/or witness statements (if required)
- normal weekly earnings (NWE) calculations
- cessation of employment details
- the employer's policies and procedures
- employment agreements
- rehabilitation reports
- current medical certificates, if not obtained from employee.

We can request information informally, (i.e. without requesting it under section 71 of the SRC Act) or formally (i.e. using section 71 of the SRC Act).

Payment of costs

There is no provision in the SRC Act authorising the payment of any costs borne by the employer in responding to a section 71 request for information by Comcare. This includes indirect or associated costs such as the fees required by the National Archives of Australia (NAA) to conduct a records search. This means Comcare will not cover employer claims for expenses associated with Comcare requests for information.

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What information Comcare can receive, send and store

Comcare technology systems are only able to receive, store and send information rated no higher than 'OFFICIAL: Sensitive'.

As outlined in our section 71 template (Letter 822 Section 71 Request Employer Statement), all employers are encouraged not to send Comcare any information containing *'PROTECTED'* or *'SECRET'* classifications.

Receiving documents with these classifications is known as a 'data spill'. If this occurs, you must follow the steps below:

1. Report the data spill. Email the IT Security Advisor (ITSA). The subject should state: *Documents marked 'Protected' (or 'Secret'/'Top Secret'). Claim number XXXX*. Attach the document/s that were sent to you. After that, do not open or interact with the document/s again. Update the metadata on the documents where possible to advise that the document is under review by ITSA to confirm classification so that it is not interacted with by other people during this process.
2. ITSA will report the data spill and contact the employer to see if the documents can be reclassified (Timelines: Comcare must wait up to 90 days for the employer's response, depending on classification – 30 days for Protected, 60 days for Secret and 90 days for Top Secret).
    a. If the employer does not respond or does not reclassify the documents, ITSA will scrub the documents from Comcare's systems. They will notify you when this is complete.
    b. If the documents are reclassified by the employer, ITSA will contact you to advise when you are able to interact with the documents again. You can also check for updates on the ticket logged by ITSA.

If you believe you require information in the provided documents to determine the claim, you need to contact the employer and advise that you have been unable to use the documents provided to you and that you require them to send the information again at an appropriate classification level. Follow the Procedure to follow up a section 71 request. This will ensure that the employee's claim is not unduly delayed while the ITSA assessment takes place.

Where information carrying a *'PROTECTED'* or *'SECRET'* classification needs to be sent to Comcare as part of the management of a claim, this can be sent by safe hands courier to Comcare's Canberra office addressed to the appropriate Comcare employee.

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When to request information informally versus formally

Whether we request information informally versus formally depends on the circumstances of the claim. Our normal approach is to request the information informally in the first instance following a conversation with the Rehabilitation Case Manager. However, there will be instances following that conversation where a formal section 71 request is required in order to gather the information.

A section 71 request is normally issued to gather information to assess liability (initial, secondary etc), and so our section 71 template letter reflects this. In most other situations, we seek information informally.

If you are unsure, please discuss with your Assistant Director and Injury Manager, and bring to a triage meeting where relevant. For further guidance, refer to the Triage page.

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Stop Clock Provisions

There are prescribed timeframes for determining claims under the *Safety, Rehabilitation and Compensation Amendment (Period for Decision-making) Regulations 2023*. The prescribed timeframes start the day that Comcare receives a claim for compensation that meets the requirements set out under section 54 and is being determined under section 14 of the SRC Act.

However, the prescribed timeframes do not apply to certain periods in which Comcare requests information or a copy of a document from the employer under section 71 of the SRC Act

The stop clock request applies on the date that Comcare provides the written section 71 request to the employer (i.e. the date that Comcare emails or sends the section 71 request to the employer).

Once the details of the stop clock request are created in the *'Manage Initial Liability Assessment'* (MILA) or *'Manage Initial Liability Task'* (MILT) dashboards, the calendar day countdown will stop.

Please refer to the Pracsys user guide: How to update 'Manage Initial Liability Assessment' (MILA) or MILT

The date that Comcare receives the required information from the employer must be used to finalise the stop clock request.

Once the stop clock request has been finalised in the MILA or MILT dashboards, the calendar countdown will recommence the next day (unless there are other stop clock requests on the claim).

Prescribed timeframes exceptions

The prescribed timeframes **do not apply to** instances where Comcare **informally** requests information from the employer regardless of whether the claim is undetermined or is a determined claim.

The prescribed timeframes also **do not apply** to instances where Comcare **formally** requests information from the employer under section 71 where:

- Comcare has already made a section 14 determination on the claim
- a new secondary condition is being determined against an existing claim
- there is a continuation of an employee's compensable condition against an existing claim.

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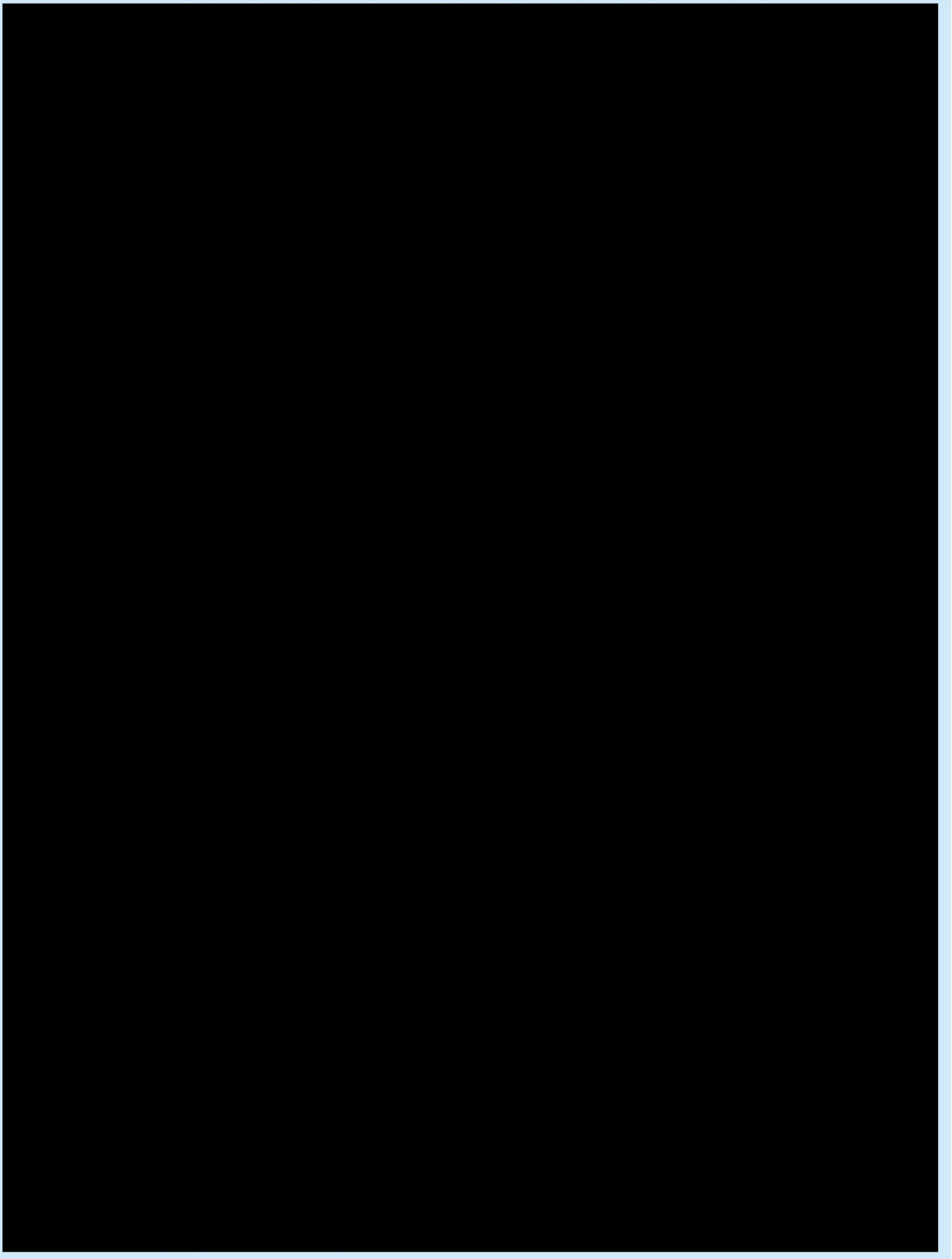

If an employer doesn’t respond to the section 71 request

While section 71 provides Comcare with the power to request information or documents, it does not provide for any powers to compel an employer to respond to that request.

If you make a request of an employer under section 71 and that employer does not respond within the timeframe set, or the received information/documents are not what you originally requested, you should follow up directly with the employer. Follow the Procedure to follow up a section 71 request.

You can, however, consider proceeding with the action on the claim at hand (such as an initial determination) without the information requested from the employer. You should discuss this with your Assistant Director in the first instance – and the claim should be taken back to triage for discussion. For further guidance, refer to the Triage page.

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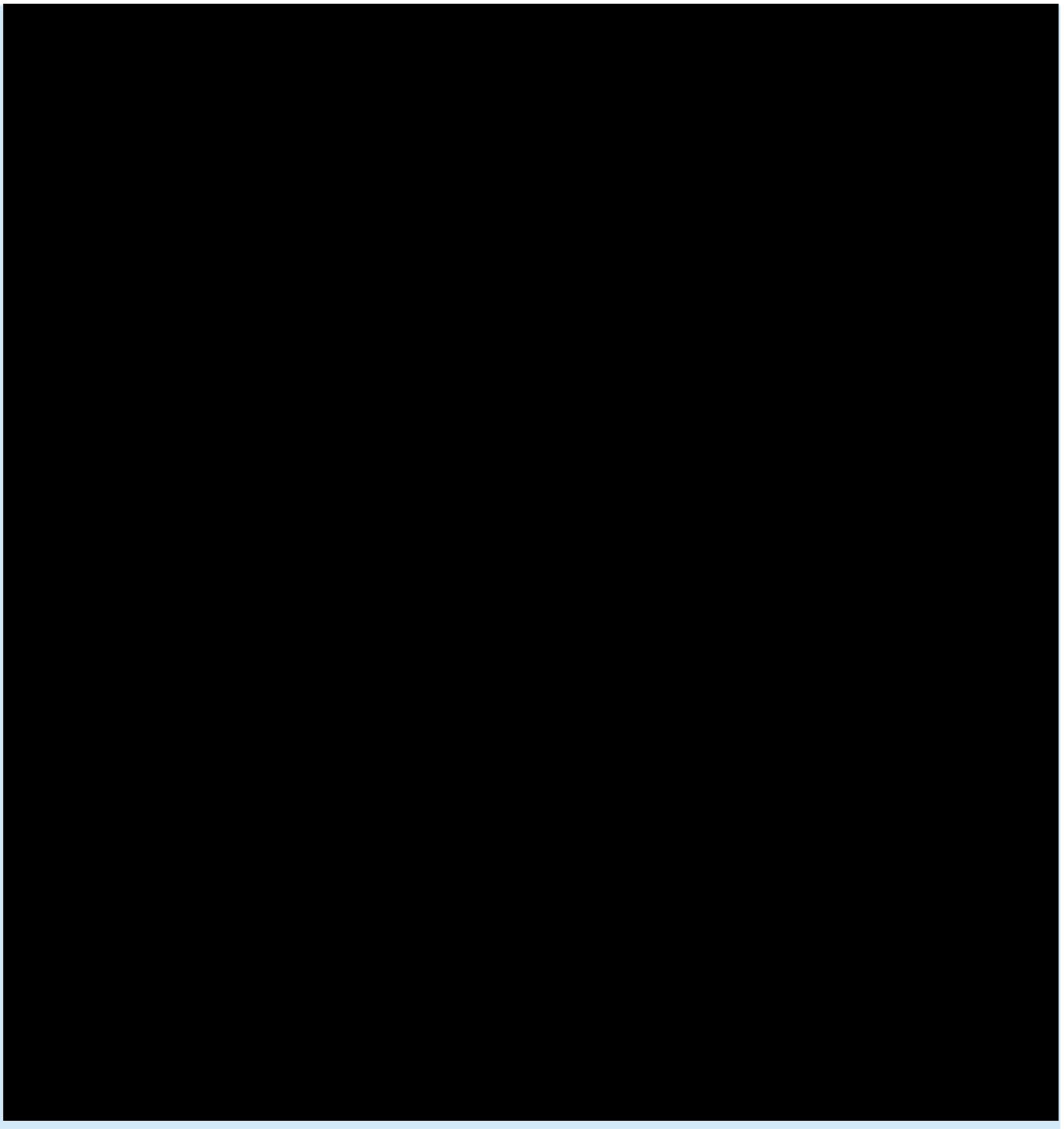

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Extension of time for a section 71 request

Following a request made under section 71, an employer may ask for an extension of time to provide the requested information or documents.

Generally, extensions are given on request provided:

1. the employer has demonstrated that they are taking action to provide the requested information, and
2. you are satisfied that the reason for the delay is reasonable.

An employer may request more than one extension of time and each request should be considered on a case by case basis.

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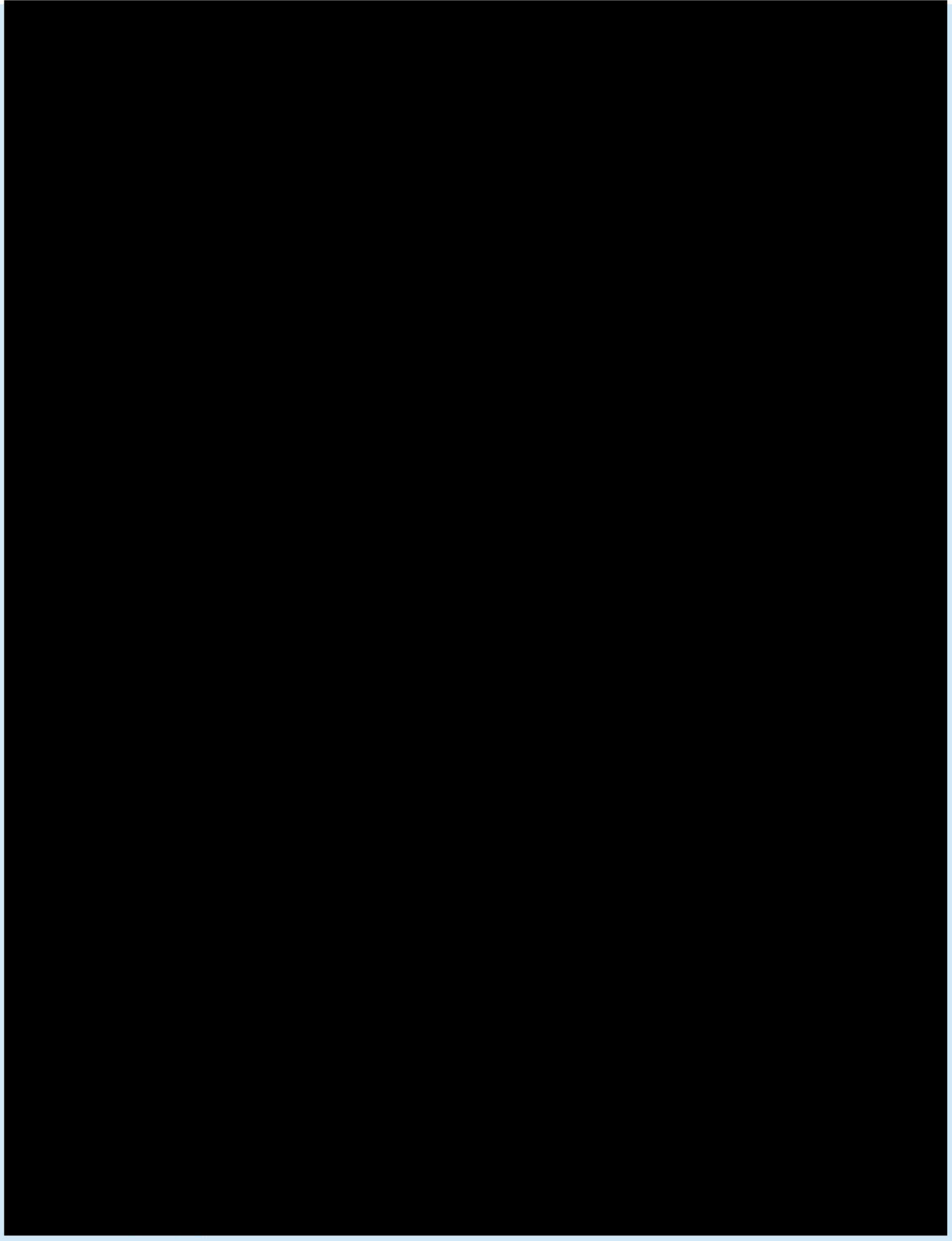

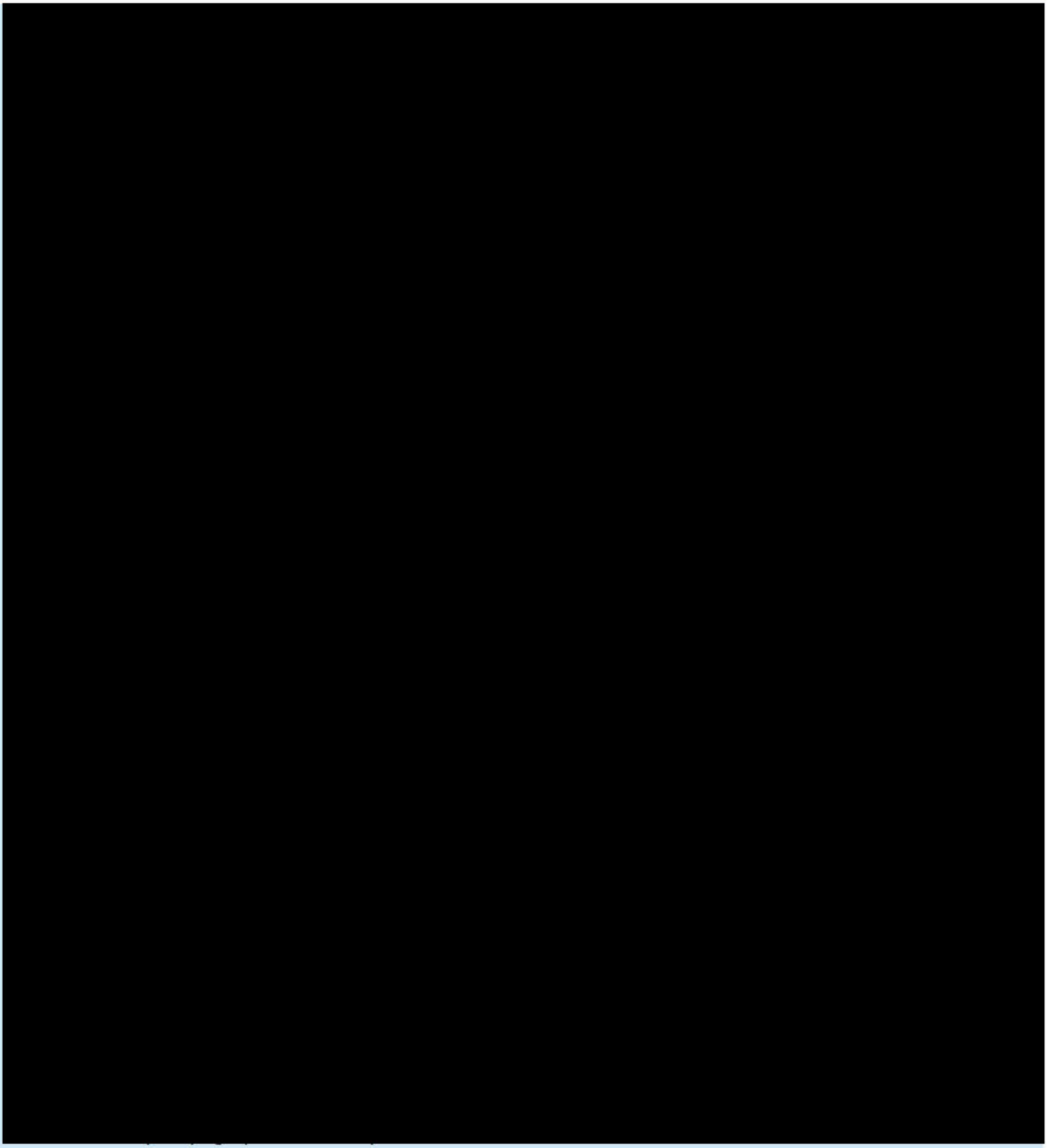

Closed circuit television

There may be cases when an employer wishes to provide closed circuit television (CCTV) footage. If this is raised, discuss with your Assistant Director.

