Queensland

Workers' Compensation and Rehabilitation Act 2003

Workers' Compensation and Rehabilitation Regulation 2025

Current as at 1 September 2025

Queensland

Workers' Compensation and Rehabilitation Regulation 2025

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Workers' Compensation and Rehabilitation Regulation 2025

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This regulation may be cited as the *Workers' Compensation and Rehabilitation Regulation 2025*.

2 Commencement

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Schedule 18 defines particular words used in this regulation.

4 WorkCover's capital adequacy—Act, s 453

For section 453(b) of the Act, WorkCover maintains capital adequacy if WorkCover's total assets are at least equal to its total liabilities.

Part 2 Employer insurance

Division 1 Policies and premium assessments

5 Application for policy

An application for a WorkCover policy must be made to WorkCover in the approved form.

6 Policies and renewals

(1) On payment of the premium shown as payable in a premium notice issued by WorkCover to an employer, WorkCover must issue to the employer a policy, in the approved form, for the period of insurance stated in the notice.

(2) A policy has no effect until—

(a) WorkCover receives the premium payable to WorkCover for the policy or the policy's renewal; or

(b) WorkCover approves an instalment plan under section 10.

7 Assessment of premium

(1) WorkCover must assess the premium payable under a policy for each period of insurance shown in a premium notice.

(2) This section does not apply to a policy for household workers.

8 Declaration of wages

(1) Each employer, other than a self-insurer, must, on or before 31 August in each year, give WorkCover a declaration of wages so WorkCover can assess the employer's premium.

(2) The declaration must be in—

(a) the approved form; or

(b) with WorkCover's approval—another form acceptable to WorkCover.

(3) If the employer gives WorkCover a declaration of wages after 31 August in a year, the employer must pay the additional premium stated in schedule 1 opposite the day when the employer gives WorkCover the declaration.

(4) This section does not apply if the employer employs only household workers.

9 Value of board and lodging

(1) This section applies if a worker's entitlements during a period of insurance include board provided by the employer.

(2) The board is taken to be wages paid, or provided, by the employer to the worker.

(3) For each week of board provided by the employer, the amount of wages under subsection (2) is the higher of the following—

(a) the value of the board;

(b) either—

(i) if an industrial instrument that provides for a weekly allowance for board applies to the employment of the worker—the amount of the weekly allowance stated in the industrial instrument; or

(ii) if subparagraph (i) does not apply—6% of QOTE.

(4) In this section—

board means accommodation, meals, laundry services or any other entitlement having a monetary value provided when lodging.

10 Payment of premium by instalments

(1) WorkCover may accept payment of a premium by instalments under an instalment plan approved by WorkCover if WorkCover is satisfied that payment of the premium by the due date would impose financial hardship on the employer.

(2) The instalment plan is subject to the following conditions—

(a) interest at an annual rate specified by WorkCover's board by gazette notice must be added to the amount of each instalment;

(b) interest must be calculated from the due date;

(c) the interest rate that applies at the start of the instalment plan remains constant until the plan ends;

(d) on approval of the instalment plan, the employer must, if required by WorkCover, enter into a payment arrangement acceptable to WorkCover;

(e) if an instalment of premium is not paid on or before the due date for payment of the instalment—

(i) the total amount of unpaid instalments and interest on unpaid instalments to that day immediately becomes payable to WorkCover; and

(ii) an additional premium under section 11 applies to the unpaid instalments and interest mentioned in subparagraph (i); and

(iii) the policy for which the premium is payable stops having effect.

Note—

See also section 48 of the Act for breach of the employer's obligation to insure.

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

(1) This section applies if an employer does not pay WorkCover, on or before the due date—

(a) the amount stated in a premium notice; or

(b) the amount by which a final assessment of an amount of premium by an industrial magistrate or the industrial court is more than the amount of premium paid under section 551(4) of the Act.

(2) For sections 61 and 62 of the Act, the additional premium payable is—

(a) if the amount mentioned in subsection (1) is paid to WorkCover within 30 days after the due date—5% of the amount; or

(b) if the amount mentioned in subsection (1) is paid to WorkCover after 30 days but within 60 days after the due date—10% of the amount; or

(c) if the amount mentioned in subsection (1) is paid to WorkCover after 60 days after the due date or if the amount is not paid—10% of the amount plus interest at the annual rate mentioned in section 10(2)(a) for the period that—

(i) starts on the due date, or a later date decided by WorkCover; and

(ii) ends on the day the amount mentioned in subsection (1) and the additional premium under paragraph (a) or (b) is paid to WorkCover.

