Workers' Compensation and Rehabilitation Regulation 2025

Explanatory notes for SL 2025 No. 116

Made under the

Workers' Compensation and Rehabilitation Act 2003

General Outline

Short title

Workers' Compensation and Rehabilitation Regulation 2025

Authorising law

Section 584 of the *Workers' Compensation and Rehabilitation Act 2003*

Policy objectives and the reasons for them

The *Workers' Compensation and Rehabilitation Act 2003* (Act) establishes the Queensland workers' compensation scheme, which provides benefits for workers who sustain injury in their employment, and dependants if a worker's injury results in the worker's death. The scheme also encourages improved health and safety performance by employers. It is intended to maintain a balance between providing fair and appropriate benefits for injured workers or dependants and ensuring reasonable cost levels for employers.

The *Workers' Compensation and Rehabilitation Regulation 2014* (2014 Regulation) is subordinate legislation made under the Act. It is a procedural regulation that supports substantive provisions in the Act and addresses technical and procedural matters within the workers' compensation scheme. The 2014 Regulation is due to expire on 31 August 2025 under the requirements of the *Statutory Instruments Act 1992*.

Key mechanisms and safeguards in the 2014 Regulation allow the workers' compensation scheme to run efficiently and effectively. These include the assessment of workers' compensation premiums and liabilities, the calculation of certain compensation entitlements, eligibility criteria for payments for serious injuries, prescribed amounts for particular heads of damages, and governance arrangements for medical assessment tribunals.

The 2014 Regulation was due to expire on 31 August 2024 but was exempted from expiry for 12 months under the *Statutory Instruments (Exemptions from Expiry) Amendment Regulation 2014* on the basis that the Act was subject to review, as at the

time a Bill for an Act to amend the Act had been introduced into the Legislative Assembly (namely, the *Workers' Compensation and Rehabilitation and Other Legislation Amendment Bill 2024*).

The policy objective of the *Workers' Compensation and Rehabilitation Regulation 2025* (2025 Regulation) is to maintain the efficient operation and regulation of the workers' compensation scheme following the expiry of the 2014 Regulation.

Achievement of policy objectives

The 2025 Regulation will achieve the policy objective by remaking the 2014 Regulation in a form that retains the overall existing policy intent.

The 2025 Regulation includes several minor changes to clarify the intent of existing provisions, update language to reflect modern drafting standards, remove obsolete provisions and enhance clarity and brevity, including changes to:

- clarify actuarial processes for calculating workers' compensation liabilities when an employer insured by WorkCover Queensland (WorkCover) becomes self-insured, and vice versa;
- clarify processes for applying for workers' compensation when a doctor, nurse practitioner or registered dentist is unavailable and when a claimant sustains an injury outside of Queensland;
- clarify the amounts that are to be taken into account in calculating a worker's normal weekly earnings to reflect the existing policy intent;
- reflect current case law on the interpretation of cost provisions for workers' compensation appeals in the Queensland Industrial Relations Commission, which limit recovery of costs to those of the 'hearing' rather than the broader 'proceeding'; and
- correct omissions made in certain schedules of the 2014 Regulation, which are intended to align with the *Civil Liability Regulation 2014* to ensure comparable awards of damages are made for comparable injuries in both work and non-work contexts.

These changes do not alter existing policy and are expected to reduce uncertainty and disputes for injured workers, employers and insurers.

In addition to these changes, the 2025 Regulation streamlines the operations of the Medical Assessment Tribunals administered by the Workers' Compensation Regulator (Regulator) by enabling the chairperson or deputy chairperson of a tribunal to delegate the constitution of a tribunal to the Regulator. This will support the efficient functioning of the tribunals in the event of absence or unavailability of the chairperson. The 2025 Regulation also requires the chairperson of a tribunal to consult with the secretary of the tribunal about the constitution of a tribunal, which formalises existing administrative arrangements.

The 2025 Regulation also makes changes to clarify the previous interpretation of the provisions in the 2014 Regulation in relation to the recovery of counsel's fees, being that counsel's fees were not recoverable by certain claimants in common law proceedings. The decision of the Queensland Court of Appeal in *Anderson v Pickles Auctions Pty Ltd* (2023) 17 QR 134 (*Anderson* decision) found that the 2014 Regulation did not exclude

recovery of counsel's fees on an assessment of the claimant's costs in common law damages proceedings. The 2025 Regulation responds to this decision by confirming that counsel's fees are not recoverable by a claimant. This is expected to result in cost savings by reducing the amount of costs payable by insurers to claimants who pursue a common law damages claim.

Consistency with policy objectives of authorising law

The 2025 Regulation is consistent with the policy objectives of the Act, which provides that a regulation may make provision for:

1. fixing and varying premiums, rates of premium, bonuses, and demerit charges in relation to policies, including providing for an increase in the rate or a charge if, because of an employer's carelessness or another reason WorkCover considers sufficient, the risk carried by WorkCover is greater than that usually carried in cases of accident insurance of a similar description;

2. payment of additional premiums in relation to policies, and fixing the rates of additional premiums, in cases where employers fail to give to WorkCover the prescribed annual returns within the time decided and notified by WorkCover;

3. authorising WorkCover to assess premiums to be paid, as WorkCover directs, by:

   (a) employers; or
   (b) other persons with whom WorkCover has made contracts of insurance; or
   (c) persons required to give returns; or
   (d) persons whom WorkCover believes to be employers;

   and to increase, reduce and enforce payment of the assessments;

4. the time in which and place where a premium is to be paid to WorkCover;

5. acceptance by WorkCover of risk under contracts of insurance other than policies, the conditions or provisions to be contained or implied in the contracts, the nature and extent of risk covered by the contracts;

6. the proper conduct of WorkCover's insurance business;

7. returns to be given to WorkCover, including –
   (a) the persons who must give the returns, whether employers or other persons; and
   (b) the time and how the returns must be given;

8. the acceptance by WorkCover of payment of premiums by instalments, including –
   (a) payment of interest; and
   (b) the rate and calculation of interest; and
   (c) security to WorkCover for payment of interest;

   and the result of and remedies on a failure to make payment due or to honour obligations under a security given to WorkCover for payment of the premium;

9. the mode of service of process in legal proceedings, or of a notice or document, that

is not provided for under chapter 14 of the Act;

10. the evidentiary value and if necessary, the admissibility into evidence, in a proceeding before a court, tribunal or person of a certificate, or copy of or extract from a document kept for anything under the Act, that is no provided for under chapter 14 of the Act;

11. the management of a claim for which there is more than one defendant;

12. costs, including costs before and after a proceeding is started, and the type and amount of costs that may be claimed or awarded to a claimant during any stage before or after the start of a proceeding; and

13. imposing a penalty for a contravention of a regulation of not more than 20 penalty units.

Inconsistency with policy objectives of other legislation

The 2025 Regulation is not inconsistent with the policy objectives of other legislation.