In your conversations with the employer, you must advise the employer that for CCTV footage to be considered as part of the decision-making process it must satisfy the following requirements:

- be of a good quality

- be dated and time stamped
- clearly identify who the employee is
- be limited to the employee's workplace
- clearly demonstrate the specific claimed incident or what the employee was doing at the time of the incident
- be in a format viewable on a personal computer.

We also require a copy of the employer's policy and guidelines that provides information concerning the purpose, recording, storage, copying and distribution of CCTV footage that is captured on their premises. This is to ensure that the CCTV footage was obtained in accordance with the employer's policy and guidelines.

If a CD of CCTV is received, you will need to ensure, following consideration of its relevance and any *Privacy Act 1988* implications, a copy is scanned to the claim file.

You will also need to consider whether it is required to be provided to the employee.

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Fitness for duty reports

Introduction

Under certain conditions, an employer may ask an employee to undertake a medical examination to identify if they are fit to return to work. Employers do not need to rely on the provisions of the *Safety, Rehabilitation and Compensation Act 1988* (SRC Act) to do so, as authority is provided in the Public Service Act 1999. For non-public service employees, most employers include provision for such an assessment in employment agreements. The reports produced from such an examination are generally known as Fitness For Duty (FFD) reports.

FFD reports may be provided to Comcare as evidence to assist in making a determination under the SRC Act.

Note: FFD reports are not rehabilitation reports as they are not conducted under section 36, section 37 or section 57 of the SRC Act.

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Requesting an existing fitness for duty report

If you or the employer believes that a FFD report may be relevant to a determination under the SRC Act, you may request the report from the employer under section 71 of the SRC Act. If required, you can request a copy of the report from the employee under section 58 of the SRC Act.

As with any requests for information to determine or manage a claim, the employer and employee should be informed of what information is being requested and the reason that Comcare needs the information. Follow the procedures for formally and informally requesting information from an employee or an employer in the Requesting information from an employee and Requesting information from an employer pages.

If you request a fitness for duty report, you will need to advise the employee or employer to make any redactions of information regarding non-compensable conditions or any other personal information not directly related to the claim. This is similar to the requirements for independent medical examination (IME) requests or information from treating medical professionals.

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How can Comcare use a fitness for duty report?

Comcare **cannot use a FFD report as the sole evidence** in determining an entitlement. This is because it does not usually address issues such as the requirement for treatment, or whether a condition is work-related. A FFD report may be useful in situations where the report conflicts with a treating legally qualified medical practitioner's (LQMP's) opinion. In cases such as these, further medical evidence should be sought.

Where a FFD report is sought but not used as evidence in making a determination
Once received, Comcare cannot 'return' a document as it forms part of the Commonwealth record. The document should be redacted on Pracsys. Alternatively, assistance can be sought from

Information Management Helpdesk to save the report in Content Manager (as Comcare has an obligation to keep a copy under the Archive Act). If further advice is required, please email Legal.Helpdesk.

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Consent to use a fitness for duty report

Comcare is authorised to collect information from third parties when it is connected to a claim activity. You will only make the request for the FFD report if you consider it relevant to making a determination on a claim. You are therefore authorised to do this under the SRC Act, regardless of whether you have consent from the employee.

However, it is better practice to ensure the employee is aware when Comcare is requesting information on their claim. Follow the procedures for formally and informally requesting information in the Requesting information from an employee and Requesting information from an employer pages.

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Requesting information from medical and allied health practitioners

Requesting information from medical and allied health practitioners

Health practitioners play an important role in the workers' compensation process. The information they provide is critical in making effective initial and ongoing liability decisions on claims as well as supporting returning the employee to health and, where possible, work.

The pages in this section provide guidance on when and how to request medical information such as medical reports, clinical notes, medical imaging reports, home-based assessments, vocational assessments and labour market assessments.

Roles and responsibilities

The Claims Manager is responsible for assessing when medical evidence or an assessment outlined in this section is required. You should consult with an Injury Manager when considering whether to obtain additional medical information or assessments, and what type of assessment or information is appropriate for determining the claim.

In this section

Obtaining a medical certificate

Medical certificates are a key part of the workers compensation process. They are required to lodge a workers' compensation claim and used to assist with assessing initial liability as well as liability for medical treatment, incapacity payments, and developing rehabilitation plans.

This page provides the following information:

- What medical certificates are.
- Required information to make a medical certificate compliant.
- What to do when a medical certificate is not available or partially completed.
- Information about medical certificates from an allied health practitioner.
- Retrospective medical certificates.
- Backdated medical certificates.
- Payment of medical certificate fees.
- Procedure to action a medical certificate
- Actioning a medical certificate for a rejected claim.
- Procedure to process a medical certificate on a rejected claim.

Obtaining medical investigation reports

Medical imaging investigations are often requested by health practitioners to confirm a diagnosis or identify new or pre-existing conditions.

This page provides the following information:

- Considering whether medical imaging is appropriate.

- Procedure to action a medical imaging report

Undertaking a labour market assessment

Comcare may need to investigate the state of the labour market when determining an employee's ability to earn, as part of determining incapacity entitlements.

This page provides the following information:

- When a labour market assessment may be needed.
- Fitness and competency of the employee to work.
- Arranging a labour market assessment.
- Paying for a labour market assessment.
- Investigating the labour market.
- Employees who have moved.
- Privacy considerations.

Obtaining a medical report or clinical notes

To assist with the management of a claim and the employee's return to health and work, a claims manager may need to request a medical report and/or clinical records in relation to the claimed condition.

This page contains the following information:

When to request a medical report.

- When to request clinical notes.
- Urgent requests for reports or clinical notes.
- Stop Clock provisions.
- Medical report questions, including Types of information to request in a medical report.
- Examples of medical report questions.
- Procedure to request a medical report or clinical notes.
- Cancelling a medical report, including Procedure to cancel a medical report.
- Payment of medical reports and clinical notes.
- Procedure to approve payment for a medical report or clinical notes.
- Unsolicited medical reports, including Procedure to action an unsolicited medical report.

Undertaking a home-based assessment

Comcare can arrange home assessments to identify the household services (including childcare), attendant care services, alterations or modifications, or home-based aids or appliances that are most appropriate for the employee's compensable injury, stage of recovery and household circumstances.

This page provides information on the following:

- When home-based assessments are conducted and what is included.
- Procedure to arrange a home-based assessment.

Obtaining a medical certificate

Introduction

A medical certificate is the primary form of medical evidence used by employees to support claims for medical treatment, incapacity payments and other benefits.

A medical certificate known as a Certificate of Capacity must be provided by a legally qualified medical practitioner (LQMP). If the employee is only claiming for medical treatment, a treatment plan or certificate from the provider of the treatment being claimed is accepted.

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Required information to make a medical certificate compliant

The SRC Act does not specify what form a medical certificate is to take (refer to section 54(2)(b)).

Comcare's Certificate of capacity is the preferred form. Comcare's Certificate of capacity enables GPs to consider work as part of recovery and focuses on what employees can do at work. Comcare will also accept worker's compensation medical certificates from state schemes, as well as any other type of medical certificate that has been issued by a legally qualified medical practitioner (LQMP).
To support proper management of the claim, a medical certificate should normally:

- Include the employee's details
- provide the date of actual examination
- state the precise diagnosis
- state the symptoms of the injury/disease
- provide the date the injury was sustained, or the disease was contracted
- provide the cause of the injury or the disease
- Include the date(s) when the patient is (or was) unfit for work
- Include recommendations/restrictions on capacity, even if certified unfit for work
- Include a review date
- list the treatment required
- be signed by the LQMP who examined the employee
- include the practice stamp or contact details.

When you are referring to a medical certificate to support decision making, the focus should be on the information provided by the LQMP, rather than the format or technicalities of the certificate.

Where you think a medical certificate is non-compliant, please visit the 'Just Ask' process page for further information.

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Medical certificate is not available or partially completed

If there is a problem with a medical certificate, you need to display empathy, sensitivity and sound judgment in deciding the correct course of action.

Late certificate

An employee claiming income support must provide a supporting medical certificate from a LQMP. However, you may encounter a situation where a medical certificate has expired, and the employee has not provided a new certificate despite regular contact with you or your predecessor.

Where there is a reasonable delay due to issues such as the availability of a LQMP, Comcare may, having regard for the merits of the case, temporarily extend a treatment plan based on other current medical information. This could include:

- recent independent medical examination (IME) reports
- treating practitioner or specialist reports.

You should support the employee to obtain a medical certificate as soon as possible and stay in regular communication.

Partially completed certificate

You may receive a medical certificate that does not provide certain specific information. In this case, you should make an assessment and not defer a compensation decision due to technicalities. However, if you are unable to determine compensation due to a lack of information, then you should refer to the What is medical treatment? and/or Incapacity for work pages and discuss the claim with your Assistant Director. You may need to gather more information from the employee, the LQMP or other sources to make the decision.

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Medical certificate from an allied health provider

If an employee is only claiming for treatment from an Allied health professional, they can provide a medical certificate from the allied health provider stating a precise diagnosis and cause for the injury or illness.

The allied health provider must be registered under the law of a state or territory that provides for the registration of health services. This includes:

- Acupuncturist
- Audiologist
- Chiropractor
- Dietician
- Exercise physiologist
- Occupational therapist
- Optometrist
- Osteopath
- Physiotherapist
- Podiatrist
- Psychologist
- Social Worker
- Speech Therapist.

The provider should only issue a certificate recommending treatment in their field of practice.

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Retrospective medical certificate

A retrospective medical certificate is signed and dated on the consultation date but certifies that in the LQMP's opinion, the employee was unwell before the day of the consultation.

Example: A LQMP sees the employee on 22 October and signs the medical certificate on 22 October, but states the person was unable to work from 11 October.

A retrospective medical certificate is valid and should generally be accepted. However, it should contain information supporting the incapacity. In the unlikely event there is insufficient medical evidence to explain the certificate, consult with your Assistant Director and/or arrange a triage meeting to review the matter further.

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Backdated medical certificate

A backdated medical certificate is one where a LQMP signs and dates a certificate as if the consultation occurred on an earlier date.

Example: A doctor sees an employee on 30 September but indicates on the certificate that the consultation occurred on 15 September.

In general, compensation should not be paid based on a backdated certificate. The Australian Medical Association's guidelines in relation to medical certificates state that certificates must be dated on the day on which they were written. Under no circumstances should certificates be backdated.

You should discuss a back-dated medical certificate with your Assistant Director or the Injury Management team.

Please see the AMA guidelines for medical certificates for further information.

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Payment of medical certificate fees

Comcare will only pay a certificate fee in NSW and the NT for an initial consultation. This is in line with standard billing arrangements in these states. Further certificate fees after the initial consultation are not payable. All other states incorporate the cost of certificates into their fee structures.

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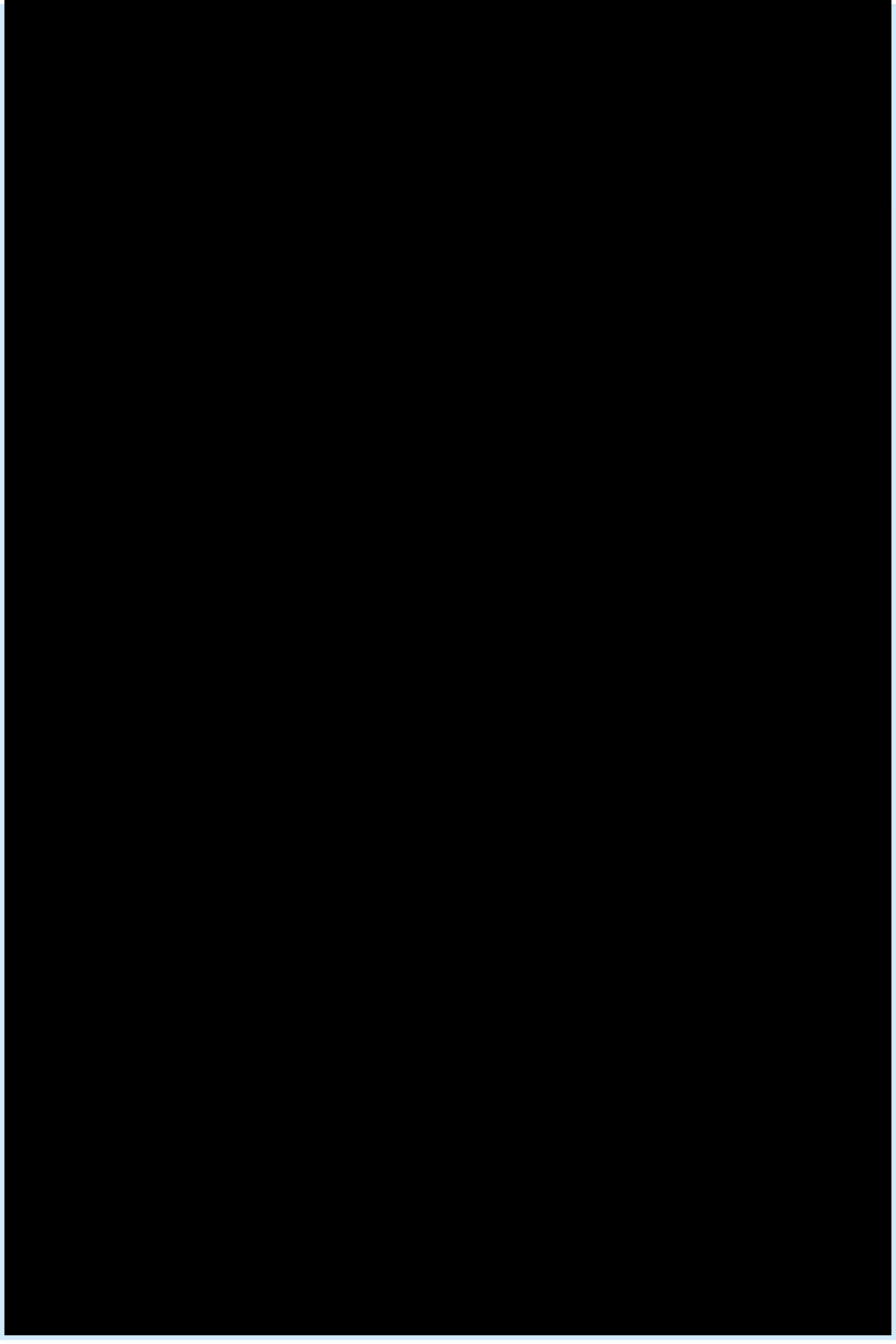

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Actioning a medical certificate for a rejected claim

An employee, employer, or a medical practitioner may submit a medical certificate after liability for a claim has been denied under section 14 of the SRC Act. When a claim has been rejected under section 14, there is no liability for any benefits.

Medical certificates for a rejected claim may be received in situations where:

- a new claim was declined but the LQMP continues to issue medical certificates
- an employee has requested a reconsideration concerning the rejection of liability
- an appeal of a reviewable decision is lodged through the Administrative Review Tribunal (ART).

Where a medical certificate is received for a rejected claim, follow the Procedure to process a medical certificate for a rejected claim.

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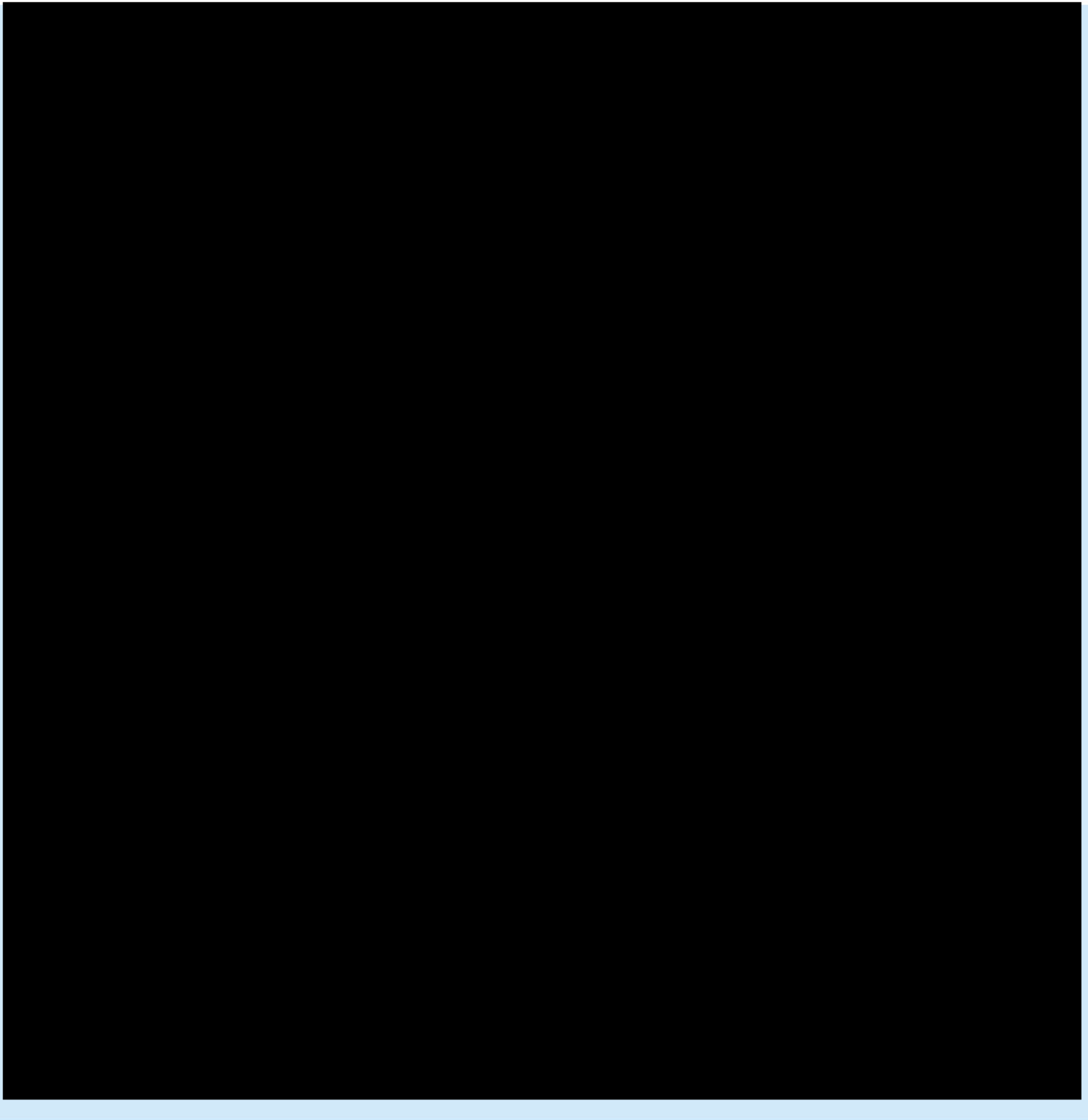

Obtaining a medical report or clinical notes

Introduction

Medical reports and clinical notes can assist with management of a claim and an employee's recovery and return to work (see above links for definitions).