(3) This section does not apply if—

(a) the employer employs only household workers; or

(b) WorkCover has approved an instalment plan under section 10 and the employer complies with the plan.

(4) In this section—

due date means—

(a) for an amount mentioned in subsection (1)(a)—the due date stated in the premium notice; or

(b) for an amount mentioned in subsection (1)(b)—the last day of the period mentioned in section 62(1)(b) of the Act.

12 Premium for ascertaining appeal court—Act, s 569

For section 569(2)(a) of the Act, the employer's premium, for a financial year, is the amount calculated using the formula—

$$premium = \frac{rate \times wages}{100}$$

where—

rate means the rate for the employer's industry or business specified by WorkCover by gazette notice under section 54(2) of the Act, or decided by WorkCover under section 54(3) of the Act, that applies to the financial year.

wages means—

(a) the wages paid, or provided, by the employer for the preceding financial year; or

(b) if the employer has been insured for only part of a financial year—a reasonable estimate of the wages that would have been paid, or provided, by the employer for the financial year.

13 Former employer may apply to cancel policy

(1) This section applies if a person (the ***former employer***) wants to cancel a policy because the former employer has stopped employing workers.

(2) The former employer must give WorkCover a written notice stating—

(a) that the former employer wants to cancel the policy because the former employer has stopped employing workers; and

(b) the day the former employer stopped employing workers (the ***end day***); and

(c) the wages paid, or provided, by the former employer during the period that—

(i) starts on 1 July last preceding the end day; and

(ii) ends on the end day; and

(d) the address to which any document addressed to the former employer may be sent.

(3) This section does not apply if the person employed only household workers.

14 Cancellation of policy if workers no longer employed

(1) This section applies if—

(a) a person (the ***former employer***) has given WorkCover a written notice under section 13(2); or

(b) WorkCover is satisfied, after making reasonable enquiries, that a person (also the ***former employer***) has stopped employing workers.

(2) WorkCover may cancel the former employer's policy.

(3) WorkCover must assess the amount of premium payable by the former employer for the period during which the Act required the former employer to hold a policy.

(4) If the premium paid by the former employer for the last employment period was more than the amount of premium assessed under subsection (3), WorkCover must refund the amount overpaid to the former employer.

(5) If the premium paid by the former employer for the last employment period was less than the amount of premium assessed under subsection (3), the former employer must pay WorkCover the amount of the deficit on or before the due date under a premium notice issued for the amount of the deficit.

Note—

See also chapter 2, part 3, division 3 of the Act for circumstances in which additional premiums may be payable by employers or former employers.

(6) In this section—

last employment period means—

(a) for a former employer mentioned in subsection (1)(a)—the period mentioned in section 13(2)(c); or

(b) for a former employer mentioned in subsection (1)(b)—the period that—

(i) starts on 1 July last preceding the day WorkCover is satisfied the former employer stopped employing workers (the ***end day***); and

(ii) ends on the end day.

Division 2 Employer excess

15 Excess period—Act, s 65

For section 65(2) of the Act, the amount prescribed in relation to a worker who sustains an injury for which compensation is payable is the lesser of the following—

(a) QOTE;

(b) the amount of the weekly payment of compensation payable to the worker under chapter 3, part 9 of the Act.

Division 3 Self-insurance

16 Definitions for division

In this division—

annual levy means the amount payable under section 81 of the Act.

provisional annual levy see section 19(2)(a).

specified date see section 18(2).

17 Application fee—Act, s 70

For section 70(c) of the Act, the fee prescribed is—

(a) for a single employer—15,000 fee units; or

(b) for a group employer—20,000 fee units.

18 Annual levy—Act, s 81

(1) For section 81(2) of the Act, this section prescribes the way to calculate a self-insurer's levy for each financial year or part of a financial year of a licence.

(2) The Regulator must specify a date (the ***specified date***) for a financial year and publish the date in the gazette.

(3) The self-insurer's levy for each financial year or part of a financial year of a licence must be calculated using the formula—

$$\text{annual levy} = (\text{estimated claims liability} \times \text{rate}) + 10{,}000 \text{ fee units}$$

where—

estimated claims liability means the self-insurer's estimated claims liability most recently agreed by the Regulator and the self-insurer under section 67, or most recently decided by the arbiter under section 102, before the specified date for the financial year.

rate means the rate published by the Regulator under section 81(6) of the Act for the particular financial year.

19 Provisional annual levy—not agreed or decided

(1) This section applies in relation to a self-insurer if, on the specified date—

(a) the self-insurer's estimated claims liability for a year has been calculated by the appointed actuary under section 62; but

(b) the Regulator and the self-insurer have not agreed on the amount of the self-insurer's estimated claims liability under section 67 and the arbiter has not decided the amount of the self-insurer's estimated claims liability under section 102.