Alternative ways of achieving policy objectives

Three options were considered in terms of the expiring 2014 Regulation:

1. Allow the 2014 Regulation to expire without replacement;

2. Remake the existing 2014 Regulation (as a new regulation) 'as-is'; or

3. Remake the existing 2014 Regulation (as a new regulation) 'with amendments'.

Option 1 was not preferred, as allowing the 2014 Regulation to expire without replacement would render key provisions of the Act inoperative. This would prevent essential workers' compensation services from being delivered (for example, assessments undertaken by the Medical Assessment Tribunals), cause uncertainty and disputes, lead to inefficiency and increase scheme administration costs.

Option 2 was not preferred, as remaking the 2014 Regulation 'as-is' would not allow for the minor amendments necessary to ensure the 2025 Regulation conforms with modern drafting standards or changes to support the efficiency of the Medical Assessment Tribunals and respond to the *Anderson* decision.

Option 3 was preferred, as remaking the 2014 Regulation 'with amendments' is necessary to ensure it continues to meet policy objectives. This option will deliver the highest net benefit in relation to the policy objective and result in streamlining processes, a simplified statutory instrument and enhanced clarity for scheme stakeholders.

Benefits and costs of implementation

There is no cost to government, business or the community in implementing the 2025 Regulation. The 2025 Regulation will provide certainty to scheme participants and minimise disruption to the workers' compensation scheme by remaking the 2014 Regulation in a way that retains or restores the existing policy intent. Specifically, the

2025 Regulation maintains existing rights and entitlements (with the exception of changes relating to the recovery of counsel's fees), provides for efficient processes for insurers and employers, and removes obsolete processes, requirements and unnecessary duplication.

Consistency with fundamental legislative principles

The 2025 Regulation is considered to be consistent with fundamental legislative principles.

Consultation

Due to the highly technical nature of the 2014 Regulation, targeted consultation was undertaken with key scheme stakeholders to inform the sunset review. Stakeholders invited to participate in consultation included workers' compensation insurers, employer and industry associations, worker associations, legal professional associations, and medical and allied health associations.

Submissions to the sunset review were made by workers' compensation insurers, legal associations, and allied health associations. All submissions received supported the remake of the 2014 Regulation 'as-is' or with amendments.

Feedback was also sought from Queensland Government agencies, with submissions supporting the remake of the 2014 Regulation 'as-is' or with amendments necessary to ensure it continues to meet policy objectives.

Following consultation with the Office of Best Practice Regulation, it was determined that full regulatory impact analysis was not required under the Queensland Government *Better Regulation Policy*. A Summary Impact Analysis Statement was instead prepared.

Notes on provisions

Part 1 Preliminary

1 Short title

This section sets out the short title of the 2025 Regulation.

2 Commencement

This section provides that the 2025 Regulation commences on 1 September 2025.

3 Definitions

This section provides for a dictionary of particular words to be used in the 2025 Regulation. The dictionary is at schedule 18.

4 WorkCover's capital adequacy—Act, s 453

This section provides that WorkCover maintains adequate capital for the purposes of section 453(b) of the Act if its total assets are at least equal to its total liabilities.

Part 2 Employer insurance

Division 1 Policies and premium assessments

5 Application for policy

This section provides that an application for a policy must be made to WorkCover in the approved form.

6 Policies and renewals

This section prescribes the steps WorkCover must take to issue a policy to an employer upon either the receipt of the premium payable or the entering into of an instalment plan.

7 Assessment of premium

This section prescribes WorkCover's obligation to assess premiums payable under insurance policies.

8 Declaration of wages

This section prescribes the obligations of employers to lodge an annual wages declaration with WorkCover for the purposes of premium calculation. Penalties for non-compliance are at schedule 1.

9 Value of board and lodging

This section provides that the value of board and lodging provided to a worker is taken to be wages paid, or provided, by the employer to the worker. Minimum amounts are specified. The term 'board' is defined for the purposes of this section.

10 Payment of premium by instalments

This section provides that WorkCover may accept payment of premium by instalments if WorkCover is satisfied that payment of premium by the due date would impose financial hardship on the employer. Interest may apply to the amount owed on the terms provided for under the section.

11 Additional premium for late payment of premium—Act, ss 61 and 62

This section prescribes the additional amount payable by an employer for late or non-payment of premium to WorkCover.

12 Premium for ascertaining appeal court—Act, s 569

This section prescribes the formula used for section 569(2)(a) of the Act to determine the court that has jurisdiction for appeals by an employer or self-insurer in relation to:

- the Regulator's decision regarding the issue of a self-insurer's licence;
- the Regulator's decision regarding the renewal of a self-insurer's licence;
- the Regulator's decision regarding the amount of levy payable by a self-insurer;
- the amount of a self-insurer's outstanding liability under section 87(2) of the Act; and
- the Regulator's decision regarding the cancellation of a self-insurer's licence.

13 Former employer may apply to cancel policy

This section prescribes the steps an employer must take to cancel a policy because the person has stopped employing workers.

14 Cancellation of policy if workers no longer employed

This section prescribes the steps WorkCover must take to cancel a policy because the employer has stopped employing workers.

Division 2 Employer excess

15 Excess period—Act, s 65

This section prescribes the employer excess period for section 65(2) of the Act as the lesser of Queensland Ordinary Time Earnings (QOTE) or the amount of the weekly payment of compensation to which the injured worker is entitled under chapter 3, part 9 of the Act.

Division 3 Self-insurance

16 Definitions for division

This section provides a dictionary definition of 'annual levy', 'provisional annual levy' and 'specified date' to be used in this division.

17 Application fee—Act, s 70

This section prescribes the application fee for self-insurance licences for section 70(c) of the Act.

18 Annual levy—Act, s 81

This section prescribes the formula to be used to calculate the annual levy payable by self-insurers for section 81(2) of the Act.

19 Provisional annual levy—not agreed or decided

This section provides for the calculation of a provisional annual levy payable by a self-insurer in circumstances in which the self-insurer's estimated claims liability for a year has been calculated by the appointed actuary but the Regulator and the self-insurer have not agreed on the amount of the self-insurer's estimated claims liability and the arbiter has not decided the amount of the self-insurer's estimated claims liability. The Regulator may use the self-insurer's estimate to calculate the annual levy payable.

20 Actual annual levy—agreed

This section provides for the provision of a notice of an annual levy payable by a self-insurer where the Regulator gave a self-insurer a written notice stating the amount of the provisional annual levy under section 19(2)(b) and the Regulator and self-insurer have agreed on the amount of the self-insurer's estimated claims liability.

21 Actual annual levy—not agreed but decided

This section provides for the provision of a notice of an annual levy payable by a self-insurer where the Regulator gave a self-insurer a written notice stating the amount of the provisional annual levy under section 19(2)(b), the Regulator and self-insurer have not agreed on the amount of the self-insurer's estimated claims liability, and the arbiter has decided the amount of the self-insurer's estimated claims liability and the decided adjusted amount is not the same as the amount of the self-insurer's estimated claims liability used to calculate the provisional annual levy.

22 Additional amount if levy not paid before due date—Act, s 82

This section prescribes the additional amount payable by a self-insurer for late or non-payment of annual levy to the Regulator for section 82(1) of the Act.

23 Condition of licence—Act, s 83

This section prescribes an obligation on self-insurers to submit wages declarations to the Regulator for section 83(1)(a) of the Act.