You can request a medical report or clinical notes from any treating practitioner the employee currently consults or previously consulted about their claimed condition. This may include their general practitioner, a specialist, or allied health professional.

You should consult with the Injury Manager to decide on the most appropriate practitioner to obtain the report or clinical notes from.

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When to request a medical report

There are a range of circumstances where you may need to request a medical report, including:

- to assist with an initial claim determination
- as part of a regular claim review
- when treatment and/or treatment goals have changed
- when new or different treatment is requested
- when treatment is not progressing as expected or as outlined in MD Guidelines
- before arranging a medical examination (section 57)
- If you would like an update on the employee's compensable condition or need to investigate an aspect of a claim
- If you receive information that the employee may no longer be suffering from their compensable condition
- when there is conflicting medical information on file that you would like to obtain the medical practitioner's views on.

There are other circumstances where requesting a medical report may be warranted. If you are unsure, you should discuss the claim further with your Assistant Director and the Injury Manager.

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When to request clinical notes

Before requesting clinical notes, you should be clear on the reason and purpose for obtaining clinical notes. You should first review the information available on the claim file and determine what further information is required. Then decide if this information can be addressed by requesting a medical report, or by a telephone conversation with the medical practitioner. In most instances, these methods should be sufficient to obtain the necessary medical information.

There are occasionally circumstances where you may determine clinical notes would be beneficial. These may include:

- where there is information or concern about a relevant pre-existing condition, and you have been unable to establish details relating to that condition via a medical report or phone call to the doctor
- where you have been unable to obtain a report from the treating practitioner
- where information you have is inconsistent and you need to establish what was reported to a treating practitioner and the date that the employee sought treatment/first reported symptoms.
- as part of the information gathering process in determining a claim or newly reported condition. This may be a more time efficient option than requesting a medical report.

Before seeking clinical notes, you must have a reasonable expectation that the clinical notes will provide the necessary information. You should liaise with your Injury Manager and Assistant Director as to who to request clinical notes from and for what time period.

Relevant clinical notes only

When requesting clinical notes, you should only request clinical information that relates to the specific claim made by the employee. The request should outline the time period required and the reason for the request. To ensure privacy is maintained in accordance with the *Privacy Act 1988*, the information provided by the practitioner should not include any information that is not relevant to the claim. Refer to the Privacy pages on Comcare's website for further information.

If you have any questions in relation to clinical notes received, you should discuss this with your Assistant Director. Further advice can be obtained from the Privacy team if required.

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Urgent requests for reports or clinical notes

There may be circumstances where you require medical information urgently. This may be when a decision needs to be made regarding initial liability or you have received an urgent request for medical treatment or surgery.

You should work collaboratively with the Injury Manager to contact the legally qualified medical practitioner (LQMP) or relevant treating practitioner and request an urgent response. Contact should first be made by telephone and can be followed by email contact. The LQMP should be made aware of the reasons for an urgent response, and you should be clear on your expectation to receive information from them within 1 week.

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Stop Clock Provisions

There are prescribed timeframes for determining initial liability claims under the *Safety, Rehabilitation and Compensation Amendment (Period for Decision-making) Regulations 2023*. The prescribed timeframes start on the day that Comcare receives a claim for compensation that meets the requirements set out under section 54 and that is determined under section 14 of the SRC Act.

However, the prescribed timeframes do not apply to certain periods in which Comcare seeks further information or documentation in relation to the claim. During these periods, the 'clock' or timeframe countdown is paused while the information is obtained. These stop clock provisions include where Comcare requests medical evidence from:

- the employee's treating legally qualified medical practitioner (LQMP), e.g. GP, specialist, psychiatrist, or dentist
  or
- a legally qualified medical practitioner nominated by Comcare, e.g. a supplementary report from an Independent Medical Examiner (IME).

In these instances, the stop clock action starts on the date that Comcare requests the medical evidence from the LQMP or IME.

The details of the stop clock action need to be created in the '*Manage Initial Liability Assessment*' (MILA) or '*Manage Initial Liability Task*' (MILT) dashboards.

Once the details are added to the MILA or MILT dashboards, this will stop the calendar day countdown.

The date that Comcare receives the required information from the LQMP or IME (or cancels the request for the report) must be used to finalise the stop clock action.

Once the stop clock action has been finalised in the MILA or MILT dashboards, the calendar countdown will recommence the next day (unless there are other stop clock actions on the claim).

Please note: The prescribed timeframes **do not apply to** instances where Comcare requests information from allied health professionals including psychologists **even if the claim is undetermined (initial liability claim or reconsideration).**

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Medical Report Questions

When requesting a medical report, you should be clear about the information you are requesting from the practitioner. The questions included should be targeted and formatted clearly, but not leading.

You should not assume the practitioner knows the SRC Act and/or Comcare's requirements.

You should first decide the purpose of the report. For example, the report may be:

- part of a claim review
- to assist an initial liability determination for a new injury/disease claim
- part of an investigation into a specific aspect of a claim
- to determine whether the employee is still suffering from their compensable condition
- to gain information on an employee's rehabilitation and return to work progress.

You should then work with the Injury Manager to tailor the questions and provide relevant information to the practitioner to ensure they provide useful information for the management of the claim. You may also consider using information from MD Guidelines to understand the compensable condition and determine appropriate questions to ask the practitioner.

It is important that a question is asked in a way that allows the practitioner to elaborate and provide context and clinical justification for their answer where relevant. Medical answers are not always 'yes' or 'no' depending on the circumstances. The practitioner should provide an explanation or justification for their opinion.

Types of information to request in a medical report

The following table provides guidance on the type of questions that should be included in a medical report request based on the purpose of the report.

Report purpose ...	Questions relating to ...
Initial determination	Injury • Details of the injury • How it is related to employment (whether and how the injury arose out of or in the course of employment) • Any pre-existing or underlying conditions that may have contributed to the condition • Treatment received or recommended for the condition • Rehabilitation or return to work potential • Diagnostic formulation, i.e. what history, signs, symptoms, assessments and/or tests and other factors (including any pre-existing or underlying conditions) they considered when forming their diagnosis • Clinical information and/or level 1 or 2 medical evidence should be requested to support medical opinion where appropriate Disease (including psychological) • Details of the disease, including any diagnostic criteria used to define it • How it is related to employment, including the degree of contribution of employment to the disease (before 13 April 2007: employment must have contributed to the claimed condition to a material degree; on or after 13 April 2007: employment must have contributed to the claimed condition to a significant degree). • Any pre-existing or underlying conditions that may have contributed to the disease • Treatment received or recommended for the condition • Rehabilitation or return to work potential • Diagnostic formulation, i.e. what history, signs, symptoms, assessments and/or tests and other factors (including any pre-existing or underlying conditions) they considered when forming their diagnosis • Clinical information should be requested to support medical opinion where appropriate
Claim review	• History of the employee's condition as reported to the practitioner • Details of treatment received and outcomes achieved • Recommended ongoing treatment, including clinical justification • Ability to undertake rehabilitation or return to work • Prognosis for recovery • Ongoing employment contribution

Treatment	• Details of treatment received and outcomes achieved • The treatment options • Recommended treatment, including clinical justification • Timeframes and goals and objectives for ongoing treatment
Rehabilitation and return to work	• Ability to undertake the rehabilitation or return to work in *any* employment • Current return to work progress (if any) • Barriers to return to work and recommended strategies • Timeframes for rehabilitation or return to work • Functional capacity and relevant goals
Permanent impairment	• The degree of the employee's permanent impairment as a result of the accepted condition. • The effect the permanent impairment has had on the employee's daily living/functional capacity

Examples of medical report questions

The following questions are provided as a guide for claims managers only. You should always ensure the questions are specific/tailored and relevant.

Note these questions are also relevant for Independent medical examinations.

Diagnosis and prognosis

What is the specific diagnosis of the condition (employee) currently suffers from? Please provide:

- a short description of the condition, including clinical signs and symptoms and diagnostic test results to support your conclusion
- the history of (employee)'s condition as reported to you
- the date (employee) first consulted with you regarding the claimed condition, or the date you consider they were first impaired as a result of their condition
- the prognosis for (employee's) claimed condition?

If (employee's) condition has already resolved, please provide details (where possible) of the condition.

Employment relationship

Injury

How was the injury sustained? Please provide specific details, including where the injury occurred.

Disease/psychological claim

In your opinion, what are the specific incidents both employment and non-employment related that have caused or aggravated (employee)'s condition?

Please list the employment and non employment incidents separately and specify when they occurred. Also, if possible, please specify the level of contribution for each incident.

Does (employee) suffer a pre-existing or underlying condition(s) relevant to the claimed condition? And, if applicable, do you consider the current condition suffered by (employee) is an aggravation of the pre-existing or underlying condition?

Please provide details of any relevant history, pre-existing or underlying conditions suffered by (employee), including any predisposition to stressors.

Previous claim

Is the condition currently suffered by (employee) a result of their accepted claim for (previous accepted condition) which occurred on (date)? Or is the current condition a result of a new set of circumstances? Please detail your response.

Old claim

If (employee's) initial condition has been superseded by a different condition, please provide your opinion on what factors have contributed to the different condition.

If you consider (employee's) employment continues to contribute to their condition, please explain the basis of your conclusion, having regard to the fact the employment incident occurred on (date of injury).

Treatment

In your opinion, what form of medical treatment is indicated for the employment-related aspects of the condition? Please address:

- the need for medication
- the frequency and duration of reasonable medical treatment required
- outcomes achieved by treatment to date (including pre and post treatment data/evidence)
- goals and objectives of treatment.

Have you referred (employee) to a specialist or other treatment provider? If yes, please provide specific details (i.e. treatment, frequency and commencement date).

Please note: When considering the reasonableness of medical treatment Comcare has regard to the Clinical Framework for the Delivery of Health Services (Clinical Framework) which outlines a set of guiding principles for the delivery of healthcare services to injured employees. The principles ensure that the provision of healthcare services is goal orientated, evidence based and clinically justified.

Please refer to the Clinical Framework available on Comcare's website when addressing the requirement for medical treatment in relation to the employee's compensable condition.

Rehabilitation and capacity for work

Does (employee) have a capacity to engage in some form of employment? If so, please identify the type of duties (employee) could undertake, in particular:

- the type of work they should be able to perform
- the number of hours per week they should be able to work
- details of any restrictions including non-work-related restrictions

If the employee is not fit to return to work at this time, please comment on any rehabilitation assistance that Comcare or their employer could provide to assist (employee)in returning to work, including any strategies to overcome current barriers.

If (employee) is not fit for work, when do you think that (he/she) would be able to undertake a rehabilitation program or some form of employment?

Is (employee) capable of undertaking a rehabilitation program? If so, please advise:

- whether the program should be graduated (if yes, please provide a schedule of weekly working hours)
- details of any work restrictions
- a timeframe in which return to normal working hours could be achieved.

Are there any other factors causing inability to work or work restrictions? If so, please provide details.

Note for the Claims Manager: Attach information about (employee's) pre-injury duties and the alternate duties that are available where relevant.

Permanent impairment psychological condition

Psychiatric impairments are assessed using Table 5.1 "Description of Level of Impairment" and Figure 5-A: "Activities of Daily Living" of the Approved Guide (2023) - Guide to the Assessment of the Degree of PI - Edition 3.0 (the Guide).

Before the assessment, please read:

- the definitions on page 2 of the Guide
- the Introduction to Edition 3.0 of the Guide on pages 4 to 6
- the Principles of Assessment on pages 7 to 11 of the Guide
- Chapter 5 – Psychiatric Conditions: Figure 5-A: Activities of Daily Living on page 34 of the Guide
- Table 5.1 – Descriptions of Level of Impairment on pages 34 and 35 of the Guide.

Does (employee) suffer from an impairment? If so, is the impairment permanent? In providing reasons for your opinion please comment on:

- whether the impairment is likely to continue indefinitely and is stable
- the likelihood, if any, of an improvement in the employee's condition
- whether the impairment could be improved by further medical or rehabilitative treatment. If so, what treatment do you recommend?

Referring to Table 5.1 of the Guide, please provide your assessment of the degree of permanent impairment having regard to the Activities of Daily Living as defined in Figure 5-A (page 34 of the Guide).

- Please note that an assessment above 10% requires you to consider whether the injured worker demonstrates a "need" for supervision and direction in activities of daily living as defined in the Guide. The terms "supervision" and "direction" are conjunctive and both must be present.

- In answering which activities of daily living, as defined in Figure 5-A, require supervision and direction, could you please assume that direction means:

    - the injured worker could not perform the activity independently
    - there is a requirement for some form of instruction as distinct from mere encouragement in carrying out the activity of daily living

    - there is a need for some form of intrusive management by a person with the necessary experience and skills
    - the injured worker needs the decision to be made for them as to when and how to engage in the activity.

Is (employee) able to undertake activities of daily living independently? If unable to do so, does the injured worker require supervision, direction or assistance to undertake the activities of daily living? Please have regard to the information set out in the previous question when providing your response.

Which activities of daily living does (employee) require supervision and direction for? Please elaborate with examples of the nature of support required.

If (employee) has a pre-existing psychiatric condition:

- are you able to isolate the effects of the pre-existing condition which was contributed to by other factors not related to the compensable incident?
- please provide a rating of permanent impairment solely for the pre-existing condition in accordance with Table 5.1 of the Guide. Please give reasons for your opinion.
- if you cannot isolate the effects of the employment-related impairment, please give an overall assessment for psychiatric impairment based on Table 5.1 of the Guide.

Please consider the attached Compensation claim for permanent impairment and non-economic loss form supplied by the employee and provide your opinion on:

- the rating provided by the employee, and
- whether the ratings are consistent with the degree of the permanent impairment claimed in relation to the compensable condition. Please provide your score and reasons for each of the sections, i.e. pain, suffering etc.

Permanent impairment physical condition

Does (employee) suffer from an impairment? If so, is the impairment permanent? In providing reasons for your opinion please comment on:

- whether the impairment is likely to continue indefinitely and is stable.
- the likelihood, if any, of an improvement in (employee's) condition.
- whether the impairment could be improved by further medical or rehabilitative treatment. If so, what treatment do you recommend?

If (employee) suffers an impairment which you believe to be permanent, what is the percentage of impairment to the body part(s), system(s) or function(s) resulting from the injury? Please provide reasons for your opinion with reference to the relevant table/s of the Guide.

Is it probable (employee's) condition will deteriorate further resulting in an increase to the overall percentage of impairment? If so, over what period of time would you expect this deterioration to occur?

Please consider the attached Compensation claim for permanent impairment and non economic loss form supplied by (employee) and provide your opinion on:

- the rating provided by the employee
- whether the ratings are consistent with the degree of the permanent impairment claimed in relation to the compensable condition. Please provide your score and reasons for each of the

sections, i.e. pain, suffering etc.

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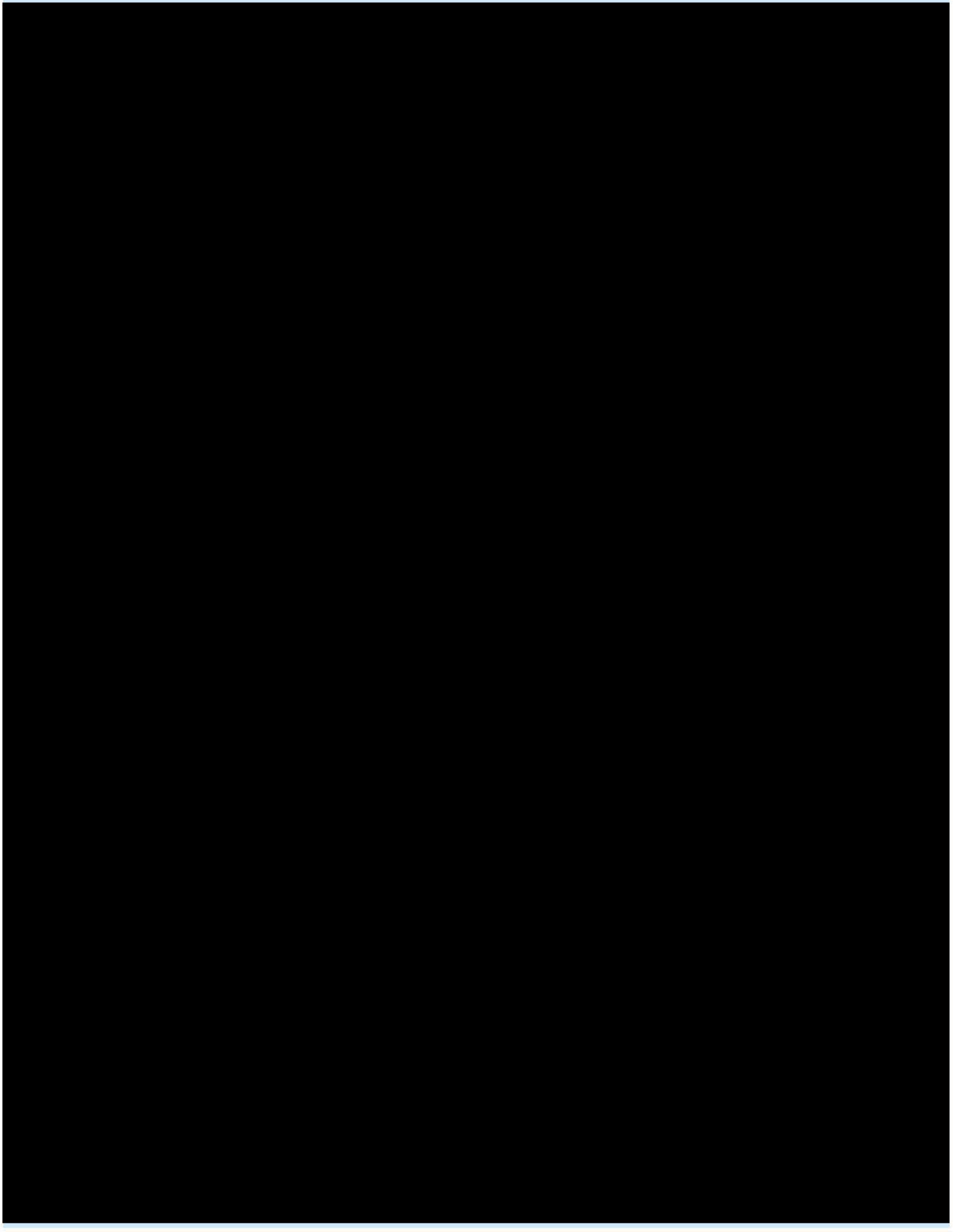