(2) The Regulator may use the amount of the self-insurer's estimated claims liability as calculated by the appointed actuary under section 62 to—

(a) calculate the self-insurer's annual levy under section 18 (the ***provisional annual levy***); and

(b) give the self-insurer written notice of the amount of the provisional annual levy under section 81(7) of the Act.

20 Actual annual levy—agreed

(1) This section applies if—

(a) the Regulator gave a self-insurer a written notice under section 19(2)(b) stating the amount of the provisional annual levy based on the amount of the self-insurer's estimated claims liability as calculated by the appointed actuary under section 62; and

(b) the Regulator and the self-insurer have agreed under section 67 on the amount of the self-insurer's estimated claims liability.

(2) The Regulator must give the self-insurer written notice of the amount of the annual levy (the ***actual annual levy***) under section 81(7) of the Act based on the agreed amount within 14 days after the Regulator and the self-insurer agree to the amount.

(3) If the actual annual levy is more than the provisional annual levy, the self-insurer must pay the Regulator the difference between the actual annual levy and the amount paid as the provisional annual levy.

(4) If the actual annual levy is less than the provisional annual levy, the Regulator must pay the self-insurer the difference between the actual annual levy and the amount paid as the provisional annual levy.

21 Actual annual levy—not agreed but decided

(1) This section applies if—

(a) the Regulator gave a self-insurer a written notice under section 19(2)(b) stating the amount of the provisional annual levy based on the amount of the self-insurer's estimated claims liability as calculated by the appointed actuary under section 62; and

(b) the Regulator and the self-insurer have not agreed under section 67 on the amount of the self-insurer's estimated claims liability; and

(c) the arbiter has decided the amount of the self-insurer's estimated claims liability under section 102 and the amount (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.

(2) The Regulator must give the self-insurer written notice of the amount of the annual levy (the ***actual annual levy***) under section 81(7) of the Act based on the decided adjusted amount within 14 days after the Regulator receives notice of the amount under section 102(4).

(3) If the actual annual levy is more than the provisional annual levy, the self-insurer must pay the Regulator the difference between the actual annual levy and the amount paid as the provisional annual levy.

(4) If the actual annual levy is less than the provisional annual levy, the Regulator must pay the self-insurer the difference between the actual annual levy and the amount paid as the provisional annual levy.

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

For section 82(1) of the Act, the additional amount payable by a self-insurer in relation to the late payment of an amount of annual levy is—

(a) if the amount is paid to the Regulator within 30 days after the due date—5% of the amount; or

(b) if the amount is paid to the Regulator after 30 days but within 60 days after the due date—10% of the amount; or

(c) if the amount is paid to the Regulator after 60 days after the due date or if the amount is not paid—10% of the amount plus interest at a rate specified by the Regulator by gazette notice for the period that—

(i) starts on the due date, or a later date decided by the Regulator; and

(ii) ends on the day the amount of the annual levy and the additional amount under paragraph (a) or (b) is paid to the Regulator.

23 Condition of licence—Act, s 83

For section 83(1)(a) of the Act, a self-insurer's licence is subject to the condition that the self-insurer must give the Regulator, for each year or part of a year of the licence, a declaration in the approved form of the wages paid, or provided by, the self-insurer.

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

(1) For section 98 of the Act, the way prescribed for the calculation of the premium payable by a self-insurer whose licence is cancelled (the ***former self-insurer***) for the first 2 periods of insurance after cancellation is according to the method and at the rate specified by WorkCover, by gazette notice under section 54 of the Act, as if the former self-insurer were insuring with WorkCover for the first time.

(2) However, the rate specified under subsection (1) must not be less than the rate calculated using the formula—

$$\text{premium rate} = \frac{(\text{administrative costs} + \text{liability} + \text{payments}) \times 100}{\text{wages}}$$

where—

administrative costs means the administrative costs associated with claims incurred by the former self-insurer during the final period of licence, calculated by multiplying payments + liability by 0.095.

final period of licence means—

(a) for a former self-insurer licensed as a self-insurer for 3 or more years immediately before cancellation of the former self-insurer's licence—3 years; or

(b) for a former self-insurer licensed as a self-insurer for less than 3 years immediately before cancellation of the former self-insurer's licence—the period of the licence.

liability means an actuarial estimate of the former self-insurer's outstanding liability at the end of the former self-insurer's licence for claims incurred by the former self-insurer during the final period of licence, excluding liability for the excess period.

payments means the actual payments made by the former self-insurer for claims incurred during the final period of licence, less recoveries received and payments made that are the equivalent of amounts payable for the excess period.

wages means the wages paid, or provided, by the self-insurer during the final period of licence.