24 Premium payable after cancellation of self-insurer's licence—Act, s 98

This section prescribes the calculation method and rate for the premium payable by a former self-insurer for the first two years after cancellation of the self-insurance licence for section 98 of the Act.

25 Deemed levy for ascertaining appeal court—Act, s 569

This section prescribes the formula to be used to calculate the deemed levy for section 569(2)(a) of the Act. The amount of the deemed levy determines the court that has jurisdiction to hear an appeal concerning certain decisions of the Regulator regarding self-insurance matters.

Part 3 Calculation of self-insurer's liability

Division 1 Outstanding liability

Subdivision 1 Preliminary

26 Definitions for division

This section provides definitions for 'application day', 'appointed actuary', 'assessment day', 'outstanding liability' and 'summary report' to be used in this division.

27 Calculation of outstanding liability—Act, s 87

This section provides that the amount of a self-insurer's outstanding liability for section 87(2) of the Act must be calculated under this division.

Subdivision 2 Actuarial calculations and reports

28 Appointment of actuaries

This section provides that WorkCover and the self-insurer must each appoint an actuary to calculate the self-insurer's outstanding liability.

29 Regulator to give appointed actuaries information

This section provides that the Regulator must give each appointed actuary the information necessary to enable the actuaries to calculate a self-insurer's outstanding liability within the period mentioned in section 31(3).

30 Actuarial calculation

This section prescribes the matters that must be included or taken into account for the actuarial calculation of the self-insurer's outstanding liability.

31 Actuarial report

This section prescribes the matters that must be included or taken into account in each actuary's report of the self-insurer's outstanding liability. The report must be completed within 35 days after the self-insurance application day.

32 Summary report

This section provides that a joint summary report must be prepared by the appointed actuaries which includes each appointed actuary's individual actuarial report and states how the individual reports of the appointed actuaries agree or differ. The report must be completed within two months after the self-insurance application day.

33 Agreement on amount

This section provides that WorkCover and the self-insurer may agree on the amount of the self-insurer's outstanding liability having regard to the summary report.

34 Referral to arbiter if no agreement on amount

This section provides that if there is no agreement between WorkCover and the self-insurer on the amount of the self-insurer's outstanding liability, the Regulator must refer the summary report to the arbiter to decide the amount.

35 Payment of amount

This section provides that WorkCover must pay the agreed or arbitrated outstanding liability amount to the self-insurer, subject to adjustments in the amount of compensation and damages claimed against and paid by the self-insurer during the final period.

36 Transfer of claims information

This section provides that WorkCover must give the self-insurer claims information (e.g. data, files) in relation to the self-insurer's outstanding liability before the day the self-insurer's licence starts.

Division 2 Total liability

Subdivision 1 Preliminary

37 Definitions for division

This section provides definitions for 'appointed actuary', 'assessment day', 'consent day', 'member', 'new insurer', 'old insurer' and 'summary report' to be used in this division.

38 Calculation of total liability after change in self-insurer's membership—Act s 90

This section provides that the amount of total liability after a change in the self-insurer's membership must be calculated under this division for section 90(9)(a) of the Act.

Subdivision 2 Actuarial calculations and reports

39 Appointment of actuaries

This section provides that the old insurer and the new insurer must each appoint an actuary to calculate the member's total liability amount.

40 Insurers to give appointed actuaries information

This section provides that the old insurer and the new insurer must give each appointed actuary the information necessary to enable the actuaries to calculate the member's total liability amount within the period mentioned in section 42(3).

41 Actuarial calculation

This section prescribes the matters that must be included or taken into account for the actuarial calculation of the member's total liability.

42 Actuarial report

This section prescribes the matters that must be included or taken into account in each appointed actuary's report on the member's total liability. The report must be completed within 35 days after the day the Regulator approves the change in the self-insurer's membership.

43 Summary report

This section provides that a joint summary report must be prepared by the appointed actuaries which includes each appointed actuary's individual actuarial report and states how the individual reports of the appointed actuaries agree or differ. The report must be completed within two months after the day the Regulator approves the change in the self-insurer's membership.

44 Agreement on amount

This section provides that the old insurer and the new insurer may agree on the member's total liability amount having regard to the summary report.

45 Referral to arbiter if no agreement on amount

This section provides that if there is no agreement over the amount of total liability between the old insurer and the new insurer, the Regulator must refer the summary report to the arbiter to decide the amount.

46 Payment of amount

This section provides that the old insurer must pay the agreed or arbitrated total liability amount to the new insurer, subject to adjustments in the amount of compensation and damages claimed against and paid by the member during the final period. The old insurer must also advise the Regulator of the details of the transition.

47 Transfer of claims information

This section provides that the old insurer must give the new insurer claims information (e.g. data, files) in relation to the member's total liability by the day the final amount is paid to the new insurer.

Division 3 Liability after cancellation of self-insurer's licence

Subdivision 1 Preliminary

48 Definitions for division

This section provides definitions for 'appointed actuary', 'assessment day', 'cancellation day', 'former self-insurer' and 'summary report' to be used in this division.

49 Calculation of liability after cancellation—Act, s 102

This section provides that the amount of a former self-insurer's liability under sections

68C and 87(1) of the Act must be calculated under this division for section 102(3) of the Act.

Subdivision 2 Actuarial calculations and reports

50 Appointment of actuaries

This section provides that WorkCover and the former self-insurer must each appoint an actuary to calculate the former self-insurer's liability.

51 Former self-insurer to give appointed actuaries information

This section provides that the former self-insurer must give each appointed actuary the information necessary to enable the appointed actuaries to complete the calculation of the former self-insurer's liability within the period mentioned in section 53(3).

52 Actuarial calculation

This section prescribes the matters that must be included or taken into account for the actuarial calculation of the former self-insurer's liability.

53 Actuarial report

This section prescribes the matters that must be included or taken into account in each actuary's report on the former self-insurer's liability. The report must be completed within 35 days after the day the former self-insurer's licence is cancelled.

54 Summary report

This section provides that a joint summary report must be prepared by the appointed actuaries which includes each appointed actuary's individual actuarial report and states how the individual reports of the appointed actuaries agree or differ. The report must be completed within two months after the day the former self-insurer's licence is cancelled.

55 Agreement on amount

This section provides that WorkCover and the former self-insurer may agree on the former self-insurer's liability amount having regard to the summary report.

56 Referral to arbiter if no agreement on amount

This section provides that if WorkCover and the former self-insurer do not agree on the former self-insurer's liability amount for sections 68C and 87(1) of the Act, the Regulator must refer the summary report to the arbiter to decide the amount.

57 Payment of amount

This section provides that the former self-insurer must pay the agreed or arbitrated liability amount to WorkCover, subject to adjustments in the amount of compensation and damages claimed against and paid by the former self-insurer during the final period.

Division 4 Estimated claims liability for lodgement of security

Subdivision 1 Preliminary

58 Definitions for division

This section provides dictionary definitions for 'appointed actuary', 'second appointed actuary' and 'self-insurer's data' to be used in this division.

59 Calculation of estimated claims liability—Act, s 84

This section provides that the amount of a self-insurer's estimated claims liability must be calculated under this division for section 84(4)(b) of the Act.