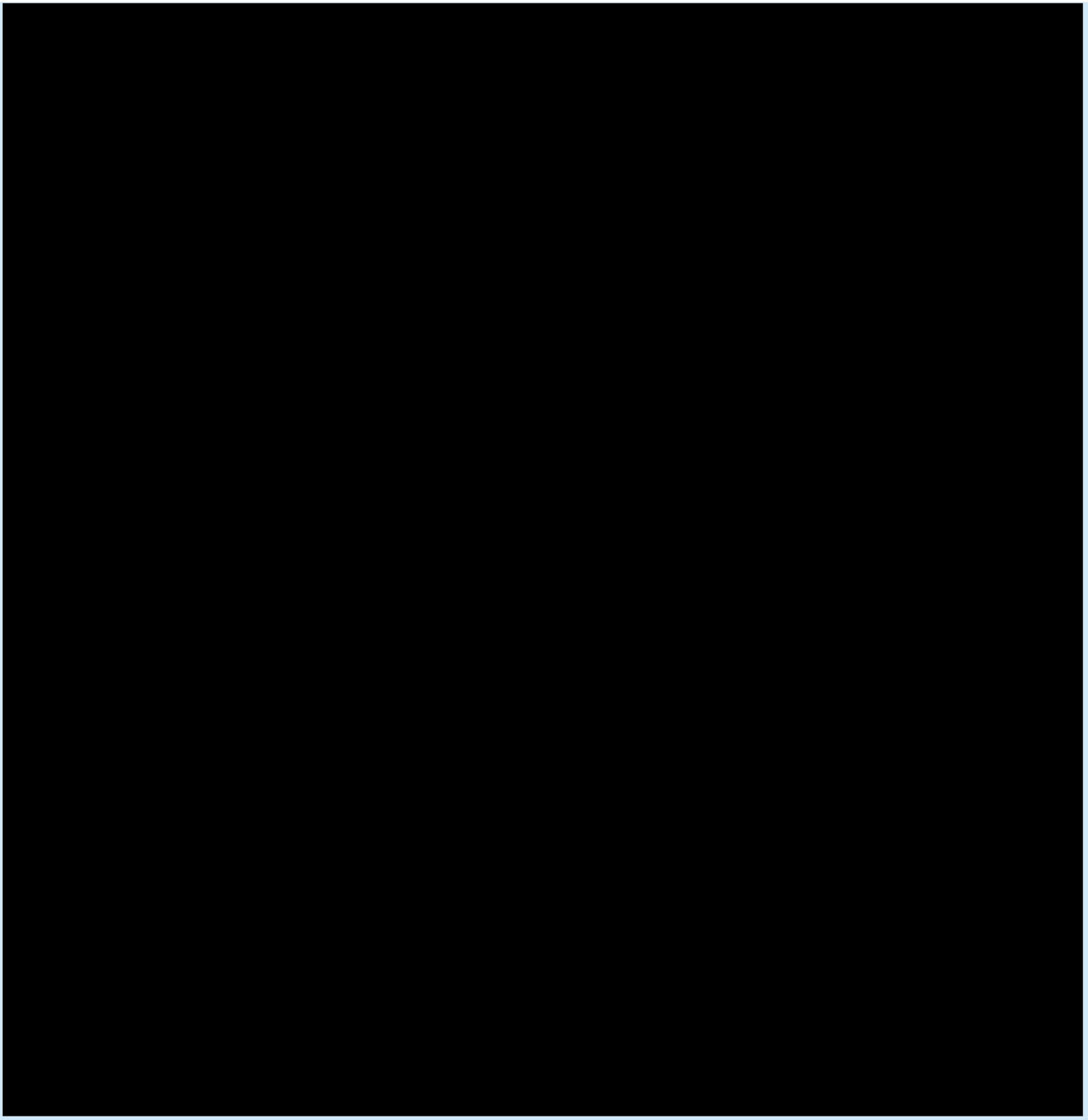

Cancelling a medical report

There may be circumstances where a medical report has not been received within requested timeframes and a decision needs to be made in respect of the employee's claim.

In these instances, the medical report may be cancelled.

If the practitioner has already written the medical report, you cannot cancel the request. The report should be obtained, and the practitioner reimbursed accordingly.

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Payment of medical reports and clinical notes

When you request a medical report or clinical notes from a treating practitioner or hospital there will usually be a fee involved for the preparation of the report or clinical notes. Although Comcare prefers to pay on receipt of the report, prepayment is possible if requested.

Where a medical report or clinical notes are requested from a treating practitioner or hospital, payment is made under section 70 of the SRC Act.

A practitioner or hospital may request pre-payment of a medical report or clinical notes before they have started writing the report. Or they may have already written the report but will not release it until they receive payment.

An employee should not be disadvantaged by the fact that their treating practitioner will not write or release the report or clinical notes without pre-payment. Comcare will, if requested, pre-pay for medical reports or clinical notes. When considering requests for pre-payment a Claims Manager needs to contact the practitioner and agree on a fee and timeframe.

When a pre-paid report is provided to Comcare, the Claims Manager needs to ensure they are happy with the quality of the report and follow up as required with the practitioner to ensure that they provide a report that adequately answers the questions asked.

Invoices for report fees are entered into Pracsys. Reports and clinical notes should be paid under the following cost code:

- Source of report: Treating practitioner (other than section 57)
- Cost code: Claim Inv-Med rep/clinical notes
- Relevant SRC Act section: section 70.

What are appropriate costs for medical reports?

The following information can be used to assist in negotiating a fee for preparation of a report (where a report is to be pre-paid) and as a guide to what you can expect to pay for medical reports. Ultimately, the quality of the report is likely to be the area for negotiation with the practitioner rather than the cost.

Variance in report costs could be due to different factors including, but not limited to:

- the number of questions asked

- the qualifications of the treating practitioner (a specialist opinion would generally cost more than a GP or physiotherapist)
- the complexity of the claim
- the research required
- the time taken to complete the report
- the level of detail provided (including reference and consideration of the Clinical Framework principles)
- out-of-hours loading (time out of hours used to prepare report).

Generally, practitioners should be advised that charges for reports should be in accordance with fee schedules established by State and Territory workers' compensation authorities. When assessing whether the cost of a medical report is appropriate, you should refer to the fee schedule in the relevant State/Territory and the factors outlined above.

Some States/Territories do not have fee schedules for medical reports. In this instance you can use the rates of the other States/Territories to establish if the fee being charged is reasonable.

Appropriate costs for clinical notes

The following information can be used to assist in negotiating a fee for preparation of clinical notes (where clinical notes are to be pre-paid) and as a guide to what Comcare can expect to pay for clinical notes.

Variance in clinical notes costs could be due to different factors including, but not limited to:

- the number of pages
- photocopying charges (i.e. cost of each photocopy)
- search fee (i.e. if a search for a particular record is required)
- costs associated with the postage and handling of the clinical notes
- labour costs (i.e. time taken for administrative staff to copy/print the records etc)
- time taken for the treating practitioner to review the patient's file to determine which clinical notes can be released that are relevant to the employee's claimed condition.

Note: Medical reports and clinical notes requested by Comcare attract the Goods and Services Tax (GST).

However, Comcare can only pay the GST component charged by the treating practitioner, if the treating practitioner (or their practice) has **an active ABN that includes a current GST registration**.

See: Goods and Services Tax (GST) for further information.

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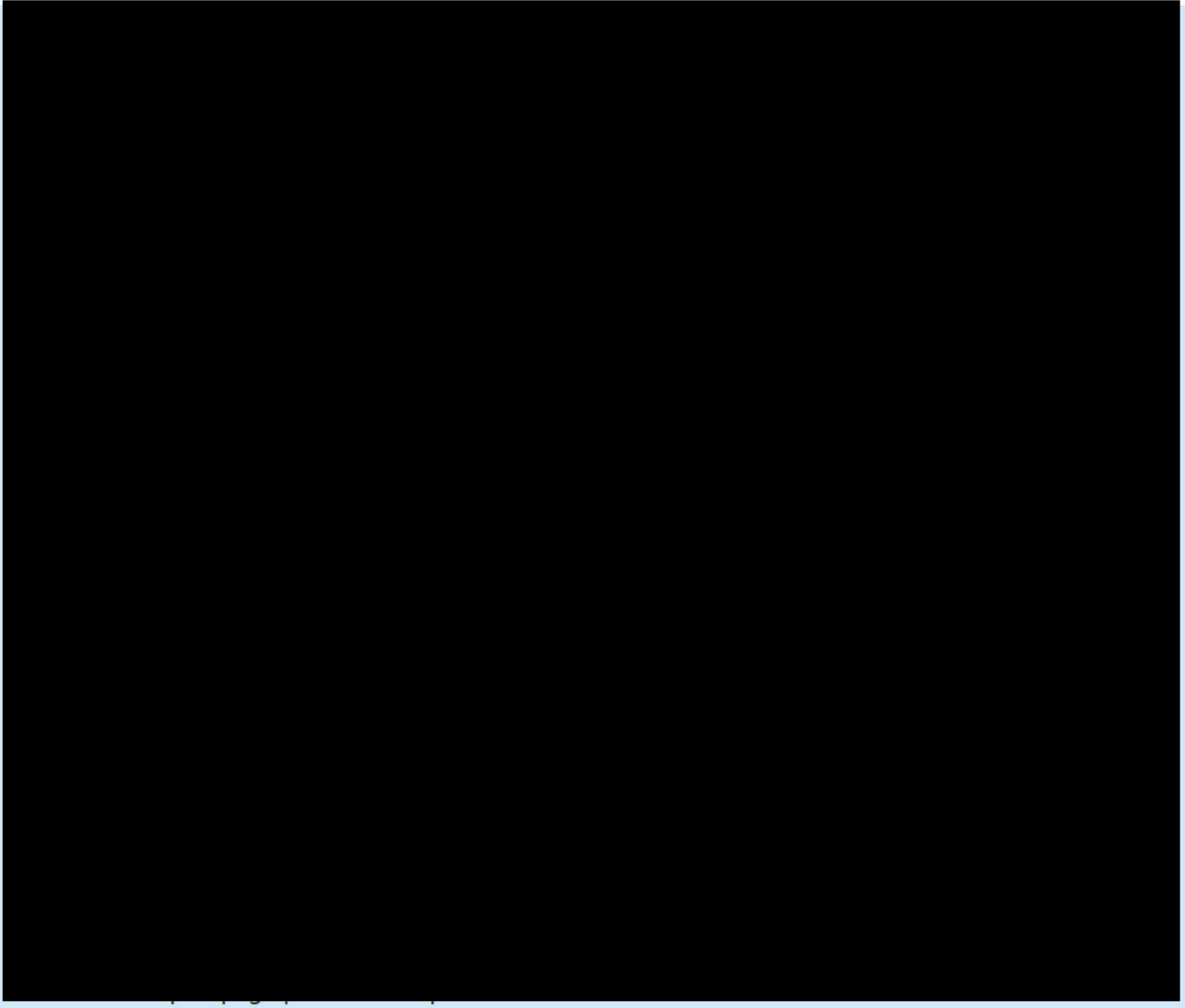

Unsolicited medical reports

An unsolicited medical report is a report obtained or provided by someone other than Comcare, such as an employee or their legal representative.

You may receive an unsolicited medical report if an employee attends a medical appointment without being requested by Comcare and asks the practitioner to provide a medical report. An employee may also be instructed by their solicitor to attend a medical appointment and ask the practitioner to provide a report.

When an unsolicited medical report is received, you must evaluate the information contained in the report. You need to check whether it provides information relevant to the employee's injury that is not already available on the claim file. You then need to decide whether the information can be used in making a decision on the claim.

Where authorised, claim investigation expenses, including payments for unsolicited medical reports, are paid under section 70 of the SRC Act. Section 70 states that Comcare has the power to do all things necessary or convenient to be done for or in connection with the performance of its functions.

The authorisation for payment of unsolicited medical reports rests with the General Manager of the Claims Management Group, who has delegation under section 70 of the SRC Act.

Example

An employee has requested a reconsideration of a determination to decline liability for medical treatment and obtains a medical report to support their reconsideration request.

If the medical report is not used as part of the reconsideration process or not required as part of the ongoing management of the claim, the cost of the medical report is not payable by Comcare.

However, if the medical report is used in the reconsideration process to make a determination in respect of medical treatment or is used as part of the ongoing management of the claim, the cost of the medical report can be paid by Comcare under section 70 of the SRC Act.

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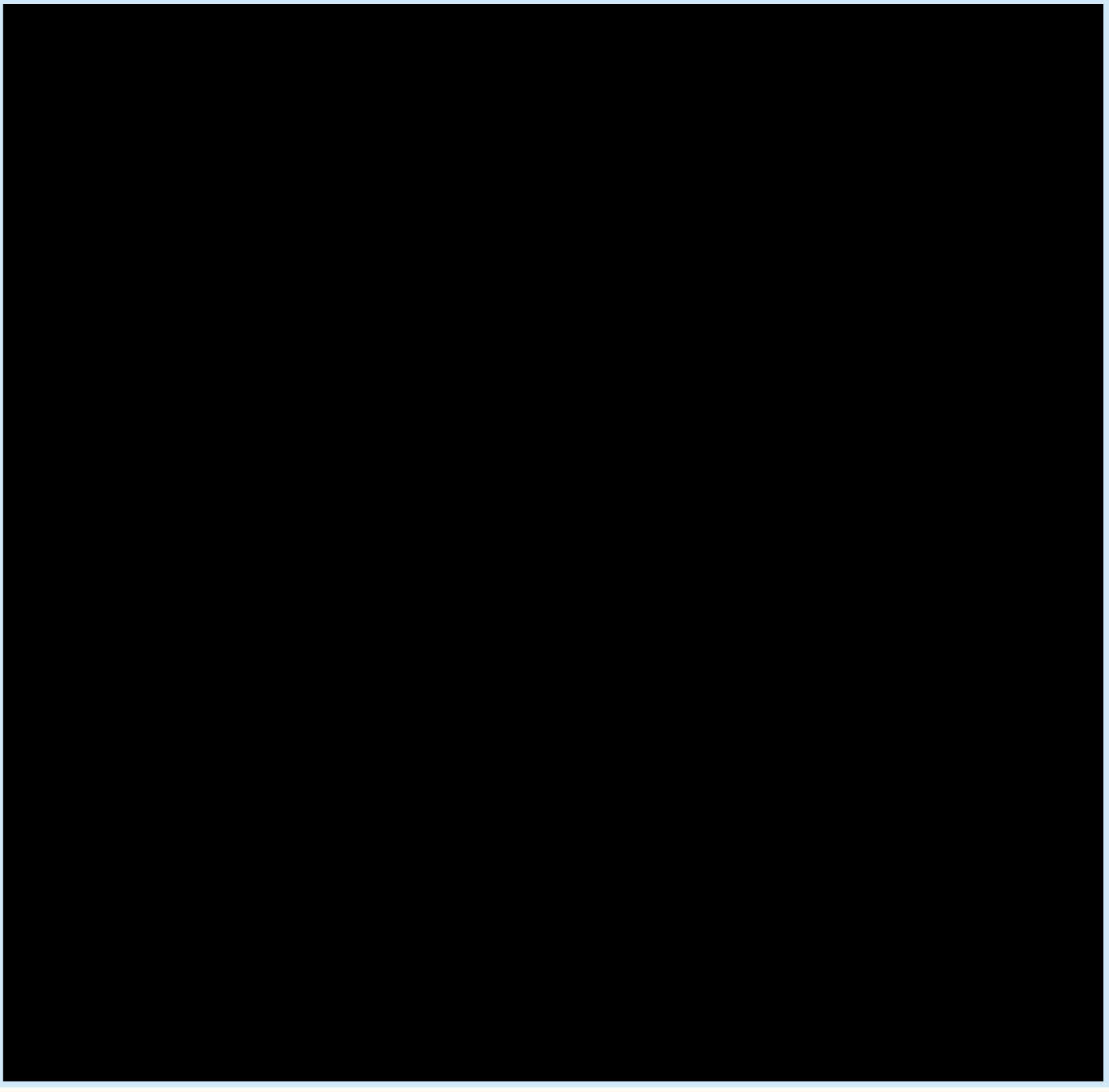

Obtaining medical investigation reports

Introduction

Medical investigations are often requested by treating practitioners to confirm a diagnosis or identify new or pre-existing conditions. Examples include imaging procedures such as MRI scans, CT scans or ultrasound, or other investigations such as Nerve Condition Studies (NCS). Medical imaging may also be required to help with the treatment of a condition, such as ultrasound-guided injections. When investigations take place for the compensable condition, Comcare should receive a copy of the report on the procedure and findings.

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Considerations for requesting medical investigations

There may be instances when a treating practitioner will need to consider whether the potential benefits of imaging outweigh the risks, such as:

- when serious pathology is suspected
- the risk to the employee of not having the investigations conducted
- whether investigations are likely to improve the overall health outcome for the employee
- whether the results are likely to change the management of the employee's condition
- when there has been an unsatisfactory response to conservative care or unexplained progression of signs and symptoms.

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Considering whether a medical investigation is reasonable

Comcare may consider medical investigations reasonable when:

- receiving a request for an investigation in association with a surgery request
- receiving a request for an investigation when the employee is meeting with a specialist
- post-operative follow-up consultations
- changes in the employee's presentation and/or reported symptoms
- changes in the employee's functional capacity
- treatment has not provided any significant improvement in the employee's presentation
- a newly reported condition has been received
- diagnostic/investigative purposes.

If you are unsure whether an investigation is appropriate, you should discuss with the Injury Manager in the first instance, who may recommend a referral to the Clinical Panel for further discussion.