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

For section 569(2)(a) of the Act, the deemed levy, for a self-insurer for a financial year of the self-insurer's licence, is the amount calculated using the formula—

$$\text{deemed levy} = \text{estimated claims liability} \times \text{rate}$$

where—

estimated claims liability means the self-insurer's estimated claims liability mentioned in section 18(3).

rate means the rate published by the Regulator under section 81(6) of the Act for the particular financial year.

Part 3 Calculation of self-insurer's liability

Division 1 Outstanding liability

Subdivision 1 Preliminary

26 Definitions for division

In this division—

application day, in relation to a self-insurer, means the day the self-insurer applied to be licensed as a self-insurer under section 70 of the Act.

appointed actuary see section 28.

assessment day, in relation to a self-insurer, means the last day of the financial quarter immediately before the application day.

outstanding liability see section 87(1)(b) of the Act.

summary report see section 32(1).

27 Calculation of outstanding liability—Act, s 87

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

Subdivision 2 Actuarial calculations and reports

28 Appointment of actuaries

WorkCover and the self-insurer must each appoint an actuary (each an ***appointed actuary***) to calculate the amount of the self-insurer's outstanding liability.

29 Regulator to give appointed actuaries information

The Regulator must give each appointed actuary the information necessary to enable the appointed actuary to calculate the amount of the self-insurer's outstanding liability within the period mentioned in section 31(3).

30 Actuarial calculation

Each appointed actuary's calculation of the amount of the self-insurer's outstanding liability must—

(a) be prepared under the actuarial standard; and

(b) apply a central estimate of the liability; and

(c) apply the risk free rate of return; and

(d) include claims administration expenses of 7% of the self-insurer's outstanding liability; and

(e) not include a prudential margin; and

(f) be based, to the extent practicable, on claims for compensation and damages made against the self-insurer before the self-insurer was granted a licence to become a self-insurer; and

(g) be based on data that is up-to-date on the assessment day.

31 Actuarial report

(1) Each appointed actuary must prepare an actuarial report under the actuarial standard of the appointed actuary's calculation of the amount of the self-insurer's outstanding liability.

(2) The actuarial report must state the following—

(a) the amount of the self-insurer's outstanding liability;

(b) the key assumptions made by the appointed actuary for the calculation;

(c) how the key assumptions made by the appointed actuary have been derived, including—

(i) the average amount of a claim for compensation against the self-insurer; and

(ii) the average amount of a claim for damages against the self-insurer; and

(iii) the amount anticipated to have been incurred by the self-insurer in potential claims for compensation or damages for which no claim has yet been made; and

(iv) the frequency of claims for compensation against the self-insurer; and

(v) the frequency of claims for damages against the self-insurer; and

(vi) the net amount of claims for compensation and damages against the self-insurer after allowing for future inflation (***inflated value***); and

(vii) the net present value of the inflated value after allowing for income from assets set aside by the self-insurer to pay the amount mentioned in paragraph (a); and

(viii) the rate of inflation used;

(d) the nature of the data used in the calculation;

(e) the appointed actuary's assessment of the data, including, for example, the accuracy of the data;

(f) how the appointed actuary interpreted the data;

(g) the actuarial model used in the calculation;

(h) the results of the calculation;

(i) the appointed actuary's confidence in the results of the calculation.

(3) Each appointed actuary must prepare the actuarial report within 35 days after the application day.

32 Summary report

(1) The appointed actuaries must also jointly prepare a report (the ***summary report***) that—

(a) includes each appointed actuary's individual actuarial report; and

(b) states how the reports mentioned in paragraph (a) agree or differ and the reasons for any difference.

(2) The appointed actuaries must give a copy of the summary report to the Regulator, WorkCover and the self-insurer within 2 months after the application day.

33 Agreement on amount

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

(1) This section applies if WorkCover and the self-insurer do not agree on the amount of the self-insurer's outstanding liability.

(2) WorkCover and the self-insurer must, by written notice, tell the Regulator that WorkCover and the self-insurer do not agree on the amount of the self-insurer's outstanding liability.

(3) If the Regulator receives a written notice under subsection (2), the Regulator must refer the summary report to the arbiter to decide the amount of the self-insurer's outstanding liability.

Note—

See sections 102 to 104 in relation to the arbiter's decision.