Subdivision 2 Actuarial calculations and reports

60 Appointment of actuary

This section provides that an actuary appointed by the Regulator must calculate the self-insurer's estimated claims liability.

61 Self-insurer to give Regulator and appointed actuary information

This section provides that the self-insurer must give the Regulator and the appointed actuary the information necessary to calculate the self-insurer's estimated claims liability.

62 Actuarial calculation

This section prescribes the matters that must be included or taken into account for the actuarial calculation of the self-insurer's estimated claims liability.

63 Actuarial report

This section prescribes the matters that must be included or taken into account in the actuary's report on a self-insurer's estimated claims liability.

64 Appointed actuary must give copy of report to Regulator and self-insurer

This section provides that the appointed actuary must give a copy of the actuarial report to the Regulator and the self-insurer before the day stated by the Regulator or a later day agreed between the Regulator and the appointed actuary.

65 Regulator to tell self-insurer whether agreement on amount

This section provides that within 35 days after the appointed actuary gives the Regulator a copy of the actuarial report, the Regulator must advise the self-insurer whether the Regulator agrees or does not agree with the appointed actuary's assessment of the estimated claims liability.

66 Referral to second appointed actuary if no agreement on amount

This section provides that if the Regulator does not agree with the amount in the appointed actuary's report, it may ask a second appointed actuary to calculate the amount of the self-insurer's estimated claims liability and provide an actuarial report.

67 Agreement on amount

This section provides that the estimated claims liability is the amount agreed to by the Regulator and the self-insurer, having regard to the appointed actuary's actuarial report or the second appointed actuary's actuarial report.

68 Referral to arbiter if no agreement on amount

This section provides that if the Regulator and the self-insurer do not agree on the amount of the self-insurer's estimated claims liability under section 67, the Regulator must refer the appointed actuary's report, the self-insurer's data and any second appointed actuary's actuarial report to the arbiter to decide the amount.

Division 5 Self-insurers who become non-scheme employers

Subdivision 1 Preliminary

69 Definition for division

This section provides a definition for 'cancellation day' to be used in this division.

70 Calculation of non-scheme employer's liability—Act, s 105I

This section provides that the amount of a non-scheme employer's liability must be estimated under subdivision 2 and finalised under subdivision 3 for section 105I(2) of the Act.

Subdivision 2 Estimating non-scheme employer's liability

71 Definition for subdivision

This section provides definitions for 'appointed actuary' and 'summary report' to be used in this subdivision.

72 Appointment of actuaries

This section provides that WorkCover and the non-scheme employer must each appoint an actuary to calculate the non-scheme employer's liability amount for section 105B(3) of the Act.

73 Non-scheme employer to give appointed actuaries information

This section provides that the non-scheme employer must give each appointed actuary the information necessary to enable the actuaries to estimate the amount of the non-scheme employer's liability within the period mentioned in section 75(3).

74 Actuarial calculation

This section prescribes the matters that must be included or taken into account for the actuarial calculation of a non-scheme employer's liability amount.

75 Actuarial report

This section prescribes the matters that must be included or taken into account in the actuary's report on a non-scheme employer's liability.

76 Summary report

This section provides that a joint summary report must be prepared by the appointed actuaries which includes each appointed actuary's individual actuarial report and states how the individual reports of the appointed actuaries agree or differ. The report must be completed within two months after the cancellation day.

77 Agreement on amount

This section provides that WorkCover and the non-scheme employer may agree on the amount of the non-scheme employer's liability having regard to the summary report.

78 Referral to arbiter if no agreement on amount

This section provides that if WorkCover and the non-scheme employer do not agree on the non-scheme employer's liability amount for section 105B(3) of the Act, the Regulator must refer the summary report to the arbiter to decide the amount.

79 Payment of amount

This section provides that the non-scheme employer must pay the agreed or arbitrated liability amount to WorkCover, subject to adjustments in the amount of compensation and damages claimed against and paid by the non-scheme employer during the final period.

Subdivision 3 Finalising non-scheme employer's liability

80 Definition for subdivision

This section provides definitions for 'appointed actuary' and 'summary report' to be used in this subdivision.

81 Appointment of actuaries

This section provides that WorkCover and the non-scheme employer must each appoint an actuary to finalise the non-scheme employer's liability 20 business days after the day that is four years after cancellation of a self-insurance licence.

82 WorkCover to give appointed actuaries information

This section provides that WorkCover must give the appointed actuaries the information

necessary to enable the appointed actuary to complete the calculation of the non-scheme employer's liability within the period mentioned in section 84(3).

83 Actuarial calculation

This section prescribes the matters that must be included or taken into account for the actuarial calculation of the finalised amount of a non-scheme employer's liability.

84 Actuarial report

This section prescribes the matters that must be included or taken into account in the actuary's report on the calculation of the finalised amount of a non-scheme employer's liability.

85 Summary report

This section provides that a joint summary report must be prepared by the appointed actuaries which includes each appointed actuary's individual actuarial report and states how the individual reports of the appointed actuaries agree or differ. The report must be completed within two months after the day that is four years after the cancellation day.

86 Agreement on amount

This section provides that WorkCover and the non-scheme employer may agree on the amount of the finalised non-scheme employer's liability, having regard to the summary report.

87 Referral to arbiter if no agreement on amount

This section provides that if WorkCover and the non-scheme employer do not agree on the finalised amount of the non-scheme employer's liability for section 105B(3) of the Act, the Regulator must refer the summary report to the arbiter to decide the amount.

88 Payment of amount

This section provides that if the agreed or arbitrated amount of the non-scheme employer's liability (finalised amount) is more than the amount paid by the non-scheme employer under section 79 (interim payment), the non-scheme employer must pay WorkCover the difference between the finalised amount and the interim payment, plus interest. If the finalised amount is less than the interim payment, WorkCover must pay the non-scheme employer the difference between the interim payment and the finalised amount, plus interest. On payment of the amount, the non-scheme employer's liability is finalised for section 105I(5) of the Act.

Division 6 Total liability—member of a group who becomes non-scheme employer

Subdivision 1 Preliminary

89 Definitions for division

This section provides definitions for 'appointed actuary', 'assessment day', final day', 'old self-insurer' and 'summary report' to be used in this division.

90 Calculation of non-scheme member's total liability—Act, s 105O

This section provides that the amount of a non-scheme member's total liability must be calculated under this division for section 105O(3)(a) of the Act.

Subdivision 2 Actuarial calculations and reports

91 Appointment of actuaries

This section provides that WorkCover and the old self-insurer must each appoint an actuary to calculate the total liability amount of the non-scheme member.

92 WorkCover and old self-insurer to give appointed actuaries information

This section provides that the old self-insurer must give each appointed actuary the information necessary to enable the appointed actuary to calculate the non-scheme member's total liability within the period mentioned in section 94(3).

93 Actuarial calculation

This section prescribes the matters that must be included or taken into account for the actuarial calculation of the non-scheme member's total liability amount.

94 Actuarial report

This section prescribes the matters that must be included or taken into account in the actuary's report on the non-scheme member's total liability amount.

95 Summary report

This section provides that a joint summary report must be prepared by the appointed actuaries which includes each appointed actuary's individual actuarial report and states how the individual reports of the appointed actuaries agree or differ. The report must be completed within two months after the final day.