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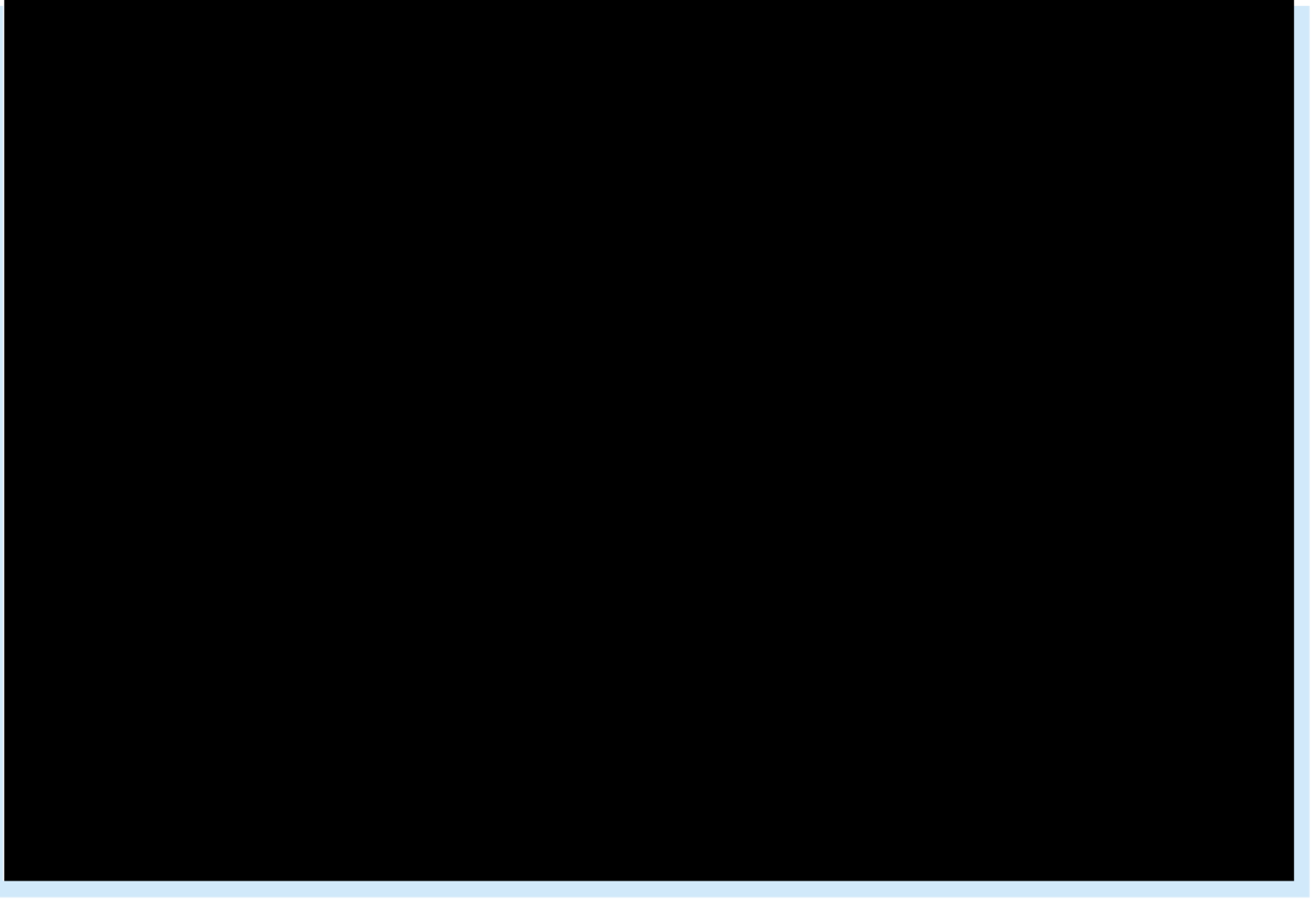

Undertaking a home-based assessment

Introduction

Employees can claim for household services, attendant care services, modifications and alterations, and home-based aids and appliances. To support determination of these claims, Comcare can arrange for a qualified Occupational Therapist (OT) to assess the employee's need for these services. This is done through a home-based assessment, also known as an Activities of Daily Living (ADL) assessment.

The power to arrange for and pay a home-based assessment is found under section 70 of the SRC Act.

Any proposed assessment of household services, attendant care services, modifications and aids and appliances should be discussed with an Injury Manager before any action is taken.

This page provides information about arranging home-based/ADL assessments.

For more information about these types of claims, refer to the following pages:

- Home help and attendant care
- Aids and appliances under sections 16 and 39
- Alterations and modifications under section 39

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When home-based assessments are conducted

Home-based/ADL assessments are undertaken in the employee's home. For employees with an ongoing need for household assistance, home-based assessments should be completed at least every 12 months. Other home-based assessments may be for temporary household assistance or for an initial review of an employee's circumstances or needs.

They are undertaken when:

- a new claim for household or attendant care services, modifications or alterations, or home-based aids and appliances is received, or we are proactively looking at providing this to the employee – to claim for services, an employee should complete an Application for household and/or attendant care services form.
- a request for an increase of the services is received, or we consider it is needed
- the amount of services claimed appears more than what is considered needful
- a review is required to determine if service provision remains relevant to the compensable condition.

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What tasks or skills does a home-based / ADL assessment evaluate?

A home-based/ADL assessment may cover one type of service, such as attendant care services, or multiple types of services. An assessment undertaken for one type of service may elicit the need for another type of service or assessment.

An ADL assessment evaluates the employee's level of function in domestic and personal care. It may also include recreational and social activities and is preferably conducted in the employee's home.

A **basic ADL** may include assessing tasks which enable a person to care for themselves (commonly undertaken with employees who have sustained catastrophic or serious injuries) such as:

- ambulating
- feeding
- dressing
- hygiene.

Instrumental ADLs require more complex thinking and organisational skills. These include:

- transportation and shopping
- managing finances
- meal preparation
- home cleaning and maintenance
- managing tasks such as communication and personal medications.

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What factors are considered in a home-based assessment?

What to include in a home-based assessment for household and/or attendant care services

At a minimum, a home-based/ADL assessment for household and/or attendant care services should include:

- Information on the household's details including:
    - the size of the residence
        - the number of people living there
        - their ages and occupations
        - the domestic activities they undertake, and
        - the number of hours per week that they perform these activities.
- Details of the pre-injury tasks and who performed them.
- An assessment of the current household needs, including if the injured employee or other household members could meet those needs.
- Consideration of the employee's functional capacity – it may be useful for the assessing OT to contact the employee's treating practitioners to confirm expectations around task performance and any likely increase in capacity or possible decline. This will inform decisions around expected length of time for services, extent of services, need for a review, etc.
- Consideration of other health conditions/injuries, both compensable and non-compensable, which may impact on the employee's functional capacity
- Recommendations for assistance including the frequency and length of time assistance is required
- Recommendations for self-management strategies.

What to include in a home-based assessment for modifications or alterations

At a minimum, a home-based/ADL assessment for modifications and alterations should include:

- identification of the area/s requiring modification or alteration because of the compensable injury
- review of current status of house (e.g. floor plan of area to be modified) and suggested changes and/or additions.

Following the assessment, the OT should provide a report which identifies:

- suggestion/s for modification and next steps, e.g. consultation with a builder
- Multiple quotes for the recommendations where possible
- how such adjustments will improve independence, health and possibly a return to community and/or work.

What to include in a home-based assessment for home-based aids and appliances

At a minimum, a home-based/ADL assessment for home-based aids and appliances should include:

- An assessment of the employee's task performance of domestic, personal and community activities of daily living (any combination), and identification of assistive aids and appliances.
- Liaison with relevant treaters before the assessment to establish clinical functional presentation. This information will inform which area should be focussed on and ensure a consistent approach.
- Quotes for any recommended aids and/or appliances

Following the assessment, the OT should provide a report which outlines recommended aids and appliances and how these devices will positively impact the compensable injury with respect to health and return to work.

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ADL assessment goals and Return to Work

The overall therapeutic goal of an ADL is for co-ordination with rehabilitation and treatment goals to improve function and independence. Where appropriate, the rehabilitation goals and treatment goals will include a return to work – it follows that this goal should be included in the context of an ADL assessment.

The individual's home-based environment and social factors are within a different context from that of the organisational and work environmental factors. This can add challenges to translating limitations in the ADL domain to the work domain, although it may still be of value.

Bringing Return to Work (RTW) into the ADL assessment context

To ensure RTW is considered in an ADL assessment, the Claims Manager and Injury Manager need to meet to discuss need for the ADL assessment – the goals and likely outcomes regarding provision of an external domestic service. The Claims Manager and/or Injury Manager can then have an initial meeting with the assessing OT to establish a mutual understanding of the assessment. The following should be discussed:

- Assess the employee's current need.
- Link the assessment to clinically observed function – have the assessing OT speak with the treating health practitioner about this.
- Establish expectations with the OT of the service being temporary wherever possible and the purpose being to support independence and RTW.
- Emphasise the need to discuss service withdrawal with the employee from the outset (as appropriate).

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ADL assessments – summary

An ADL assessment provides a multi-purpose opportunity:

- It assesses a worker's ability to perform multiple integrated functions on a day-to-day basis and identifies supports required to maximise independence.
- It sets expectations on domestic service provision; supports gradual service withdrawal to a level reflective of function noted in a clinical setting.
- It provides an opportunity for Comcare to facilitate an integration between treatment and progressive independence in managing activities of daily living.
- It puts a focus on independence and increased capacity and links to RTW capability.
- It establishes communication with the treating health practitioner which focusses on capacity, independence and work readiness and the performance of daily living tasks as part of a work hardening and work readiness regime.
- Most importantly, it supports the employee to return to work where appropriate.

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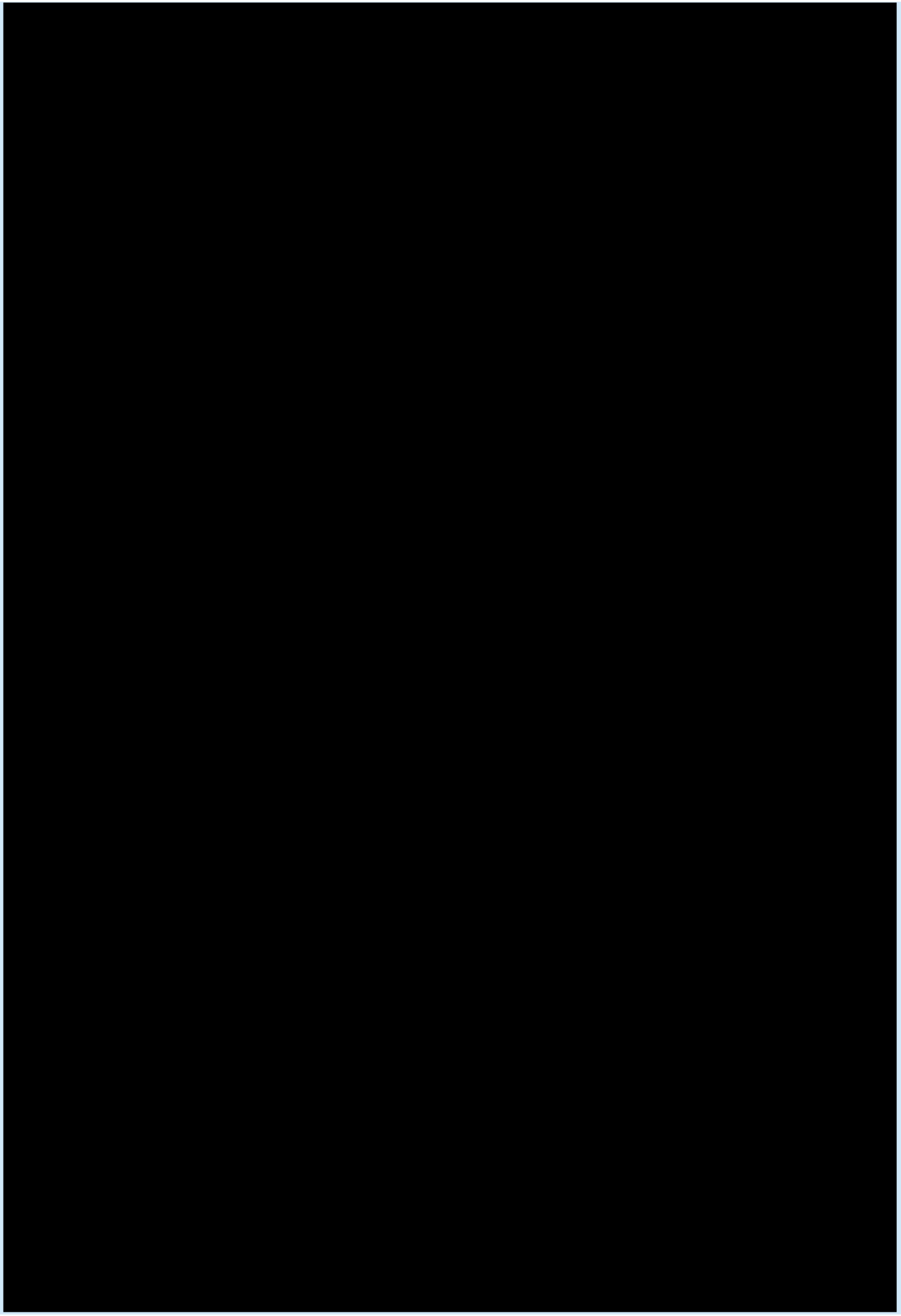

Driving assessments

An OT can also undertake a driving assessment for an employee who has not been driving due to their compensable injury. A driving assessment may be appropriate when:

- an employee has medical advice that they should not drive for a certain period of time or until their injury reaches a certain level of recovery – the assessment can be conducted when this point is reached, to ensure the employee is capable of driving as expected
- an employee wishes to claim for modifications to a car, i.e. changing the steering controls to compensate for their injury – the assessment can identify if the proposed modifications are appropriate
- an employee has been assessed by a medical practitioner as unfit to drive, but they now wish to begin driving again, as they believe it will assist with their recovery and return to work.

Evidence to support an OT driving assessment includes:

- a recommendation by an OT that a driving assessment be conducted
- medical evidence that states that a driving assessment should be conducted at a certain time in the employee's rehabilitation
- medical evidence that supports a driving assessment for the employee's rehabilitation.

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Undertaking a labour market assessment

Introduction

While assessing incapacity payment entitlements, you may need to determine an employee's ability to earn. This is detailed in the Assessment of ability to earn pages. As part of this assessment, you may need to investigate the state of the labour market. This page provides information on how to do this.

Investigating the labour market may be necessary in circumstances where an employee:

- is self-employed
- failed to seek suitable employment, but has both fitness and competency to engage in paid employment
- is volunteering but has both fitness and competency to engage in paid employment
- is studying but has fitness and competency to engage in paid employment.

Information obtained from a labour market assessment can be given to an employee to tell them about employment opportunities available to them.

It is preferred that the employee's job-seeking efforts are supported by a job-seeking program. This assures that the employee is provided with opportunity and specialised support to gain employment. These services are available via a Workplace Rehabilitation Provider and are funded through provision of a Rehabilitation Program under section 37 of the SRC Act.

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Fitness and competency

To ensure employment options are suitable and sustainable, the psychological and physical capability of the employee needs to be considered. This information can be sourced different ways:

- Medical evidence and/or information provided by the employer, e.g. fitness for duty (not an SRC Act assessment) or a section 36 rehabilitation assessment (under the SRC Act) This information should detail functional capacity, both physical and psychological.

You can request additional information from the employee's treating practitioner or arrange for a medical examination (section 57) with an appropriately qualified specialist (such as an occupational physician or rehabilitation specialist). For further guidance, refer to the Obtaining a medical report or clinical notes or Independent medical examinations pages.

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Arranging a labour market assessment

A labour market assessment (LMA) is performed by a Comcare-approved Workplace Rehabilitation Provider (WRP) that offers this service, and an LMA is typically performed as part of a vocational assessment. Not all WRPs offer labour market assessments. Please read the information under Privacy below when engaging an expert to conduct this assessment.

The vocational specialist working for the WRP will review the employee's profile against various employment data to generate specific recommendations for the employee.

A labour market expert can identify opportunities for employment, including actual available positions in the employee's locality, and estimates of earning potential in those identified employment opportunities.

A labour market expert may be:

- an occupational therapist with appropriate labour market expertise
- a vocational assessor with labour market expertise
- a rehabilitation counsellor (working with employment agencies or rehabilitation providers).

Before arranging a labour market assessment, you will need to have details of the employee's current capacity for employment (see above under Fitness and competency) and details of their skills, experience and training. This will help to identify the type of employment the employee is suited for. If this information is not already available, you may first need to arrange a vocational assessment. For further guidance, refer to the Arranging a vocational assessment page.

The Injury Management Team can help with understanding the assessment process and the detail that should be included in a referral.

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Payment of a Labour Market Assessment

Payment of a labour market assessment is made under section 70 of the SRC Act.

Refer to the Processing an invoice page for information about paying an invoice.

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Investigating the labour market

If it is not possible to engage a labour market expert, you can investigate the labour market using information obtained from advertised vacancies in online job sites.

If you need assistance to do this, speak with your Assistant Director and Senior Injury Manager.

Employees who have moved

Where an employee has moved to a new locality with fewer employment prospects, you or the labour market expert may look at employment opportunities at the employee's previous locality. Whether an employee's move was considered reasonable or not is for you to determine based on the individual circumstances of the claim.

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Privacy

A labour market assessor should not require any personal/identifying information about the employee. Although the Privacy Statement in the current Comcare claim form permits the disclosure of personal information to, or collection of personal information from, a labour market assessor, it is not necessary as de-identified information would be sufficient for assessment purposes. Therefore, as better practice, you should not release any identifying details about the employee to the labour market expert, including their name, date of birth, their specific address, who they worked for when injured, etc.

The labour market expert only needs to know general information, such as the relevant location where the employee lives, the types of occupation the employee has undertaken in the past, their skills, experience and training, and any restrictions on capacity for employment. The labour market expert can then provide you with details of available employment options in the relevant location and information on the potential earnings associated with those employment options.

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Independent Medical Examinations overview

Independent medical examinations overview

As part of the initial determination process or while managing an employee's accepted claim, you may need to arrange for an employee to be examined by a **legally qualified medical practitioner**. This may fall under section 57 (medical liability examinations) or section 36 (rehabilitation assessments) of the *Safety, Rehabilitation and Compensation Act 1988* (SRC Act).

Independent medical examinations (IMEs) can provide important medical information to help manage a claim for compensation. However, there are important things to consider before scheduling an IME. This section of the manual explains the requirements and considerations around IMEs.

IME's are also conducted in line with Comcare's IME policy.

Roles and responsibilities

The rehabilitation authority, usually the Rehabilitation Case Manager, is responsible for arranging rehabilitation assessments in relation to the employee's capability to undertake a rehabilitation program under section 36 of the SRC Act.

The Claims Manager in consultation with the Injury Manager is responsible for scheduling medical examinations and managing the examination reports under section 57 of the SRC Act as part of their claims management responsibilities.

The Review Officer in consultation with the Assistant Director, Reconsiderations and/or the Director, Reconsiderations and Appeals is responsible for scheduling medical examinations as part of the reconsideration process.

In this section

Independent medical examinations

This page sets out the information you need to know to decide when to arrange an independent medical examination. It also includes:

- Summary of IME requirements
- What is an IME?
- Assessing the need for an IME
- Requirements when an IME is determined as necessary
- IMEs are determinations under section 60
- Administration when organising an IME
- During and after an IME

- Procedure to organise and book an IME
- Procedure to action an independent medical examination report
- Procedure to action non-attendance or obstruction of a medical examination.

Independent medical examinations

Published 01/09/2025

This page covers the process and information required to assess and organise an independent medical examination (IME) in accordance with the legislative requirements.

Summary of IME requirements

Section 57 of the SRC Act gives Comcare the power to require the employee to undergo an independent medical examination for the purpose of assessing, determining or managing a claim for compensation.

The Guide for Arranging Rehabilitation Assessments and Requiring Examinations sets out the limitations and requirements that Comcare must follow when considering and arranging such examinations.

The requirements are summarised below.

- Section 9 - Requiring medical examinations
- Section 10 - Qualifications of examiners

- Section 11 - Notice of determination
- Section 12 - Limitations on frequency and number of examinations
- Section 13 - Other relevant matters

Section 9 - Requiring medical examinations

1. First, consider whether Comcare has sufficient information about the **employee's circumstances** (defined in the Guide and including the employee's injury, other medical and personal circumstances, capacity for work and claimed need for treatment or support).

2. If not, i.e. Comcare has **insufficient or inconsistent information** to assess, determine or manage the claim, Comcare should send a **written request for the necessary information to the employee's treating practitioner**, asking for a written response within no fewer than **14 calendar days**.