35 Payment of amount

(1) WorkCover must pay to the self-insurer the amount of the self-insurer's outstanding liability (the ***final amount***)—

(a) agreed to by WorkCover and the self-insurer; or

(b) if there is no agreement—decided by the arbiter under section 102(2)(b)(ii).

(2) WorkCover must pay the self-insurer—

(a) 75% of the final amount on the day the self-insurer's licence starts; and

(b) the balance of the final amount within 1 month after the day the self-insurer's licence starts.

(3) However, the final amount paid by WorkCover must be adjusted by WorkCover's appointed actuary to take into account—

(a) the amount of compensation and damages, if any, paid by the self-insurer during the final period; and

(b) claims for compensation and damages, if any, lodged against the self-insurer during the final period.

(4) In this section—

final period, in relation to a self-insurer, means the period that—

(a) starts on the assessment day; and

(b) ends on the day the self-insurer becomes liable for the self-insurer's outstanding liability.

36 Transfer of claims information

WorkCover must, before the day the self-insurer's licence starts, give the self-insurer all the information in WorkCover's possession about the claims for compensation and **damages** that relate to the self-insurer's outstanding liability.

Division 2 Total liability

Subdivision 1 Preliminary

37 Definitions for division

In this division—

appointed actuary see section 39.

assessment day, in relation to a member, means the last day of the financial quarter immediately before the day the old insurer applied to the Regulator under section 89 of the Act for a change in the group membership on the old insurer's licence.

consent day, in relation to a member, means the day the Regulator approved the old insurer's application under section 89 of the Act for a change in the group membership on the old insurer's licence.

member means a member to whom section 90 of the Act applies.

new insurer see section 38.

old insurer see section 38.

summary report see section 43(1).

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

For section 90(9)(a) of the Act, when a member leaves a self-insurer that is a group employer (the ***old insurer***) and becomes part of another self-insurer (the ***new insurer***) the amount of the member's total liability must be calculated under this division.

Subdivision 2 Actuarial calculations and reports

39 Appointment of actuaries

The old insurer and the new insurer must each appoint an actuary (each an ***appointed actuary***) to calculate the amount of the member's total liability.

40 Insurers to give appointed actuaries information

The old insurer and the new insurer must give each appointed actuary, in the approved form, the information necessary to enable the appointed actuary to calculate the amount of the member's total liability within the period mentioned in section 42(3).

41 Actuarial calculation

Each appointed actuary's calculation of the **amount of the** member's total liability must—

(a) be prepared under the actuarial standard; and

(b) apply a central estimate of the liability; and

(c) apply the risk free rate of return; and

(d) include claims administration expenses of 7% of the member's total liability; and

(e) not include a prudential margin; and

(f) be based, to the extent practicable, on claims for compensation and damages made against the member; and

(g) be based on data that is up-to-date on the assessment day.

42 Actuarial report

(1) Each appointed actuary must prepare an actuarial report under the actuarial standard of the appointed actuary's calculation of the amount of the member's total liability.

(2) The actuarial report must state the following—

(a) the amount of the member's total liability;

(b) the key assumptions made by the appointed actuary for the calculation;

(c) how the key assumptions by the appointed actuary have been derived, including—

(i) the average amount of a claim for compensation against the member; and

(ii) the average amount of a claim for damages against the member; and

(iii) the amount anticipated to have been incurred by the member in potential claims for compensation or damages for which no claim has yet been made; and

(iv) the frequency of claims for compensation against the member; and

(v) the frequency of claims for damages against the member; and

(vi) the net amount of claims for compensation and damages against the member after allowing for future inflation (***inflated value***); and

(vii) the net present value of the inflated value after allowing for income from assets set aside by the member to pay the amount mentioned in paragraph (a); and

(viii) the rate of inflation used;

(d) the nature of the data used in the calculation;

(e) the appointed actuary's assessment of the data, including, for example, the accuracy of the data;

(f) how the appointed actuary interpreted the data;

(g) the actuarial model used in the calculation;

(h) the results of the calculation;

(i) the appointed actuary's confidence in the results of the calculation.

(3) Each appointed actuary must prepare the actuarial report within 35 days after the consent day.

43 Summary report

(1) The appointed actuaries must also jointly prepare a report (the ***summary report***) that—

(a) includes each appointed actuary's individual actuarial report; and

(b) states how the reports mentioned in paragraph (a) agree or differ and the reasons for any difference.

(2) The appointed actuaries must give a copy of the summary report to the Regulator, the old insurer and the new insurer within 2 months after the consent day.

44 Agreement on amount

The old insurer and the new insurer may agree on the amount of the member's total liability having regard to the summary report.