96 Agreement on amount

This section provides that the old self-insurer and WorkCover may agree on the non-scheme member's total liability amount having regard to the summary report.

97 Referral to arbiter if no agreement on amount

This section provides that if the old self-insurer and WorkCover do not agree on the total liability amount of the non-scheme member, the Regulator must refer the summary report to the arbiter to decide the amount.

98 Payment of amount

This section provides that the old self-insurer must pay the amount of the non-scheme member's agreed or arbitrated total liability to WorkCover, subject to adjustments in the amount of compensation and damages paid by the non-scheme member and claims lodged against the non-scheme member.

99 Transfer of claims information

This section provides that the old self-insurer must give WorkCover claims information (e.g. data, files) in relation to the non-scheme member's total liability no later than the day the final amount is paid.

Division 7 Actuarial arbiter

100 Appointment of arbiter

This section prescribes the process for selecting and appointing the actuarial arbiter.

101 Functions of arbiter

This section prescribes the functions of the actuarial arbiter.

102 Arbiter must decide amount of liability

This section prescribes the matters required to be included in the arbiter's decision.

103 Arbiter's decision is final

This section provides that unless the Supreme Court decides the arbiter's decision is affected by a jurisdictional error, the arbiter's decision is final and cannot be challenged.

104 Arbiter's costs

This section prescribes the way that the arbiter's costs are to be apportioned among relevant parties to the arbiter's decision.

Part 4 Compensation

Division 1 Calculation of normal weekly earnings

105 Calculation of NWE—Act, s 106

This section provides that the way to calculate normal weekly earnings (NWE) is prescribed under this division for section 106(3) of the Act.

106 What amounts may be taken into account

This section lists the types of amounts that may be taken into account for the purposes of calculating NWE.

107 NWE if impracticable to calculate worker's earnings

This section provides for ways of calculating NWE if it is impracticable to calculate the worker's rate of remuneration because of the period of time for which the worker has been employed or the terms of the worker's employment.

108 NWE if worker employed by 2 or more employers

This section provides for the way of calculating NWE where a worker has concurrent contracts of service with 2 or more employers. Only earnings from the employers by whom the worker was employed when the injury was sustained may be taken into account.

109 NWE if insurer considers calculation unfair

This section provides that if an insurer considers that the calculation of NWE under this division would be unfair to the worker, the NWE may be calculated in a way the insurer considers to be fair.

Division 2 Application for compensation

110 Evidence and particulars for application for compensation—Act, s 132

This section specifies the additional evidence or particulars which must accompany an injured worker's application for compensation for section 132(3)(b) of the Act.

111 Evidence and particulars for assessment of DPI—Act, s 132A

This section specifies the evidence which must accompany an application for compensation for assessment of the degree of permanent impairment (DPI) for section 132A(3)(c)(ii) of the Act. The application must include evidence and particulars of the injury and its cause, and the nature, extent and duration of incapacity resulting from the injury.

112 Evidence and particulars for certificate of dependency—Act, s 132B

This section provides that a request for a certificate stating a person is a dependant of a deceased worker must be accompanied by the evidence and particulars prescribed in the section.

113 Doctor, nurse practitioner or registered dentist required to give medical certificate not available

This section provides that if a claimant does not lodge a medical certificate with an application for compensation because the issuing person (being a doctor, nurse practitioner or registered dentist) is unavailable, a declaration is able to be completed. The declaration is only acceptable proof of incapacity for a maximum of three days.

114 Doctor, nurse practitioner or registered dentist required to give medical certificate outside Queensland

This section provides that if a worker sustains an injury in another State or country and does not lodge a medical certificate with an application for compensation, the applicant may give the insurer a document that is substantially to the same effect of the medical certificate from the doctor, nurse practitioner or registered dentist who attended the worker.

115 Requirement to submit to personal examination by registered person—Act, ss 135 and 510

This section provides that a request for a personal examination of a claimant or worker must be made in writing and specifies the details required to be included in the request for sections 135 and 510 of the Act.

Division 3 Entitlement to compensation for permanent impairment—generally

116 Additional lump sum compensation for workers with terminal latent onset injuries—Act, s 128B

This section specifies that the amounts of additional lump sum compensation for workers with latent onset injuries that are terminal are detailed in schedule 2 for section 128B(2)(c) of the Act.

117 Calculation of lump sum compensation—Act, s 180

This section provides that lump sum compensation for a worker's DPI is calculated by multiplying the maximum statutory compensation by the worker's DPI for section 180(1) of the Act.

118 Additional lump sum compensation for workers with DPI of 30% or more—Act, s 192

This section specifies that the amounts of additional lump sum compensation for workers who sustain an injury that results in a DPI of 30% or more are detailed in schedule 3 for section 192(2) of the Act.

119 Occupational therapist's assessment of level of dependency and day to day care requirements—Act, ss 193 and 224

This section prescribes the modified barthel index as the way of assessing a worker's level of dependency for sections 193(4) and 224(3) of the Act. The modified barthel index is the guidelines and modified scoring of the barthel index stated in the article 'Improving the sensitivity of the Barthel Index for stroke rehabilitation' by S Shah, F Vanclay and B Cooper published in the Journal of Clinical Epidemiology, 1989, vol 42 no 8, pp 703-709.

120 Occupational therapist's assessment report—Act, ss 193 and 224

This section prescribes the information required in the occupational therapist's report regarding the level of day to day care provided by a person at a worker's home for the purposes of determining additional lump sum compensation for gratuitous care for

sections 193 and 224 of the Act.

121 Additional lump sum compensation for gratuitous care—Act, s 193(6)

This section specifies that the amounts of additional lump sum compensation and graduated scale for gratuitous care are detailed in schedule 4. This section also provides that for section 193(6)(c) of the Act, the occupational therapist's report given under section 193(5) of the Act is prescribed.

Division 4 Entitlement to additional compensation for permanent impairment—Act, s 193A

Subdivision 1 Preliminary

122 Purpose of division

This section states the purpose of this division in relation to section 193A of the Act.

123 Definitions for division

This section provides definitions for 'injury', 'panel', 'qualifying condition', 'section 193A compensation' and 'section 193A notice' to be used this division.

124 Application of division

This section provides that this division applies only to a worker to whom section 193A of the Act applies.

Subdivision 2 Amount and condition of entitlement

125 Amount of compensation—Act, s 193A

This section provides that the compensation for an injury sustained by a worker that has met the qualifying condition is provided for under schedule 5.

126 Qualifying condition—Act, s 193A

This section prescribes the condition that must be satisfied for a worker to be entitled to compensation under section 193A of the Act.

Subdivision 3 Process for deciding qualifying condition

127 Application of subdivision

This section provides that this subdivision applies if a worker's DPI has been decided.

128 Insurer to consider qualifying condition

This section prescribes what the insurer must decide when considering whether the qualifying condition is satisfied for the worker.

129 Notification

This section provides that the insurer must give the worker a notice after deciding matters referred to in section 128 and lists the matters which must be stated in the notice.

130 Worker may request reasons

This section provides that if the insurer has decided the qualifying condition is not satisfied for the worker, the worker may request written reasons for the decision within 10 business days after receiving the notice. The insurer must give the worker reasons for the decision within 10 business days after receiving the worker's request.