3. Comcare should rely, as much as possible, on the information provided by the treating practitioner before requiring an IME.

4. Only then, if the information is still insufficient or inconsistent, can Comcare require an IME.

5. When the need for an IME has been established, Comcare must **seek certain views**, either verbally or in writing, from the employee and give them at least **3 business days** to respond.

6. The views that Comcare must seek from the employee are about the **selection of the medical examiner**, whether they need an **emotional support person** to be present and **any other relevant matter** (this could include the ability of the employee to travel to an IME or cultural needs, such as a certain gender examiner or language requirement).

7. Comcare needs to take these views into account.

8. Comcare must advise the employee that **they have the right to have an emotional support person** with them for all or part of the examination.

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Section 10 - Qualifications of examiner

The medical examiner must be a legally qualified medical practitioner and qualified by their training or registration to assess the employee's injury.

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Section 11 - Notice of determination

1. Once it has been determined that an IME is required, Comcare must provide a **notice of determination** to the employee in writing, outlining the terms of the determination, the reasons for it, and a notice of the employee's rights to apply for a reconsideration of the determination under section 62(2), and their obligations to attend the IME even if they have requested a reconsideration, if that reconsideration has not taken place by the date of the appointment.

The notice should also explain that the countdown for the prescribed timeframes that apply to the claim will stop on the day the notice is issued and restart when the medical examination report is received.

2. The notice also needs to include Comcare's reasons for accepting or not accepting, in whole or part, the employee's views as requested in section 9(7). And it needs to include Comcare's reasons for relying or not relying, in whole or part, on the employee's treating practitioner and the information they provided, if any.

3. The notice must include the offer of an emotional support person.

4. The notice must be sent to the employee **at least 14 days before the date of the examination**, unless the employee has agreed to a shorter notice period. If so, the notice must be sent no later than the agreed notice period.

Waiver: If the employee has agreed to waive the 14-day determination letter timeframe, this information **must** be recorded in Pracsys.

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Section 12 - Limitations on frequency and number of examinations

1. The employee cannot be required to attend an IME more frequently than **once every six months**.

2. This applies if the employee undergoes the examination, and they and their support person do not in any way obstruct the examination.

3. The **exceptions** to the six-monthly limitation include:

- the employee or their treating practitioner or another medical practitioner has requested an IME
- the employee's circumstances have changed
- the injury requires multidisciplinary treatment and one practitioner cannot address all the requirements of the IME
- the examiner fails to provide a report after the IME within the requested timeframe
- a reconsideration request is made or an application for review of a reviewable decision is made to the Administrative Review Tribunal, where there is insufficient or inconsistent information and a decision has not yet been made.

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Section 13 - Other relevant matters

1. Comcare can follow these directions in whatever order works operationally.

2. Comcare does not have to require an employee to undergo an IME and there is no restriction on allowing the employee's treating practitioner to be the examiner if they are a LQMP. However, as you must seek the information from the treating practitioner before considering an IME, it is unlikely they would be considered appropriate to conduct the IME if they have been unable or unwilling to provide the necessary information at the earlier stage.

3. Comcare must **record the views of the employee including the offer of an emotional support person**.

4. Comcare must **provide a copy of the examiner's report** to the employee or their legal representative or treating practitioner.

For more detailed information, see the guidance in this page.

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What is an IME?

Included in this section:

- What is an IME
- Relevant legislation
- Roles and responsibilities
- The Guide
- Combined medical (section 57) and rehabilitation (section 36) examinations
- Qualifications of examiners

What is an independent medical examination (IME)?

An employee may be required to attend an independent medical examination (IME) by a legally qualified medical practitioner (LQMP), referred to as the **examiner** in the guidance below:

- as part of the initial determination process or
- as part of the management of an employee's accepted claim or
- where a request for a reconsideration has been received.

An independent medical examination (IME) aims to gather necessary medical information about the employee's injury or illness that is required to assess, determine or manage their claim.

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Relevant legislation

The relevant sections of the *Safety, Rehabilitation and Compensation Act 1988 (SRC Act)* that give Comcare the power to request that an employee attend an independent medical examinations (IME) are:

- section 36 (employee's capacity to undertake a rehabilitation program) and
- section 57 (for managing claims for workers' compensation).

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Roles and responsibilities

It is the responsibility of the **Claims Manager** or the **Review Officer**, in the case of a request for a reconsideration, to arrange an IME.

The Injury Management team continues to play a vital role in this process. This includes:

- being involved in the discussion as to whether a medical examination is required
- identifying the appropriate specialist to conduct the examination
- contributing to the schedule of questions
- ensuring clinically appropriate questions are included, and
- contributing to the schedule of documents to be submitted to the medical specialist.

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The Guide

Section 57A of the SRC Act requires Comcare to prepare a *Guide for Arranging Rehabilitation Assessments and Requiring Examinations* (the Guide). View the Guide and the Explanatory Statement.

The Guide's purpose is to support ethical, transparent and accountable decision-making in relation to:

- arranging a rehabilitation assessment and examination under section 36 of the SRC Act or
- requiring medical examinations arranged under section 57 of the SRC Act.

The Guide came into force on 18 September 2024.

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Combined medical (section 57) and rehabilitation (section 36) examinations

The employee's Rehabilitation Case Manager is responsible for determining whether an assessment is needed under section 36 to determine an employee's capacity to participate in a rehabilitation program. For more information about rehabilitation assessments and programs, see the Rehabilitation section of the Claims Manual.

If both a medical assessment and a rehabilitation assessment are required, it may be appropriate for you and the Rehabilitation Case Manager (RCM) to arrange for an employee to attend a combined medical (section 57) and rehabilitation (section 36) examination.

Benefits of a combined assessment

A combined assessment will:

- minimise the number of examinations employees are required to attend
- ensure consistency of specialist opinion
- help develop collaborative relationships between you and RCMs
- improve timeframes for early intervention, rehabilitation and appropriate medical treatment to advance employees' ability to recover and return to work as quickly as possible, and
- reduce overall claim costs.

Working with the Rehabilitation Case Manager

It is important that you, the Injury Manager, and Rehabilitation Case Manager (RCM) agree on the appropriate medical specialty for the combined assessment.

The RCM should issue a notice to the employee under section 36 but also forward the completed Rehabilitation assessment referral form (section 36(1)) or the completed Rehabilitation assessment/examination form (36(3)) with the appropriate costing to Comcare so that the CAIS Rehabilitation team can register it.

Process to arrange a combined assessment

If it is agreed to conduct a combined section 36/section 57 assessment, Comcare takes ownership of this appointment. The Claims Manager or Review Officer will book the assessment and upload all relevant documentation. Please follow the Procedure to organise and book an IME and have regard to the following additional requirements:

1. When contacting the employee during this procedure (**Step 5**), include the following points in your discussion.
    a. Explain the purpose and benefit of the combined assessment.
    b. Advise that their Rehabilitation Case Manager will contact them to explain the section 36 component of the assessment.
2. When you book the combined assessment with the required specialist/examiner through the IME provider portal (**Step 6**), advise that the assessment is combined in the "Additional Information" section.
3. You will still issue a separate section 57 notice of determination letter regarding the medical examination (**Step 8**) and the RCM will issue a separate notice of determination letter for the section 36 assessment.
4. Referral to examiner (**Step 10**): The Rehabilitation Case Manager is required to prepare and send you a letter of instruction under section 36. This letter is to be sent to you at least one week before the IME booking. The summary should include a schedule of questions, details of the rehabilitation activities to date, and specific details about the employee's pre-injury job, current return to work arrangements and opportunities.
5. You also need to prepare a case summary for the medical examiner including a letter of instruction and a schedule of questions that you want the medical examiner to answer in relation to the employee's condition.
6. You then need to upload the case summary, the two letters of instruction plus the schedules of questions that the medical examiner is required to answer in relation to the individual section 36 and section 57 reports and any other relevant documentation to the MedEbridge platform.

What if an employee objects?

If an employee objects to attending a combined assessment, you should explain the benefit to them of attending a combined assessment (as opposed to two separate assessments). If the employee still has concerns, ask them to explain their reasons for the objection. You, the Injury Manager and the Rehabilitation Case Manager should then discuss whether it is appropriate to arrange separate assessments.

Receipt and implementation of report

If you receive the reports from the medical examiner through the MedEbridge platform, you need to provide the section 36 report to the RCM.

Once you and the Injury Manager have reviewed the section 57 report, you need to contact the Rehabilitation Case Manager (RCM) to set up a meeting between you, the Injury Manager and RCM to:

- discuss the section 36 (rehabilitation assessment) report from a liability and rehabilitation perspective (note that you can discuss the section 57 (medical assessment) report as well, if the

RCM feels it would be beneficial)
- discuss how each party will proceed based on the specialist's assessment and recommendations for the benefit of the employee's recovery and return to work
- identify what impact the outcomes will have in relation to the management of the claim and the rehabilitation process and any further actions required, and
- implement all actions within an agreed timeframe.

After a combined section 36/57 examination has occurred, the RCM may want to request a supplementary or clarification report for the section 36 assessment. In this case, if the assessment was arranged by Comcare, the RCM needs to request this via the Claims Manager. Due to privacy, Medilaw and mlcoa are unable to liaise with the agency if the appointment was scheduled by Comcare. It is the RCM's responsibility to write their supplementary or clarification questions and send these to the Claims Manager. They will then upload them to MedEbridge, under the 'new order > reviews' tab. Once the additional report has been received, the Claims Manager can download this off MedEbridge and send to the RCM.

Costs for a supplementary report will be invoiced to Comcare and processed by CAIS on behalf of the rehabilitation authority under section 36 provisions.

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Qualifications of examiners

Before you or the Review Officer (in the case of a reconsideration) arrange a medical examination, the Guide requires you to be reasonably satisfied that the examiner is:

- a legally qualified medical practitioner registered with the Australian Health Practitioner Regulation Agency (AHPRA).
- qualified, by their training or registration, to assess the employee's injury.

Please note: Medical examiners selected through Comcare's contracts with Medilaw or mlcoa are required to be registered with AHPRA and must complete a minimum of 8 hours per week of clinical practice which meet the requirements for medical examiners under the Guide.

The Injury Manager assigned to the claim will provide a clinical recommendation to you or the Review Officer for the appropriate specialist to complete the assessment.

Please see the List of IME specialties for details of different types of specialists and what injuries and illnesses they are responsible for.

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IME providers

Timeframes for receiving a medical report

Independent medical examination providers

Comcare currently has a contract with the *Medilaw Group* and *mlcoa* for the delivery of independent medical examination (IME) services for Comcare.

Medilaw group

Medilaw specialist directory
Medilaw group contact details - Contactable if you have any queries regarding an IME booking.

Medilaw group - Telehealth services

Where a telehealth appointment has been made, Medilaw or mlcoa will send the information sheets and instructions to you through the MedEbridge platform under the 'Attachments' section.

MedEbridge have also developed the following FAQ document which will be updated frequently. Please continue to send through queries and questions to the Assistant Director, IME and Injury Management Practice so that they can include these in the FAQs document.

mlcoa

mlcoa Comcare Panel | 2025 Specialist Directory

If you have any other concerns or queries in relation to Medilaw or mlcoa, please contact the Assistant Director, IME and Injury Management Practice.

Which individual examiner should I choose?

In selecting an examiner, you should consider the following:

- Whether the employee has a treating specialist (although an IME can be conducted by the employee's treating practitioner, an IME should only be conducted when all reasonable efforts to obtain the necessary information from the employee's treating practitioner have failed. Therefore, it is unlikely that an IME conducted by that practitioner will be successful).
- The qualifications, experience or expertise of the examiner.
- Whether the examiner is registered in the state or territory where the examination is to be conducted.
- Whether the employee has previously been assessed by the examiner and if so, whether the use of the same examiner is appropriate.
- The quality and comprehensiveness of any previous medical reports prepared by that examiner and the objectivity displayed towards the employee's compensable condition and/or towards the employee's personal circumstances.
- Whether the examiner can provide appointments and quality reports with minimal delay.
- The proximity of the examiner to the employee. For employees in rural areas, consideration can be given to completing the assessment via telehealth, or if travel is appropriate, in the nearest major city/town.

Important: When considering the employee's injury/illness and personal circumstances, you may need to consider a medical practitioner who is not part of the Medilaw Group or mlcoa to conduct the examination. If this is the case, please discuss this with the Assistant Director, IME and Injury Management Practice.

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Assessing the need for an IME

Included in this section:

When might an IME be necessary?

Independent medical examinations are used to obtain a specialist opinion in relation to an employee's compensable condition. There are several reasons for arranging a medical examination which include, but are not limited to, the following:

- An employee is not receiving treatment from a legally qualified medical practitioner (LQMP) or evidence-based treatment from an allied health provider.
- There is insufficient or conflicting medical evidence on the employee's claim file or new claim.
- A claim is medically complex.
- An employee has developed a new or secondary condition.
- An employee has submitted a claim for permanent impairment.
- There is evidence the employee's treating LQMP or practitioner is adopting the role of an advocate.
- There is difficulty establishing a link between employment and the claimed condition.
- The condition has stabilised.
- Clarification of capacity. For example, determining that the employee is able to study but is unable to return to any form of work.

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Consider the ‘employee’s circumstances’

Before considering whether an employee should undergo a medical examination, section 9(1) of the Guide requires you to consider whether you have sufficient information about:

- the employee’s circumstances or
- any change in the employee’s circumstances or
- the employee's capability to undertake a rehabilitation program.

‘**Employee’s circumstances**' is a defined term in the *Guide for Arranging Rehabilitation Assessments and Requiring Examinations* and includes a range of matters that you may need information on when determining liability for compensation. These include:

- the injury
- other medical conditions that may be relevant to the claim, for example pre-existing or secondary injuries
- the requirement for medical treatment
- the employee's capacity for work
- the employee's claim for permanent impairment and non-economic loss
- the employee's need for alterations, modifications or aids or appliances
- the employee's need for household services or attendant care services
- understanding suitable employment requirements and availability
- personal circumstances - such as any biopsychosocial factors that may be impacting the employee’s return to work

- any other relevant matter.

Important: Attendance at medical examinations can be distressing. You should consider the impact that attending a medical examination may have on an employee, as part of the employee's circumstances.

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Seek information from the treating practitioner

Section 9(2) of the Guide requires you to do everything reasonable to obtain the necessary information that you need to determine or manage a claim from the employee's treating practitioner **BEFORE** arranging an independent medical examination.

This means that if you believe there is insufficient or inconsistent information about the employee's circumstances, including their claimed injury, you should:

- request in writing that the employee's treating practitioner provides the required information, and
- specify that the information must be provided to Comcare in writing, and
- specify a date, allowing at least 14 calendar days from the date of the request, for the information to be provided.

This must all be documented in the IME Decision Making Checklist in the '*Manage IME Assessments*' (MIME) function in Pracsys.

Stop clock provisions: If the employee's treating practitioner is a legally qualified medical practitioner and the claim is for compensation under section 14, then the prescribed timeframes apply. The clock for determining the claim will stop on the day you request the information from the treating practitioner and will restart on the day you receive the report.

Section 9(3) of the Guide states that you should rely on the employee's treating practitioner and the information they provide as much as possible before requiring the employee to undergo an independent medical examination.

Once you have considered the employee's circumstances (section 9(1)) and have relied, as much as possible, on the information provided by the treating practitioner (section 9(3)), then if you still believe there is insufficient or inconsistent information for you to determine or manage the claim, it is appropriate to require the employee to undergo a medical examination (section 9(4) of the Guide).

You should use internal resources including Injury Management or the Clinical Panel to support you with gathering and interpreting the medical information from the treating practitioner to make an informed decision. If an informed decision cannot be achieved, then it is reasonable to consider arranging an Independent Medical Examination (IME).

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How often can you schedule an independent medical examination?

Section 12 of the Guide provides the requirements around frequency of IMEs.

Section 12(1) states that you cannot require an employee to undergo an IME more often than once every six months.

However, section 12(2) explains that this frequency only applies if:

- the employee undergoes the examination, and
- the employee does not in any way obstruct the examination, and
- the support person does not in any way obstruct the examination.

Exceptions to the six-month limitation

There are several exceptions to the frequency rule (section 12(3)). If an exception applies, you can schedule additional medical examinations as appropriate. The exceptions are as follows:

- An examination is requested by the employee or their treating practitioner.
- Another medical practitioner has recommended a further examination or re-examination.
- There has been a change in the 'employee's circumstances' as defined in section 4 of the Guide.
- The injury requires multidisciplinary medical treatment (i.e. a complex case) and it is appropriate for the Claims Manager to require the employee to undergo more than one examination, with a different medical practitioner.
- The assessor fails, for any reason, to provide a written report within the timeframe set by you.
- A request for a reconsideration of a determination is made but a reviewable decision in response to that request has not yet been made.
- An application for review of a reviewable decision is made to the AAT but a final decision has not yet been made.

Section 36 assessments do not impact the frequency limitation

The limitations placed on the frequency of arranging section 57 medical examinations are not impacted by the arrangement of a section 36 rehabilitation examination. That is, a Claims Manager could organise a Section 57 medical examination in the same six-month period as a section 36 rehabilitation examination organised by a rehabilitation authority.

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Requirements when an IME is determined as necessary

Once you have determined that an independent medical examination is necessary, you must:

- advise the employee of their right to bring an emotional support person to the examination.
- take into account the employee's views on the medical examiner.

These are detailed in this section.

The employee’s right to an emotional support person

Section 9(8) of the Guide states that Comcare must advise the employee that they may have an emotional support person accompany them to all or part of the examination and seek their views as to whether they would like to bring one to the appointment. You can explain this right to the employee when you seek their views.

Record: You must record the offer of an emotional support person in both the determination letter and in the claim comments.

Travel costs for support persons

Sometimes a support person is medically required to assist the employee to attend the medical examination. In this case, there needs to be medical evidence that shows that it is medically necessary that the employee has someone attend with them.

Where an employee requires a support person for medical reasons, Comcare will meet reasonable travel costs associated with the support person attending.

Please see Receiving and actioning travel requests for more information.

Where the support person is not medically required to assist the employee, Comcare will not meet travel costs associated with the companion attending.

Expectations for support person

The employee's support person must not interfere with or in any way obstruct the examination. They should not attempt to answer questions put to the employee by the examiner.

The selected examiner may be unable to continue with the examination due to the behaviour of the support person. In this case, the examiner may choose to terminate the examination and will advise Comcare of their reasons for doing this in writing.

Please note: It is not appropriate for the employee to take their children to the medical examination. Employees should make alternative arrangements for their children while they attend the medical examination.

Informing the examiner

If an employee would like a support person to attend the independent medical examination, the examiner must be informed before the appointment. This should be done through the MedEbridge portal.

The examiner may not agree to any support person attending the medical examination. In such a case, the employee should be informed, and a different examiner should be sought who will allow the support person to attend.

If a suitable examiner is unable to be found, the employee will need to attend the examination. The support person will be required to wait in the waiting room during the appointment.

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Seeking the employee's views on the IME

You must seek and take into account the employee's views about:

- the selection of the medical practitioner to conduct the medical examination
- whether the employee requires an emotional support person to be present at all or part of the examination (you must also advise the employee that they have this right)
- any other relevant matter that may affect the employee's successful attendance at the examination, such as:
    - any medical or mobility restrictions the employee has
    - geographical location and accessibility
    - the employee's or examiner's gender
    - language or communication barriers.