45 Referral to arbiter if no agreement on amount

(1) This section applies if the old insurer or the new insurer do not agree on the amount of the member's total liability.

(2) The old insurer and the new insurer must, by written notice, tell the Regulator that the old insurer and the new insurer do not agree on the amount of the member's total liability.

(3) If the Regulator receives a written notice under subsection (2), the Regulator must refer the summary report to the arbiter to decide the amount of the member's total liability.

Note—

See sections 102 to 104 in relation to the arbiter's decision.

46 Payment of amount

(1) The old insurer must pay to the new insurer the amount of the member's total liability (the ***final amount***)—

(a) agreed to by the old insurer and the new insurer; or

(b) if there is no agreement—decided by the arbiter under section 102(2)(b)(ii).

(2) The old insurer must pay the final amount—

(a) within 3 months after the consent day; or

(b) on or before a later day agreed to by the old insurer and the new insurer.

(3) However, the final amount paid by the old insurer must be adjusted by the old insurer's appointed actuary to take into account—

(a) the amount of compensation and damages, if any, paid by the member during the final period; and

(b) claims for compensation and damages, if any, lodged against the member during the final period.

(4) The old insurer must, by written notice, tell the Regulator the following information not later than the day the final amount is paid to the new insurer—

(a) the final amount paid, as adjusted under subsection (3);

(b) the day the new insurer assumes liability for compensation and damages claimed against the member;

(c) the name and contact details of the old insurer, the new insurer and the member.

(5) In this section—

final period, in relation to a member, means the period that—

(a) starts on the assessment day; and

(b) ends on the day the new insurer assumes liability for the member's total liability.

47 Transfer of claims information

The old insurer must, not later than the day the final amount is paid to the new insurer under section 46, give the new insurer all the information in the old insurer's possession about the claims for compensation and damages that relate to the member's total liability.

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

Subdivision 1 Preliminary

48 Definitions for division

In this division—

appointed actuary see section 50.

assessment day, in relation to a former self-insurer, means the last day of the financial quarter immediately before the cancellation day.

cancellation day, in relation to a former self-insurer, means the day the former self-insurer's licence was cancelled.

former self-insurer means a self-insurer whose licence has been cancelled.

summary report see section 54(1).

49 Calculation of liability after cancellation—Act, s 102

For section 102(3) of the Act, the amount of a former self-insurer's liability under sections 68C and 87(1) of the Act must be calculated under this division.

Subdivision 2 Actuarial calculations and reports

50 Appointment of actuaries

WorkCover and the former self-insurer must each appoint an actuary (each an ***appointed actuary***) to calculate the amount of the former self-insurer's liability under sections 68C and 87(1) of the Act.

51 Former self-insurer to give appointed actuaries information

The former self-insurer must give each appointed actuary, in the approved form, the information necessary to enable the appointed actuary to calculate the amount of the former self-insurer's liability under sections 68C and 87(1) of the Act within the period mentioned in section 53(3).

52 Actuarial calculation

Each appointed actuary's calculation of the amount of the former self-insurer's liability under sections 68C and 87(1) of the Act must—

(a) be prepared under the actuarial standard; and

(b) apply a central estimate of the liability; and

(c) apply the risk free rate of return; and

(d) include claims administration expenses of 7% of the former self-insurer's liability under sections 68C and 87(1) of the Act; and

(e) not include a prudential margin; and

(f) be based, to the extent practicable, on claims for compensation and damages made against the former self-insurer before the self-insurer was granted a licence to become a self-insurer; and

(g) be based on data that is up-to-date on the assessment day.

53 Actuarial report

(1) Each appointed actuary must prepare an actuarial report under the actuarial standard of the appointed actuary's calculation of the amount of the former self-insurer's liability under sections 68C and 87(1) of the Act.

(2) The actuarial report must state the following—

(a) the amount of the former self-insurer's liability under sections 68C and 87(1) of the Act;

(b) the key assumptions made by the appointed actuary for the calculation;

(c) how the key assumptions made by the appointed actuary have been derived, including—

(i) the average amount of a claim for compensation against the former self-insurer; and

(ii) the average amount of a claim for damages against the former self-insurer; and

(iii) the amount anticipated to have been incurred by the former self-insurer in potential claims for

compensation or damages for which no claim has yet been made; and

(iv) the frequency of claims for compensation against the former self-insurer; and

(v) the frequency of claims for damages against the former self-insurer; and

(vi) the net amount of claims for compensation and damages against the former self-insurer after allowing for future inflation (***inflated value***); and

(vii) the net present value of the inflated value after allowing for income from assets set aside by the former self-insurer to pay the amount mentioned in paragraph (a); and

(viii) the rate of inflation used;

(d) the nature of the data used in the calculation;

(e) the appointed actuary's assessment of the data, including, for example, the accuracy of the data;

(f) how the appointed actuary interpreted the data;

(g) the actuarial model used in the calculation;

(h) the results of the calculation;

(i) the appointed actuary's confidence in the results of the calculation.