131 Giving information

This section provides that if the insurer has decided it does not have enough information to determine whether the qualifying condition is satisfied for the worker, the worker may take steps to give further information to the insurer. If the worker gives information to the insurer under this section, the worker must advise the insurer whether the worker has engaged a lawyer or incurred legal costs in giving the information.

132 Decision based on worker's information

This section specifies steps the insurer must take if the worker has given the insurer information under section 131.

133 Meeting before decision made

This section specifies steps the insurer must take if the worker has given the insurer information under section 131 and the insurer proposes to decide the qualifying condition is not satisfied for the worker.

Subdivision 4 Review of insurer's decision

134 Definition for subdivision

This section provides for a definition of 'decision' to be used in this subdivision.

135 Application of subdivision

This section provides that this subdivision applies to a worker who has received written reasons for an insurer's decision that the qualifying condition is not satisfied for the worker, or a worker for whom an insurer is taken to have decided the qualifying condition is not satisfied. The insurer is taken to have decided the qualifying condition is not satisfied for the worker if the insurer does not make a decision within the timeframe under section 132(3).

136 Application for review

This section provides that the worker may apply for a panel review of the decision within 20 business days and lists what must be included in the worker's application. The worker

must give the insurer a copy of the application.

137 Insurer to give information to panel

This section prescribes that the insurer must give the review panel and the worker any information the insurer has considered in deciding whether the qualifying condition is satisfied for the worker as soon as practicable after receiving the worker's review application.

138 Review by panel

This section provides that the review panel must decide to confirm the decision, or cancel the decision and substitute a new decision, and the panel must give the worker and the insurer written notice of its decision with reasons.

139 Panel's decision is final

This section provides that a decision of the panel under section 138 is final and conclusive unless the Supreme Court decides the decision is affected by jurisdictional error.

140 Insurer must notify amount of entitlement

This section provides that the insurer must give the worker a written notice stating the amount of section 193A compensation the worker is entitled to if the panel has substituted the insurer's decision with a new decision that the qualifying condition is satisfied for the worker.

Subdivision 5 Establishment of panel

141 Panel—Act, s 193A(3)

This section provides for the establishment of a review panel and prescribes the function of the panel.

142 Appointment to panel

This section prescribes the process of appointment to the panel by the Minister.

143 Administrative matters

This section provides that the Regulator may decide administrative matters about the panel that are not provided for under this subdivision. This includes the way in which the panel must meet.

Subdivision 6 Miscellaneous

144 Liability not affected

This section clarifies that a decision made by an insurer or the panel under this division does not affect the insurer or employer's liability for any other purpose or proceeding.

Division 5 Entitlement to compensation for pneumoconiosis

145 Working out pneumoconiosis score using chest image—Act, s 36F

This section provides that a worker's pneumoconiosis score is determined in the way prescribed by schedule 6 for section 36F(b) of the Act.

146 Lump sum compensation for workers with pneumoconiosis—Act, s 128G

This section provides that the lump sum compensation amounts, graduated scale and bands for workers with pneumoconiosis are set out in schedule 7 for sections 128G(2) and 128G(3) of the Act.

Division 6 Liability for caring allowance

147 Payment of caring allowance—Act, s 225

This section prescribes the way in which a payment of caring allowance is calculated for section 225(a) of the Act.

Part 5 Rehabilitation

Division 1 Rehabilitation and return to work coordinators

148 Functions—Act, s 41

This section prescribes the functions of a rehabilitation and return to work coordinator for section 41(1)(b) of the Act.

149 Criteria for obligation of employer to appoint—Act, s 226

This section prescribes the criteria under which an employer must appoint a rehabilitation and return to work coordinator for section 226(1) of the Act. An employer who employs workers at a workplace in a high risk industry (specified by the Regulator by gazette notice) meets the criteria if the wages of the employer in Queensland for the preceding financial year were more than 2,600 times QOTE. Otherwise, an employer meets the criteria if the wages of the employer in Queensland for the preceding financial year were more than 5,200 times QOTE.

Division 2 Scheme directions

150 Scheme direction providing for standard for rehabilitation—Act, s 329A

This section provides that for the purposes of section 329A(1)(b) of the Act, a scheme direction may provide for the standard for rehabilitation. This clarifies the application of section 752 of the Act, by which the existing *Guideline for standard for rehabilitation* prescribed for the purposes of section 228(1)(a) of the Act was transitioned to a scheme direction.

Part 6 Treatment, care and support payments

Division 1 Assessing entitlement

Subdivision 1 Preliminary

151 Definitions for division

This section provides definitions for 'children's functional independence measure' and 'functional independence measure' to be used in this division.

Subdivision 2 Eligibility criteria

152 Purpose of subdivision—Act, s 232M

This section provides that this subdivision prescribes the eligibility criteria for particular serious personal injuries for section 232M(2)(a) of the Act.

153 Eligibility criteria for permanent spinal cord injury

This section prescribes the eligibility criteria for a permanent spinal cord injury resulting in a permanent neurological deficit.

154 Eligibility criteria for traumatic brain injury

This section prescribes the eligibility criteria for a traumatic brain injury resulting in a permanent impairment.

155 Eligibility criterion for amputation of leg through or above femur

This section provides that the eligibility criterion for the amputation of a leg through or above the femur is that the amputation involves the loss of 65% or more of the length of the femur.

156 Eligibility criteria for amputation of more than 1 limb or parts of different limbs

This section prescribes the eligibility criteria for the amputation of more than 1 limb or parts of different limbs.

157 Eligibility criteria for full thickness burn to all or part of body

This section prescribes the eligibility criteria for a full thickness burn to all or part of the body.

158 Eligibility criterion for inhalation burn resulting in permanent respiratory impairment

This section provides that the eligibility criterion for an inhalation burn resulting in a permanent respiratory impairment is that the worker's functional ability as a result of the injury is assessed as 5 or less for a motor or cognitive item using the relevant independence measure.

159 Eligibility criterion for permanent blindness caused by trauma

This section prescribes the eligibility criterion for permanent blindness caused by trauma.

Subdivision 3 Assessing eligibility criteria

160 Assessments using measures to be carried out by particular persons

This section prescribes who may carry out an assessment using the functional independence measure or children's functional independence measure for deciding whether a serious personal injury meets the eligibility criteria.

Division 2 Assessing worker's needs

Subdivision 1 Assessment process

161 Assessments generally—Act, s 232O

This section prescribes the requirements for an assessment of needs for preparation of a support plan for section 232O(1)(a) of the Act. The section prescribes the matters that the insurer must consult with the injured worker about in carrying out the assessment and states that the insurer may also consult with any other person the insurer considers appropriate.

162 Intervals for carrying out assessments—Act, s 232O

This section specifies the relevant intervals in which an assessment under section 232O(1)(a) of the Act must be carried out for section 232O(2)(a) of the Act.

163 Appropriately qualified person must give advice about particular needs—Act, s 232O

This section prescribes the requirements for assessing a matter mentioned in section 232O(1)(a) of the Act if the insurer is assessing a worker's needs for home, transport or workplace modification, or attendant care and support services that are personal assistance services or assist a person to participate in the community.