While not required in the Guide, for ease of booking an appropriate appointment, you should also discuss the employee's availability regarding date and time.

Document the employee's views

Seeking the employee's view can be done verbally or in writing. You must document the employee's views in writing. This must be done in the IME Decision Making Checklist in the '*Manage IME Assessments*' (MIME) function in Pracsys and will be included in your written notice of determination.

You must also document the offer an emotional support person and whether or not the employee has indicated that they will have an emotional support person with them during the medical examination.

Timeframe to respond

You must give the employee a period in which to respond. This period must be at **least three business days** from the date of your request. If the employee responds sooner than your due date, you can proceed to issue the notice of determination and schedule the IME as soon as the employee responds.

Interpreters for examinations

If the employee asks for an interpreter at the examination, Comcare can arrange for a professional interpreter to attend. Comcare will meet the costs of the interpreter.

It is not appropriate for the interpreter to be a family member or friend. This is to ensure the interpretation of what the employee is saying is not affected by the family/friend's own view.

If required, interpreters can be arranged and booked online from Translating and Interpreting Services (TIS) National.

Reconsideration requests or intent not to attend: If the employee indicates that they will be requesting a reconsideration in relation to the medical examination or indicates that they will not be attending and/or raise any objections to attending the medical examination, please discuss this with your Assistant Director as soon as possible.

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IMEs are determinations under section 60

Included in this section:

- Written notice of determination and what you must include.
- If you determine that an IME is no longer required.

Notice of determination

A decision to require an employee to attend a medical examination under section 57 of the SRC Act is a determination for the purposes of section 60 of the SRC Act from 14 June 2024.

The determination must include:

- the terms of the determination
- the reasons for the determination
- Comcare's reasons for accepting or not accepting, in whole or part, the employee's views as requested in section 9(7)
- the offer of an emotional support person
- Comcare's reasons for relying or not relying, in whole or part, on the employee's treating practitioner and the information they provided (if any)
- where applicable, an explanation that the countdown for the prescribed timeframes that apply to the claim will stop on the day the notice is issued and restart when the medical examination report is received
- a notice of the employee's rights to apply for a reconsideration of the determination under section 62(2), and their rights to request a review of the reconsideration outcome by the Administrative Review Tribunal
- the employee's obligations to attend and not in any way obstruct the IME without a reasonable excuse, even if they have requested a reconsideration, if that reconsideration has not taken place by the date of the appointment.

You are required to clearly document your conversations and considerations, and you can use this documentation to draft your notice of determination.

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If you determine that an IME is no longer required

If you have issued a notice of determination to the employee requiring them to attend an IME, this is a determination under section 60 of the SRC Act.

If you then determine that the IME is no longer necessary, for example because you have received new information from the employee's treating practitioner, you will have to issue a 'reconsideration on own motion'.

When considering whether to undertake a reconsideration on own motion, you should discuss the claim with your Assistant Director.

For further information, please see: Reconsideration of own motion

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Administration when organising an IME

Included in this section:

- Costs
- Documentation required
- Cancellations
- Claiming incapacity to attend an IME

Costs of an independent medical examination

Comcare currently has a contract with the *Medilaw Group* and *Mlcoa* for the delivery of independent medical examination (IME) services for Comcare. The costs associated with examinations are set according to an agreed pricing list.

If the Medilaw Group or Mlcoa do not have a suitable examiner to conduct the examination, please contact the Assistant Director, IME and Injury Management Practice.

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Documentation required

Once the medical examination has been booked, you need to supply a case summary, outlined in this section, to the examiner.

You also need to provide a list of questions that you would like the examiner to answer in relation to the employee's condition as part of the examination.

Please see: Obtaining a medical report or clinical notes for a list of questions you may want to ask the examiner.

Case summaries

A case summary is used to provide background information to an examiner about an employee's compensable condition or undetermined workers compensation claim. A case summary should only contain facts relevant to the employee's compensable or undetermined condition and must not be used to lead the examiner in any way.

The Injury Manager will work collaboratively with you to assist in developing a detailed case summary and schedule of questions to be provided to the examiner.

Below is a brief outline of what should be included in a case summary.

Background to injury

Provide a brief history of the claim focusing on how the injury occurred and what stage it is currently at. The history can include the following but is not limited to:

- when the claim was lodged by the employee
- diagnosis of the injury sustained (including diagnosis on the initial medical certificate)

- details as to how the injury occurred
- what the accepted condition is (if claim is accepted), and
- any secondary conditions/other claims.

The Claim Chronology document can be used to assist in providing a detailed history of complex claims to the examiner. For further guidance, refer to the Claim chronology page.

Incapacity

Information about the employee's treatment, rehabilitation and any incapacity the employee has had due to their compensable condition. The summary should include but is not limited to:

- treatment the employee has undertaken in relation to their condition(s)
- outcome of any treatment
- details of any rehabilitation program in which the employee has participated
- the outcome of any rehabilitation program
- any time off work the employee has had in relation to their condition(s), and
- the employee's duties at work (pre-injury, current and proposed).

Attachments

All documents provided to the examiner for the examination should be clearly labelled with a letter or number in the top right-hand corner.

A list of attachments should be included in the letter to the examiner. The list of attachments should be under the date of your signature block with corresponding letters or numbers so the examiner can easily refer to the documents attached. All documentation must be uploaded to the MedEbridge portal no later than five business days prior to the assessment.

Examples of the documents to be provided to the examiner include but are not limited to:

- copy of workers' compensation claim form
- relevant medical certificates
- medical reports
- rehabilitation reports
- service provider reports, e.g. imaging
- employer/employee statements.

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Cancellations

Cancellations by the examiner

Where an examiner cancels an IME, there is no fee. You will need to arrange a new appointment and contact the employee as soon as possible to advise them of the situation. You need to provide the new appointment details in writing to the employee and employer.

Cancellations by the employee or Comcare

If the IME needs to be cancelled, you or the Claims Support Officer must log in to the IME portal and cancel the appointment.

Reasons for the cancellation and explanation of the situation must be documented in Pracsys.

Three full business days' notice are required to avoid any cancellation charges.

If the employee needs to cancel the appointment, you will need to determine whether the reason/s for the cancellation are reasonable.

Refer to the Reasonable excuse section for details on what is reasonable.

Cancellation by employee with reasonable excuse

If there is a reasonable excuse, cancel and re-schedule the appointment for a date and time that suits the employee.

If the only changes to the medical appointment are the time and date, you do not have to send another section 57 determination letter to the employee. You are however still required to inform the employee in writing of the new details of the medical appointment.

However, if you are required to change the medical examiner and/or the qualifications of the medical examiner when changing the medical appointment (for example, because the original examiner is not available), then a new section 57 determination letter will need to be sent to the employee.

Cancellation by employee with no reasonable excuse

If the reason/s for cancelling the appointment are not reasonable, the appointment should proceed, and you will need to advise the employee of their obligations under section 57 of the SRC Act.

For further information see Non-attendance at a medical examination.

Reasonable excuse

What constitutes a reasonable excuse depends on the facts of each case. To be reasonable, an excuse must show that an employee was physically, mentally or emotionally unable to participate in or attend the examination rather than unwilling to do so. Examples of excuses that may be considered reasonable include but are not limited to:

- medical inability, supported by medical evidence
- a risk of injury or aggravation (supported by medical evidence) to the employee in undertaking the medical examination
- urgent and unforeseeable family matters, and
- other unforeseen circumstances about which the employee was not able to notify Comcare in advance.

The following may not be considered reasonable, remembering that the employee should have been given sufficient notice (at least 14 days) of the examination:

- resignation
- travel overseas
- relocation interstate
- dissatisfaction with how an examination is delivered, or belief that an exam is not necessary
- belief that the IME could be uncomfortable or unpleasant (different to the belief that the IME could be detrimental).

If you are unsure whether an excuse is reasonable, consult your Assistant Director and refer to the Reasonable excuse - examples guidance document.

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Claiming incapacity to attend an IME

Where an employee is required to undergo a medical examination, they may, depending on the provisions of their employer's Enterprise Agreement, be considered 'on duty' when attending.

This means there will be no loss of earnings or leave credits involved. Therefore, the employee will not need to lodge a claim for time off work.

The employee should consult with their employer about how the absence will be dealt with under their Enterprise Agreement.

If the Enterprise Agreement does not provide direction, an employee may be able to claim incapacity for the period of the examination. They will need to complete a claim for time off work form (CTOW) and submit it to Comcare.

Please see: Incapacity for work for more information.

If a claim is undetermined or rejected, Comcare cannot pay for time off work. The employee will need to seek paid or unpaid leave from their employer to cover the absence.

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^ During and after the IME

Included in this section:

- IME reports and reporting
- Complaints
- Injury sustained at or during an IME
- Non-attendance at an IME

IME reports

Summary of report for the employer

If you need to provide a summary of the report to the employer, please use the relevant prompts in the template below and email the summary to the employer.

Subject heading: IME Report Summary

Dear [RCM, Name],

This email is to provide you with a summary of the IME report to assist in facilitating recovery and return to work.

IME Provider:
Report Date:
Specialist Name:
Employee Name:
Claim Number:

Diagnosis:

- *The condition/s formally diagnosed by the Doctor.*

Causation:

- *Has the specialist concluded that there is a causal link between employment and the condition/injury?*
- *Has the specialist indicated a significant employment contribution for the claimed condition/s?*

Prognosis/Capacity:

- *Expected recovery timeframes.*
- *Recommended treatment and duration.*

Rehabilitation & Return to Work:

- *Timeframes for returning to work, or if at work, timeframe to achieve normal hours/duties.*
- *Workplace modifications recommended to support return to work (i.e. ergonomics, physical restrictions)*
- *Reasonable adjustments recommended to support return to work (i.e. working from home, reduced hours, reduced/alternate days)*

If you wish to obtain a full copy of this IME report, a request can be made under Section 59: Request access to information

Regards.

[Comcare Delegate, Name]

Releasing medical reports

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

The person best placed to determine the risk involved is the employee's treating practitioner or specialist. It would therefore be considered appropriate to consult with the doctor/specialist before releasing any potentially sensitive information to the employee.

Supplementary Report Requests

If you require a supplementary report from the medical examiner, requests for a Supplementary Report will follow the Procedure to organise and book an IME

Permanent Impairment IME Reports

Requests for a Permanent Impairment IME report will follow the Procedure to organise and book an IME

Reconsideration IMEs (including Supplementary Report requests)

Requests for Reconsideration IMEs will require the Review Officer to email the IMT mailbox to initiate communication with the relevant Injury Manager. The process will then follow the Procedure to organise and book an IME

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Complaints about the independent medical examination process

IME reports or internal processes

Concerns, queries or complaints regarding the independent medical examination (IME) reports or internal processes should be escalated to the Assistant Director, IME and Injury Management Practice.

These might include concerns around report timeliness, report quality and contents, or an aspect of the internal IME process. The Assistant Director will address the issue with the service provider to ensure a resolution is achieved.

You and the relevant Injury Manager can directly liaise with the Assistant Director, IME and Injury Management Practice, to escalate such issues. You should copy your Assistant Director into the correspondence.

Assistant Directors and Directors can also engage directly with the Assistant Director, IME and Injury Management Practice to address any concerns regarding IMEs.

IME examination or conduct of an IME provider

If you receive concerns or complaints about the actual IME examination or the conduct of an IME provider, you should inform your Assistant Director, Director and the Claims Complaints and Feedback team immediately.

The Claims Complaints and Feedback team will work with the Assistant Director, IME and Injury Management Practice to assess the concern or complaint and to find a resolution.

If required the Assistant Director, IME and Injury Management Practice will work with the service provider to obtain a response to the complaint and assist in achieving the overall resolution with the Claims Complaints and Feedback team.

Please ensure that you keep an accurate record of all conversations in relation to the concern or complaint raised by the employee or their representative.

For further information about the management of complaints, please see:

Complaints and feedback

Complaints Handling Framework Nov 2022

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Injury sustained at an independent medical examination

If an employee reports an injury sustained whilst travelling to or from an examination, or during the course of the examination, the employee will need to lodge a new claim for compensation for the new injury.

Liability for the new injury will be determined by Comcare. For further guidance, refer to the Newly reported conditions page.

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Non-attendance at an independent medical examination

An employee may refuse or fail, without a reasonable excuse, to undergo an independent medical examination (IME), or they or their support person may in some way obstruct an examination.

Where an employee fails to attend or they or their support person obstructs a medical appointment, you must provide the employee with an opportunity to give a reasonable excuse within **14 calendar days**. You are then responsible for deciding whether the employee's excuse is reasonable.

If you do not consider the excuse reasonable, under section 57(2) of the SRC Act, the employee's rights to compensation under the SRC Act may be suspended until the medical examination takes place. For information about suspending a claim, refer to Suspending claims.

If the employee does not attend the IME, Comcare may be charged a non-attendance fee by the IME provider.

You will need to determine if the employee has a reasonable excuse for not attending the appointment before paying the non-attendance fee.

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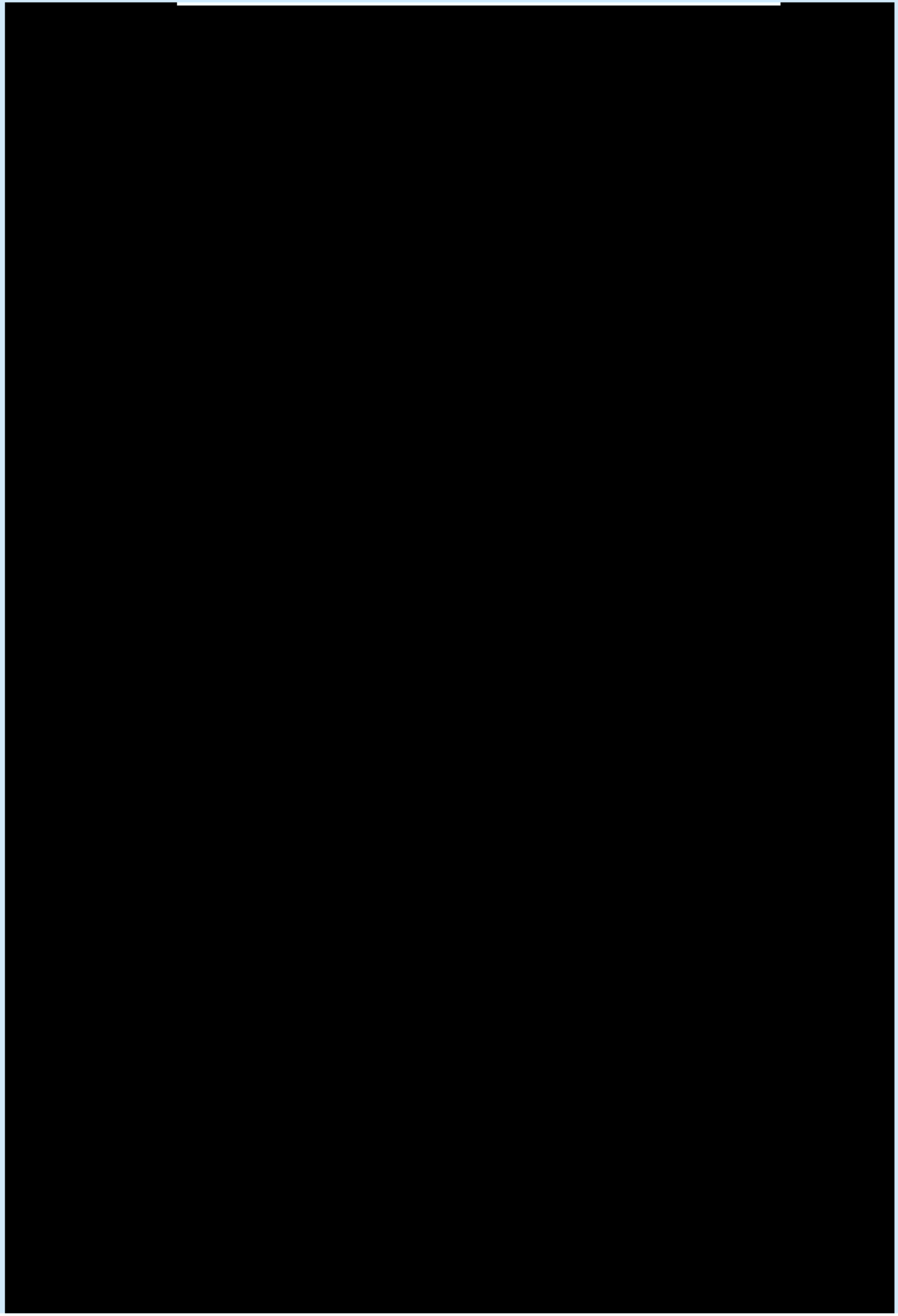