(3) Each appointed actuary must prepare the actuarial report within 35 days after the cancellation day.

54 Summary report

(1) The appointed actuaries must also jointly prepare a report (the ***summary report***) that—

(a) includes each appointed actuary's individual actuarial report; and

(b) states how the reports mentioned in paragraph (a) agree or differ and the reasons for any difference.

(2) The appointed actuaries must give a copy of the summary report to the Regulator, WorkCover and the former self-insurer within 2 months after the cancellation day.

55 Agreement on amount

WorkCover and the former self-insurer may agree on the amount of the former self-insurer's liability under sections 68C and 87(1) of the Act having regard to the summary report.

56 Referral to arbiter if no agreement on amount

(1) This section applies if WorkCover and the former self-insurer do not agree on the amount of the former self-insurer's liability under sections 68C and 87(1) of the Act.

(2) WorkCover and the former self-insurer must, by written notice, tell the Regulator that WorkCover and the former self-insurer do not agree on the amount of the former self-insurer's liability under sections 68C and 87(1) of the Act.

(3) If the Regulator receives a written notice under subsection (2), the Regulator must refer the summary report to the arbiter to decide the amount of the former self-insurer's liability under sections 68C and 87(1) of the Act.

Note—

See sections 102 to 104 in relation to the arbiter's decision.

57 Payment of amount

(1) The former self-insurer must pay to WorkCover the amount of the former self-insurer's liability under sections 68C and 87(1) of the Act (the ***final amount***)—

(a) agreed to by WorkCover and the former self-insurer; or

(b) if there is no agreement—decided by the arbiter under section 102(2)(b)(ii).

(2) However, the final amount paid by the former self-insurer must be adjusted by the former self-insurer's appointed actuary to take into account—

(a) the amount of compensation and damages, if any, paid by the former self-insurer during the final period; and

(b) claims for compensation and damages, if any, lodged against the former self-insurer during the final period.

(3) In this section—

final period, in relation to a former self-insurer, means the period that—

(a) starts on the assessment day; and

(b) ends on the cancellation day.

Division 4 Estimated claims liability for lodgement of security

Subdivision 1 Preliminary

58 Definitions for division

In this division—

appointed actuary see section 60.

second appointed actuary see section 66(1).

self-insurer's data means data that will enable the calculation of the amount of the self-insurer's estimated claims liability.

59 Calculation of estimated claims liability—Act, s 84

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

Subdivision 2 Actuarial calculations and reports

60 Appointment of actuary

The Regulator must appoint an actuary (the ***appointed actuary***) to calculate the amount of the self-insurer's estimated claims liability.

61 Self-insurer to give Regulator and appointed actuary information

The self-insurer must give the Regulator and the appointed actuary, in the approved form, the information necessary to enable the appointed actuary to calculate the amount of the self-insurer's estimated claims liability.

62 Actuarial calculation

The appointed actuary's calculation of the amount of the self-insurer's estimated claims liability must—

(a) be prepared under the actuarial standard; and

(b) apply a central estimate of the liability; and

(c) apply the risk free rate of return; and

(d) include claims administration expenses of 7% of the self-insurer's estimated claims liability; and

(e) not include a prudential margin; and

(f) be based, to the extent practicable, on claims for compensation and damages made against the self-insurer; and

(g) be based on data that is up-to-date on—

(i) for a calculation in relation to the renewal of the self-insurer's licence—the last day of the financial quarter immediately before the day the renewed licence starts; or

(ii) otherwise—the day immediately before the amount is calculated.

63 Actuarial report

(1) The appointed actuary must prepare an actuarial report under the actuarial standard of the appointed actuary's calculation of the amount of the self-insurer's estimated claims liability.