Subdivision 2 Matters to be considered in assessing needs

164 Purpose of subdivision—Act, s 232N

This section provides that this subdivision prescribes matters the insurer must consider in deciding whether an eligible worker's treatment, care and support needs are necessary and reasonable in the circumstances for section 232N(b) of the Act.

165 Benefit to worker

This section prescribes matters the insurer must consider in deciding whether providing treatment, care or support for the worker is likely to maximise the worker's independence, participation in the community and employment, and assist the worker

in managing the injury.

166 Appropriateness of service

This section prescribes matters the insurer must have regard to in deciding whether treatment, care or support for the worker is consistent with the worker's other treatment or support and is consistent with industry best practice.

167 Appropriateness of provider

This section prescribes matters the insurer must have regard to in deciding whether treatment, care or support for the worker is provided by an appropriate provider.

168 Cost-effectiveness

This section prescribes matters the insurer must have regard to in deciding whether treatment, care or support for the worker is cost-effective.

Subdivision 3 Other requirements

169 Registered provider must provide particular needs

This section lists the treatment, care or support prescribed for section 232K(2)(b) of the Act.

Subdivision 4 Support plans and service requests

170 Support plans—Act, s 232O

This section prescribes requirements about an eligible worker's support plan for section 232O(3) of the Act.

171 Amending support plans—Act, s 232O

This section prescribes requirements for amending an eligible worker's support plan under section 232O(4)(a) of the Act, for section 232O(5) of the Act.

172 Deciding servicer request—Act, s 232P

This section prescribes the matters an insurer must consider in deciding a service request relating to an eligible worker for section 232P(4) of the Act.

Division 3 Payment options

173 Circumstances in which payment request may be made—Act, s 232Q

This section prescribes the circumstances for making a payment request for the treatment, care or support expenses of an eligible worker for section 232Q(3)(b) of the Act.

174 Deciding payment request—Act, s 232R

This section prescribes matters relating to an insurer deciding a payment request for payment of all or part of an expense for the treatment, care or support of an eligible worker for section 232R(2) of the Act.

175 Limit on amount payable under payment request—Act, s 232R

This section provides for limits on the amount payable for medical treatment, rehabilitation or hospitalisation of the worker for section 232R(4) of the Act.

Division 4 Review of entitlement

176 Review of worker's entitlement—Act, s 232S

This section prescribes that the insurer must give the worker written notice of a review of a worker's entitlement at least 20 business days before carrying out the review, and the insurer may ask the worker to give information to the insurer that is needed to make a decision about the worker's entitlement, for section 232S(3) of the Act.

Part 7 Damages

Division 1 Particulars in notice of claim

177 Notice of claim for damages—Act, s 275

This section provides that this division prescribes the particulars that must be contained in a notice of claim for damages for section 275(3) of the Act.

178 Particulars of claimant and worker

This section prescribes the particulars that must be included in a notice of claim for damages.

179 Particulars of event

This section prescribes the particulars of the event that must be included in a notice of claim for damages.

180 Injury particulars

This section prescribes the particulars of the injury or injuries that are the subject of the claim that must be included in the notice of claim for damages.

181 Particulars of hospital, treatment and rehabilitation

This section prescribes the particulars of medical treatment and rehabilitation services that must be included in the notice of claim for damages.

182 Particulars if claim for diminished income earning capacity

This section prescribes the particulars of diminished income earning capacity for the 3

year period immediately before the event that must be included in the notice of claim for damages if the claimant claims damages for diminished income earning capacity.

183 Particulars if injury causes death

This section prescribes the particulars that must be included in the notice of claim for damages if the claim relates to an injury causing death.

184 Particulars of mitigation

This section provides that a notice of claim must include particulars of all steps taken by the worker or claimant to mitigate their loss.

Division 2 General provisions

185 Time for adding another person as contributor—Act, s 278A

This section prescribes the time limit for adding another person as contributor for section 278A(1) of the Act. The time limit is the later of 30 business days after the insurer receives the notice of claim, or 5 business days after the insurer identifies someone else as a contributor.

186 Contribution notice to contain particular information—Act, s 278B

This section prescribes the particulars that must be included in a contribution notice for section 278B(1)(a) of the Act.

Part 8 Assessment of damages

187 Prescribed amount of damages for loss of consortium or loss of servitium—Act, s 306M

This section prescribes the amount of damages for loss of consortium (between spouses, the entitlement to companionship, love, affection, comfort, and support of the other) and loss of servitium (loss or impairment of the services, duty, or labour to be rendered by one person to another) for section 306M(1)(b) of the Act.

188 Rules for assessing injury scale value—Act, s 306O

This section provides that a court must have regard to the ranges of injury scale values mentioned in schedule 14 for section 306O(1)(c)(i) of the Act. The matters to which a court is to have regard in the application of schedule 14 are contained in schedule 13.

189 General damages calculation provisions—Act, s 306P

This section provides that schedule 17 prescribes the way in which general damages are to be calculated for section 306P(2) of the Act.

190 Prescribed amount of award for future loss—Act, s 306R

This section prescribes the amount of award for future loss for section 306R(2) of the

Act.

Part 9 Costs

Division 1 Hearing before industrial magistrate or industrial commission

191 Costs of hearing before industrial magistrate or industrial commission

This section provides that a decision to award costs of a hearing before an industrial magistrate or the Queensland Industrial Relations Commission is at the discretion of the magistrate or commission. Costs are to be awarded in accordance with the *Uniform Civil Procedure Rules 1999*, unless the magistrate or commission is satisfied the amounts are inadequate having regard to the work involved or the importance, difficulty or complexity of the matter to which the hearing relates. In these instances, the magistrate or commission may allow costs up to 1.5 times the amounts provided for under the *Uniform Civil Procedure Rules 1999*.

192 Payment of additional amount for costs

This section provides for additional costs to be paid by the Regulator or an insurer in relation to expert witnesses.

Division 2 Claim for damages

193 Application of division

This section provides that this division applies to a claimant whose DPI is 20% or more, has a terminal condition, or is a dependant.

194 Costs before proceeding started

This section prescribes the legal professional costs of a claim incurred before a proceeding in a court is started.

195 Costs after proceeding started

This section prescribes the legal professional costs of a claim incurred after a proceeding in a court is started. It also clarifies the previous interpretation under the 2014 Regulation in relation to the recovery of counsel's fees, being that such fees were not recoverable.

196 Outlays

This section provides for allowable outlays incurred by the claimant. This section applies in addition to sections 194 and 195. It also clarifies the previous interpretation under the 2014 Regulation in relation to the recovery of counsel's fees, being that such fees were not recoverable.

Part 10 Medical assessment tribunals

197 Medical assessment tribunals—Act, s 492

This section lists the medical assessment tribunals to be maintained for section 492 of the Act.

198 Constitution of General Medical Assessment Tribunal—Act, s 494

This section provides for the constitution of the General Medical Assessment Tribunal.

199 Chairperson and deputy chairperson of General Medical Assessment Tribunal

This section provides that the chairperson must preside over meetings of the General Medical Assessment Tribunal except under certain circumstances.