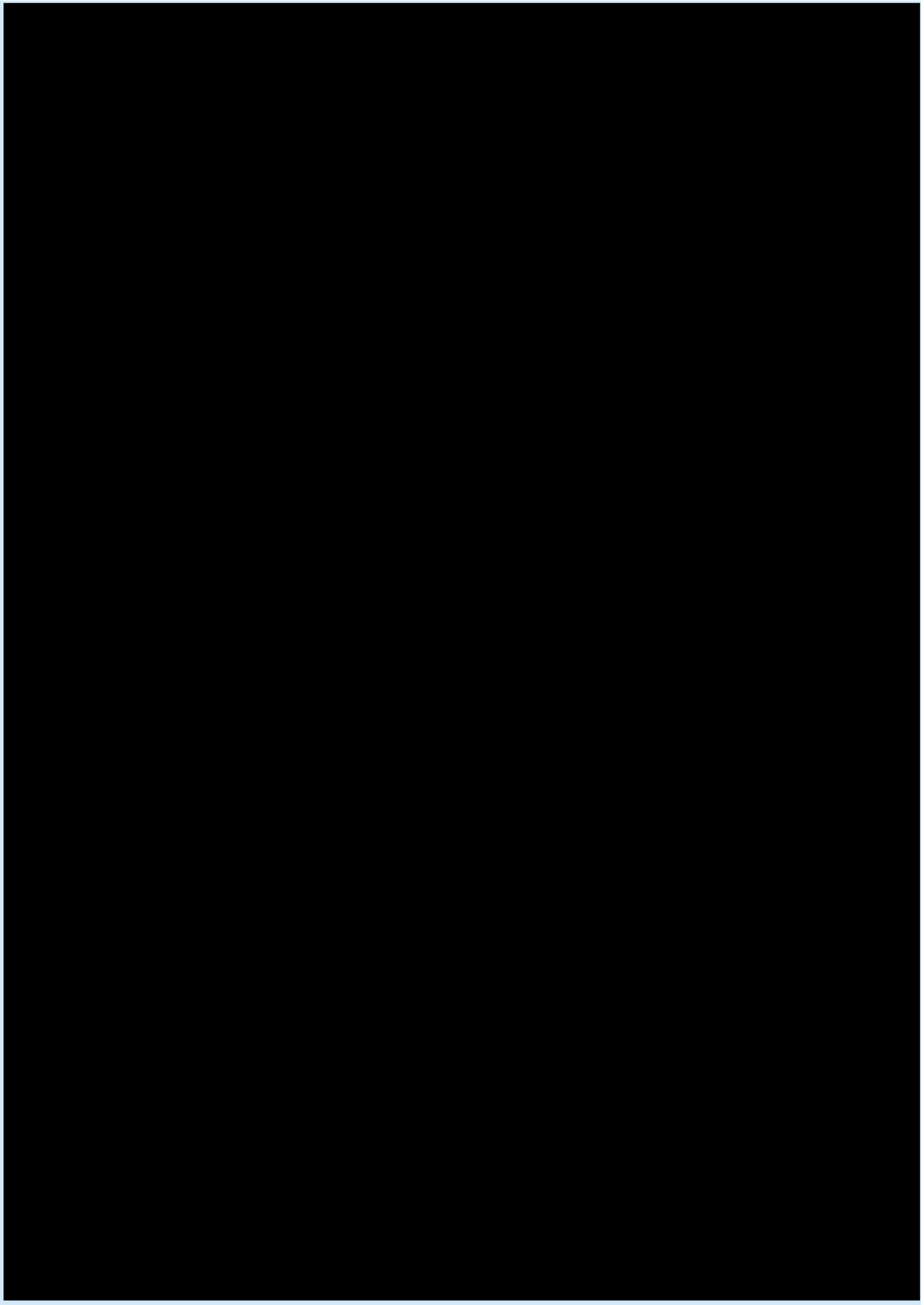

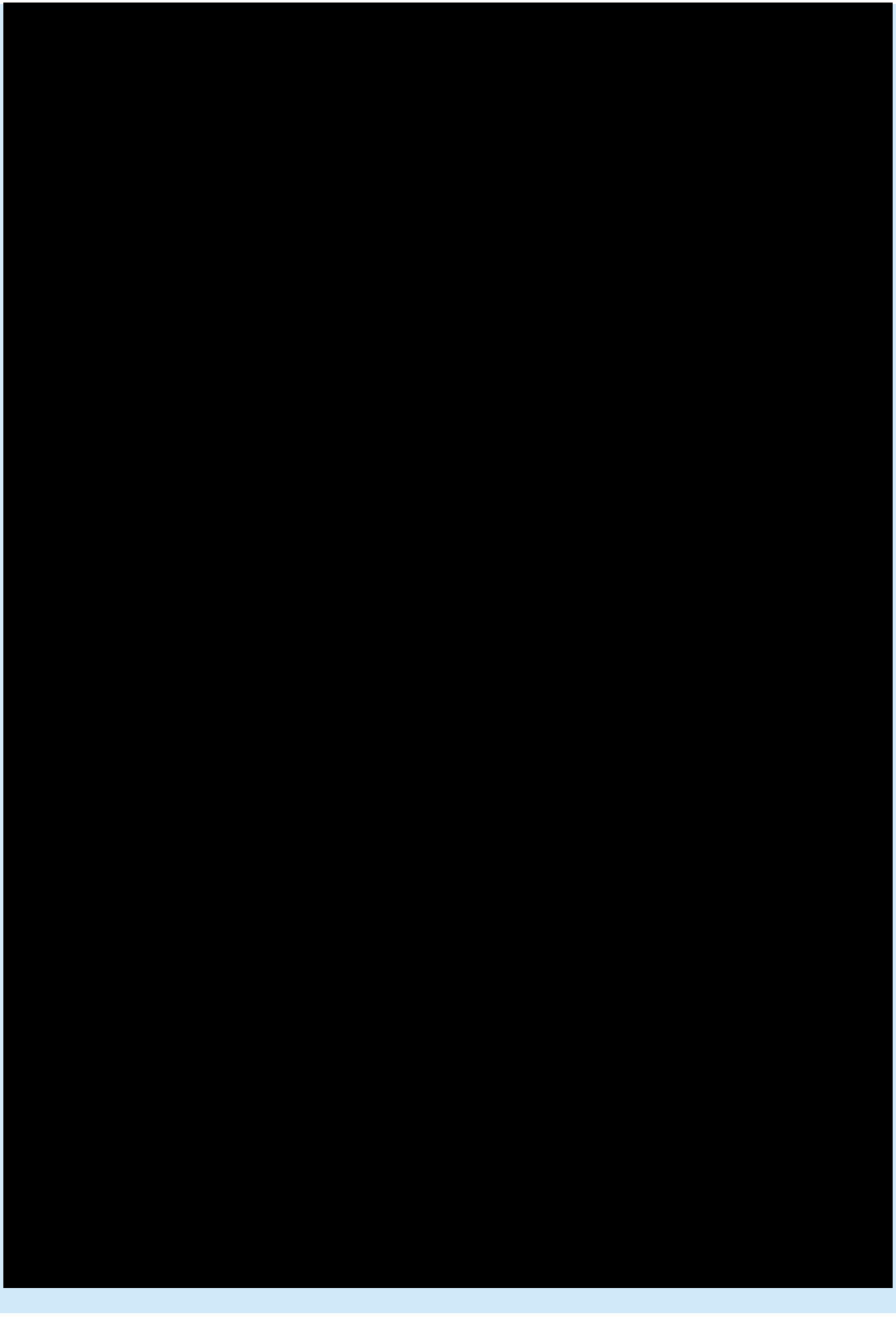

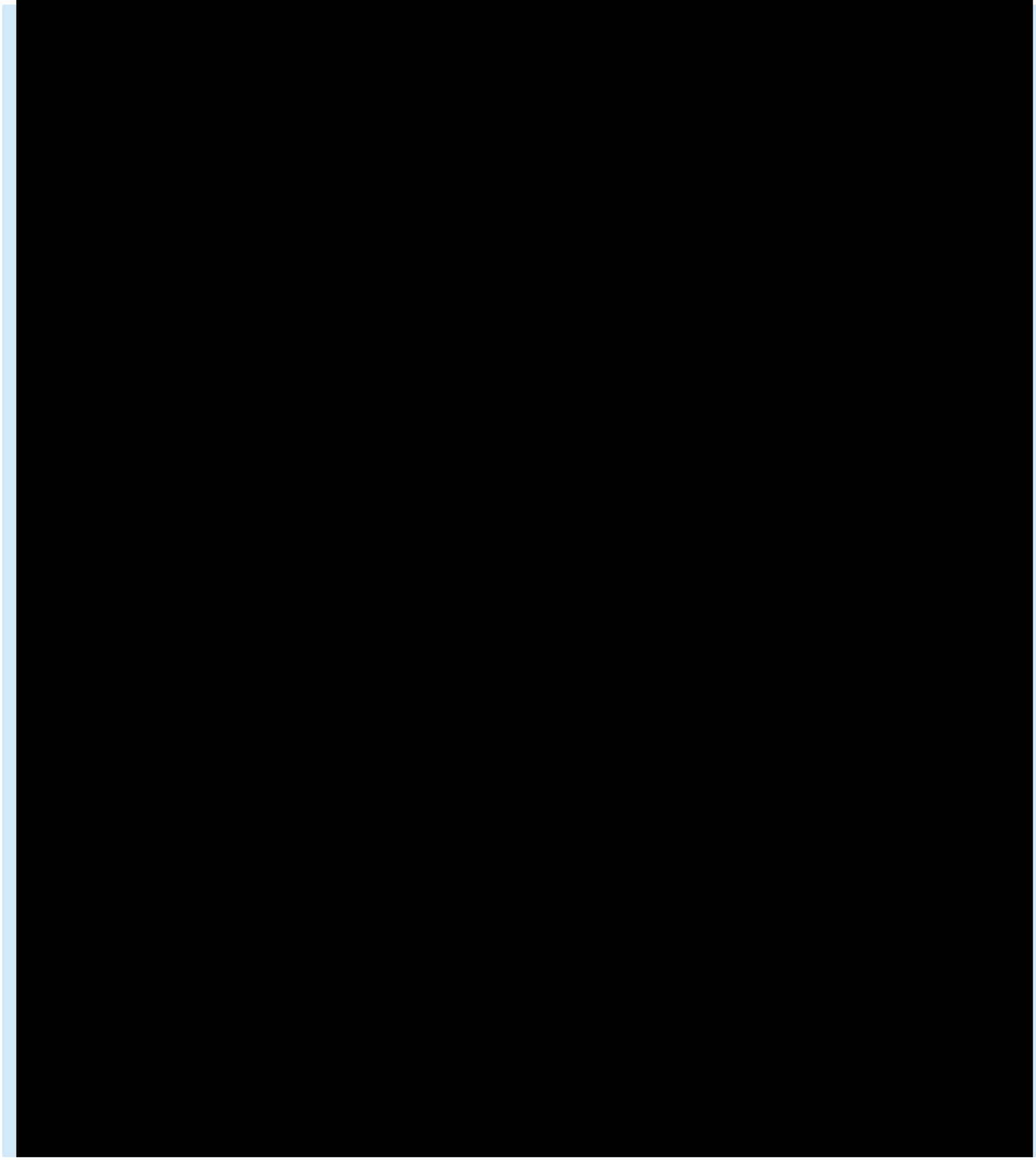

Clinical panel

Clinical panel

The Clinical Panel consists of a team of medical and allied health professionals. They are available for more complex clinical advice and reviews to ensure employees receive the most appropriate treatment for their injury and/or illness.

The Clinical Panel offers advice to medical practitioners and allied health professionals to adopt clinically justified treatment and evidence-based practices. It aims to improve sustainable decision making and ultimately improve health and return to work outcomes for employees.

Undertaking a clinical panel review

The Clinical Panel provides advice to Claims and Injury Managers and medical and allied health practitioners by conducting clinical reviews. These help to ensure employees receive the most appropriate treatment for their injury or illness.

This page contains information about:

- the roles of Injury Managers versus the Clinical Panel
- the purpose of the Clinical Panel Review
- what the Clinical Panel can review
- referring a claim to the Clinical Panel
- the review process and implementing outcomes including actioning the review in Pracsys
- Walk-Up referrals including arranging Walk-Up referrals, and
- pharmacy invoice review procedure.

Click here for Clinical Panel Review Form

Clinical panel review form

Undertaking a clinical panel review

Published 26/11/2025

Introduction

The Clinical Panel consists of a team of medical and allied health professionals. They are available for more complex clinical advice and reviews to ensure employees receive the most appropriate treatment for their injury and/or illness.

The panel also offers advice to medical practitioners and allied health professionals to adopt clinically justified treatment and evidence-based practices. It aims to improve sustainable decision making and ultimately improve health and return to work outcomes for employees.

The panel consists of experienced and independent medical and allied healthcare professionals, including:

- audiologist
- medical practitioners
- physiotherapists
- pharmacists
- psychiatrists
- psychologists
- specialist prosthodontist and
- consultant physician in rehabilitation/pain medicine

These professionals are experts in their fields and, being currently active clinicians, they can assist with decision making about clinical issues during claim management.

Types of Clinical Panel Review

There are two types of Clinical Panel Review, a **full review** and a **Walk-Up** referral.

A **full review** is appropriate for more complex questions related to treatments and interventions including surgery and/or hospital admissions, and claims. It takes place once you have submitted a request for Clinical Panel Review (or when a claim is identified by the Clinical Panel team as requiring review). The Clinical Panel reviews the information you and the Injury Manager have provided on the claim (via the Clinical Panel Review Form) and notifies you when they have completed their review.

Clinical Panel **Walk-Up referrals** are brief video conferences between you, the Injury Manager, and a Clinical Panel Doctor concerning less complex medical queries. Walk-Up referrals provide you the opportunity to ask questions without the need for a full Clinical Panel Review. See Clinical Panel Medical Walk-Up referrals for more information.

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Role of Clinical Panel vs Injury Managers

Injury Managers are the first line of support for Claims Managers who have questions about medical and psychological treatment. Injury Managers are all allied health professionals. They work within the

Claims Operations teams and use their clinical and rehabilitation knowledge to help optimise return to health and work outcomes.

The Clinical Panel is the next line of support. The panel is made up of a team of medical and allied health professionals. They can give more complex clinical advice and conduct reviews of planned treatments to ensure employees receive the most appropriate treatment for their injury or illness.

In **all cases**, you need to first consult an Injury Manager for advice on medical or psychological treatment and/or intervention for an employee. Additionally, some situations **require** you to consult the Clinical Panel (consult with your Injury Manager first). See the section on What to refer for more information.

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Purpose of a Clinical Panel Review

The focus of a review by a member of the Clinical Panel is to ensure treatment is **clinically justified**.

The Clinical Framework for the Delivery of Health Services provides more information about the meaning of **clinically justified** in its Purpose Statement and in Principle One.

The review may require peer discussion between the treating practitioner and a member of the Clinical Panel. In all discussions, the aim is to agree on an appropriate treatment for the employee which is in line with the Clinical Framework principles.

These communications are documented by the Clinical Panel member in the Clinical Panel Review form (CPR).

Where consensus cannot be reached, it is likely the panel will recommend that an Independent Medical Examination should be conducted. For further guidance, refer to the Independent medical examinations page.

As part of the clinical review process, the Clinical Panel will ask treating practitioners to discuss information about an employee who has a claim. Comcare's Privacy statement advises employees that Comcare can collect relevant information about employees from healthcare professionals where the employee has provided authority.

Selection of claims for Clinical Panel Review

Claims may be recommended for Clinical Panel review in the following ways:

- you and the Injury Manager agree that a Clinical Panel Review is required for a particular claim
- the Clinical Panel identifies claims based on certain criteria and data, including treatment type, frequency, duration, or treatment provider (this may be based on business priorities or because an issue has been identified).

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What to refer to the Clinical Panel for review

The following are examples of items that could be appropriate to refer to the Clinical Panel. This list is not exhaustive. Please contact Clinical Panel Support for assistance if you are unsure. All referrals should first be discussed with the appropriate Injury Manager.

Mandatory referral

The following **must** be referred to the panel:

- Major surgeries, any surgery involving a joint, or any other surgery where Clinical Panel input may be useful (for further guidance, refer to the Surgery page).
- Medicinal cannabis (for further guidance, refer to the Medication, pharmaceuticals and medicinal cannabis page).
- NENET (non-established and new emerging therapy) including Platelet Rich Plasma (PRP) injections and stem cells.
- Pain therapies, Implantable Pain Therapies (IPTs), stem cells, ketamine infusions, spinal injection therapies and similar pain interventions (for further guidance, refer to the Pain Therapy page).
- Assistance Dogs.

Possible referral required

Consult with your Injury Manager (IM) to confirm if referral is needed in the following cases:

- Clarification of diagnosis or medical information on undetermined claim.
- Employee having high frequency and/or prolonged medical treatment.
- Request for hospital admission.
- Assistance with strategising for a medically complex claim, e.g. review scheduling, questions for treaters, etc.
- Reviewing pharmaceuticals and how/if they relate to the compensable condition.
- Interpreting imaging, clinical notes and complex medical reports.
- Review of evidence provided by the treating and/or assessing practitioner in relation to treatment of the workplace injury.
- Review of evidence provided by the treating and/or assessing practitioner in relation to the causation of the workplace injury and relationship to claimed condition.
- New complex psychological claims that may benefit from early Clinical Panel involvement to assist with strategy, including review of diagnosis and appropriate treatment.
- Requests for treatment where limited clinical justification has been provided.
- Requests for advice on rare or new medical treatment/therapies, especially where the evidence base is not clear. For example, NENET.
- Requesting peer contact due to difficulties in communication with providers, requirement for a complex medical discussion and/or review of the treatment recommendations.
- Reviewing costs of treatments that appear unreasonable.
- Transcranial magnetic stimulation (TMS) requests (for further guidance, refer to the TMS page).

Please see the list of the Top 10 most common conditions at Comcare.

These include:

- Adjustment reaction
- Carpal Tunnel Syndrome
- Major Depressive Disorder
- PTSD
- Lumbar Sprain (Acute low back pain)
- Knee injury
- Sensorineural hearing loss
- Lateral epicondylitis (tennis elbow)
- Shoulder injury
- Anxiety.

The Clinical Panel, along with the Injury Management Team, may also be able to help with decision making and treatment planning for these conditions.

Note:

- Permanent Impairment (PI) - the Clinical Panel can assist with medical clarification but is unable to advise regarding which tables might be the most appropriate to use. See the section on Permanent Impairment for more guidance.

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Clinical Panel Review process

Submission of a review request

Refer to the Procedure for referring a claim to the Clinical Panel to submit a request for Clinical Panel review.

When a review request has been submitted, you will receive an email confirmation with an estimated timeframe for the review to be conducted.

You will receive a further notification, in the form of a calendar invitation, once the review has been scheduled. A Clinical Panel consultant will contact you to discuss the Panel's conclusions and recommendations.

The Injury Manager can assist with interpreting and actioning recommendations as needed.

Implementing outcomes

The Clinical Panel Support Officer will upload the completed Clinical Panel review form in Pracsys. The system automatically creates an Action Plan Diary.

The Clinical Panel recommendations need to be actioned by you within **five days** of the recommendation being scanned into Pracsys.

If you disagree with the Clinical Panel recommendations, you need to discuss your reasoning with your Injury Manager and Assistant Director. Ensure that, where a recommendation isn't followed, there are clear notes on the claim file to explain the reasons why.

For further information, refer to the Procedure for actioning a Clinical Panel Review section below.

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Clinical Panel Medical Walk-Up referrals

Clinical Panel Walk-Up referrals are brief conversations between you, the Injury Manager, and a Clinical Panel Doctor concerning less complex medical queries.

Walk-Up referrals provide you the opportunity to ask questions without the need for a full Clinical Panel Review. They occur weekly, subject to the Doctor's availability.

An allocated timeframe of 20 minutes per claim is scheduled. This consists of 15 minutes to read the documentation and discuss the claim and 5 minutes for the Clinical Panel Doctor to write up their recommendations.

Where the information or question is complex and/or detailed, a full Clinical Panel Review is preferred to allow adequate time for the Doctor to review. The Clinical Panel support team will contact you if it is determined that the request is not suitable for a Walk-Up.

The total maximum of attached documents for review will generally be limited to 10 pages. The Doctor needs to be able to read and absorb the material and discuss the claim, all within the 15-minute time allocation. No pre-reading is done. Too much documentation will make this unreasonable.

Examples of when a Walk-Up referral may be appropriate can include the following:

- Viewing and interpreting medical reports or scans.
- Review of outcome measures for spinal block testing.
- Review of outcome measures following an approved trial period of medicinal cannabis.
- Assistance with what information may need to be gathered prior to referral for a full Clinical Panel review.
- Reasonableness of surgery or injections (if a previous Clinical Panel Review has been completed and further information was recommended, and that information has now been received).

Note: Transcranial magnetic stimulation (TMS) requests cannot be conducted as a Walk-Up and need to be submitted as a Clinical Panel Review.

Psychiatry walk-ups: Psychiatry walk-ups are a service that is **not** being provided by the Clinical Panel at present.

Walk-Up referrals are a quicker alternative to having less complex questions answered. However, they do not replace a Clinical Panel Review. Depending on the case, the Clinical Panel Doctor may recommend the file is referred for a full review. In this instance, you will need to submit a full Clinical Panel Review form.

Following completion of a Walk-Up, the Clinical Panel Doctor will write their recommendation into Pracsys under 'Manage Claim Comment' (MCOM).

Refer to the section below regarding the Procedure for arranging a Walk-Up referral for further information.

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Clinical Panel invoice review process

The Clinical Panel has a process in place to review pharmacy invoices for compliance with Comcare's Pharmacy policies. This FAQ document provides you with information you need to know about this process.

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