200 Constitution of specialty medical assessment tribunal—Act, s 494

This section provides for the constitution of a specialty medical assessment tribunal.

201 Chairperson and deputy chairperson of specialty medical assessment tribunal

This section provides that the chairperson must preside over meetings of a specialty medical assessment tribunal except under certain circumstances.

202 Constitution of Composite Medical Assessment Tribunal—Act, s 494

This section provides for the constitution of the Composite Medical Assessment Tribunal.

203 Chairperson and deputy chairperson of Composite Medical Assessment Tribunal

This section provides that the chairperson must preside over meetings of the Composite Medical Assessment Tribunal except under certain circumstances.

204 Consultation with secretary of tribunal

This section prescribes that the chairperson of a tribunal must consult with the secretary of the tribunal about the constitution of that tribunal.

205 Delegation by chairperson or deputy chairperson

This section prescribes that the chairperson or deputy chairperson of a tribunal may delegate a power to the Regulator to choose an appointee to the panel of doctors for the tribunal, or choose a deputy chairperson to act as chairperson of the tribunal.

Part 11 Miscellaneous

206 First responders—Act, s 36EB

This section provides that each of the occupations or professions mentioned in schedule 10 is prescribed for section 36EB(a) of the Act.

207 Eligible employees—Act, s 36EC

This section provides that each of the entities mentioned in schedule 11 is prescribed for section 36EC(1)(a) of the Act.

208 Presumption of injury—Act, s 36ED

This section provides that the way prescribed for section 36ED(1)(a) of the Act is using the diagnostic criteria under DSM 5 for post-traumatic stress disorder.

209 Information statements—Act, ss 46B and 132AA

This section prescribes content that must be included in an information statement given by an employer to a worker, or an insurer to a worker or a worker's employer, providing information about the worker's compensation scheme, for sections 46B(3) and 132AA(2) of the Act.

210 Declaration of designated courts—Act, s 114

This section provides that schedule 12 prescribes the designated courts which are competent to determine disputes over the State with which a worker's employment is connected for the purposes of a corresponding workers' compensation law for section 114(4) of the Act.

211 Declaration of provisions that are a State's legislation about damages for a work related injury—Act, s 322

This section provides that schedule 12 prescribes a list of interstate legislative provisions that are that State's legislation about damages for a work related injury.

212 WorkCover funding and provision of programs and incentives—Act, s 385A

This section lists entities that are a prescribed entity for section 385A(4) of the Act.

213 Documents and particulars to be kept—Act, s 532D

This section prescribes the documents and particulars about workers required to be kept by employers and contractors for section 532D(1) of the Act.

214 Allowances and expenses for person required to attend for examination—Act, s 532S

This section provides that for section 532S(4) of the Act, a person required to attend for examination under chapter 12, part 1A of the Act is entitled to the same allowances and expenses as a witness in a District Court proceeding.

215 Reasons for decisions must address certain matters—Act, ss 540 and 546

This section prescribes the matters that reasons for decisions must address for sections 540(4)(a) and 546(3AA) of the Act.

Part 12 Savings and transitional provisions

216 Definition for part

This section provides a definition for 'expired regulation' to be used in this part.

217 Date fixed for annual levy before commencement

This section provides that the date fixed by the Regulator by gazette notice for the purpose of section 17(2) of the expired regulation is taken to be the specified date under section 18(2) of the 2025 Regulation.

218 Actuarial arbiter appointed before commencement

This section provides that a person who held an appointment under section 93 of the expired regulation as the actuarial arbiter continues to be the actuarial arbiter under section 100 on the same terms of appointment as immediately before commencement.

219 Chairperson and members of panel appointed before commencement

This section provides that a person who held an appointment as the chairperson or a member of the panel under section 112S of the expired regulation before the commencement of this Regulation continues to hold that position on the same terms of appointment after commencement.

220 Legal professional costs of claim incurred in relation to proceeding in court

This section provides that section 195 applies in relation to legal professional costs of a court proceeding only if the notice of claim given under section 275 of the Act in relation to the injury is given after commencement.

221 Outlays incurred in relation to claim

This section provides that section 137 of the expired regulation continues to apply in relation to claims for which a notice of claim was given before the commencement in circumstances where costs and outlays were not finalised before the commencement. Section 196 applies in relation to all other claims.

222 Saving of operation of transitional provision

This section provides that section 20A of the *Acts Interpretation Act 1954* applies to section 149 of the expired regulation.

223 Reference to provisions of expired regulation

This section provides that in a document, a reference to the repealed regulation may be taken as a reference to the current regulation to the extent necessary and if context permits.

Schedule 1 Additional premium

This schedule prescribes the penalties for non-compliance with the obligations of employers to lodge an annual wages declaration with WorkCover for the purposes of premium calculation.

Schedule 2 Graduated scale for additional lump sum compensation for workers with terminal latent onset injuries

This schedule prescribes the amounts of additional lump sum compensation for workers with latent onset injuries that are terminal.

Schedule 3 Graduated scale of additional lump sum compensation for workers with DPI of 30% or more

This schedule prescribes the amounts of additional lump sum compensation for workers who sustain an injury that results in a DPI of 30% or more.

Schedule 4 Graduated scale for additional lump sum compensation for gratuitous care

This schedule prescribes the amounts of additional lump sum compensation for gratuitous care.

Schedule 5 Section 193A compensation for particular workers

This schedule prescribes the amounts a worker who sustains a DPI is entitled to, and the legal cost amount if the worker has engaged a lawyer, for section 193A of the Act.

Schedule 6 Pneumoconiosis score

This schedule provides for the calculation of a pneumoconiosis score using chest image for section 36F of the Act.

Schedule 7 Lump sum compensation for workers with pneumoconiosis

This schedule provides for the calculation of lump sum compensation for workers with pneumoconiosis for section 128G of the Act.

Schedule 8 Graduated scale of care required for payment of caring allowance

This schedule provides for the calculation of caring allowance payments.

Schedule 9 Legal professional costs

This schedule prescribes legal professional costs for section 194(2) of the 2025 Regulation.

Schedule 10 First responders

This schedule prescribes occupations or professions prescribed as first responders for section 36EB of the Act.

Schedule 11 Eligible employees

This schedule prescribes eligible employees for section 36EC of the Act.

Schedule 12 Designated courts and legislation about damages for work related injury

This section prescribes designated courts for section 114 of the Act.

Schedule 13 Matters to which court may or must have regard in the application of sch 14

This schedule prescribes matters to which a court is to have regard in the application of the ranges of injury scale values in schedule 14.

Schedule 14 Ranges of injury scale value

This schedule contains the ranges of injury scale values, which are modelled on provisions of the *Civil Liability Regulation 2014.*

Schedule 15 Matters relevant to PIRS assessment by medical expert

This schedule prescribes matters relevant to assessments under the psychiatric impairment rating scale (PIRS) by medical experts.

Schedule 16 Psychiatric impairment rating scale

This schedule contains the psychiatric impairment rating scale which is modelled on provisions of the *Civil Liability Regulation 2014*.

Schedule 17 General damages calculation provisions

This schedule prescribes the way in which general damages are to be calculated.

Schedule 18 Dictionary

This schedule contains a dictionary of particular words used in the Regulation.