(2) The actuarial report must state the following—

(a) the amount of the self-insurer's estimated claims liability;

(b) the key assumptions made by the appointed actuary for the calculation;

(c) how the key assumptions made by the appointed actuary have been derived, including—

(i) the average amount of a claim for compensation against the self-insurer; and

(ii) the average amount of a claim for damages against the self-insurer; and

(iii) the amount anticipated to have been incurred by the self-insurer in potential claims for compensation and damages for which no claim has yet been made; and

(iv) the frequency of claims for compensation against the self-insurer; and

(v) the frequency of claims for damages against the self-insurer; and

(vi) the net amount of claims for compensation and damages against the self-insurer after allowing for future inflation (***inflated value***); and

(vii) the net present value of the inflated value after allowing for income from assets set aside by the self-insurer to pay the amount mentioned in paragraph (a); and

(viii) the rate of inflation used;

(d) the nature of the data used in the calculation;

(e) the appointed actuary's assessment of the data, including, for example, the accuracy of the data;

(f) how the appointed actuary interpreted the data;

(g) the actuarial model used in the calculation;

(h) the results of the calculation;

(i) the appointed actuary's confidence in the results of the calculation.

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

The appointed actuary must give a copy of the actuarial report to the Regulator and the self-insurer before—

(a) the day stated by the Regulator; or

(b) a later day agreed to by the Regulator and the appointed actuary.

65 Regulator to tell self-insurer whether agreement on amount

Within 35 days after the appointed actuary gives the Regulator a copy of the actuarial report, the Regulator must give the self-insurer a written notice stating whether the Regulator agrees or does not agree with the appointed actuary's assessment of the self-insurer's estimated claims liability.

66 Referral to second appointed actuary if no agreement on amount

(1) After receiving a copy of the appointed actuary's report, the Regulator may ask another actuary appointed by the Regulator (the ***second appointed actuary***) to—

(a) calculate the amount of the self-insurer's estimated claims liability under section 62; and

(b) give the Regulator an actuarial report under section 63(2).

(2) The Regulator must give the second appointed actuary the appointed actuary's report and the self-insurer's data.

67 Agreement on amount

If, at any time, the Regulator and the self-insurer agree on the self-insurer's estimated claims liability, having regard to the appointed actuary's actuarial report or the second appointed actuary's actuarial report, the self-insurer's estimated claims liability is the amount agreed to by the Regulator and the self-insurer.

68 Referral to arbiter if no agreement on amount

(1) This section applies if the Regulator and the self-insurer do not agree under section 67 on the amount of the self-insurer's estimated claims liability.

(2) The Regulator must refer the appointed actuary's actuarial report, the self-insurer's data and any second appointed actuary's actuarial report to the arbiter to decide the amount of the self-insurer's estimated claims liability.

Note—

See sections 102 to 104 in relation to the arbiter's decision.

(3) The Regulator must make the referral within 14 days after the day the Regulator gives the self-insurer a written notice under section 65 stating that the Regulator does not agree with the

appointed actuary's assessment of the self-insurer's estimated claims liability.

Division 5 Self-insurers who become non-scheme employers

Subdivision 1 Preliminary

69 Definition for division

In this division—

cancellation day, in relation to a non-scheme employer, means the day the non-scheme employer's continued licence is cancelled under section 105E of the Act.

Note—

Under section 105F(d) of the Act, on cancellation of the continued licence, WorkCover replaces the non-scheme employer, for any proceeding taken by a claimant or worker against the non-scheme employer, as insurer.

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

(1) For section 105I(2) of the Act, the amount of a non-scheme employer's liability under section 105B(3) of the Act must be calculated by—

(a) estimating the amount under subdivision 2; and

(b) finalising the amount under subdivision 3.

(2) The amount of the non-scheme employer's liability under section 105B(3) of the Act is the finalised amount calculated under subdivision 3.

(3) The non-scheme employer's liability under section 105B(3) of the Act is finalised for section 105I(5) of the Act when—

(a) the finalised amount is calculated under subdivision 3; or

(b) if the finalised amount is different to the final amount paid under section 79—the amount payable by the non-scheme employer under section 88(2) or by WorkCover under section 88(3) is paid.

Subdivision 2 Estimating non-scheme employer's liability

71 Definitions for subdivision

In this subdivision—

appointed actuary see section 72.

summary report see section 76(1).

72 Appointment of actuaries

WorkCover and the non-scheme employer must each appoint an actuary (each an ***appointed actuary***) to estimate the amount of the non-scheme employer's liability under section 105B(3) of the Act.

73 Non-scheme employer to give appointed actuaries information

The non-scheme employer must give each appointed actuary, in the approved form, the information necessary to enable the appointed actuary to estimate the amount of the non-scheme employer's liability under section 105B(3) of the Act within the period mentioned in section 75(3).

74 Actuarial calculation

Each appointed actuary's calculation of the estimated amount of the non-scheme employer's liability under section 105B(3) of the Act must—

(a) be prepared under the actuarial standard; and

(b) apply a central estimate of the liability; and

(c) apply the risk free rate of return; and

(d) include claims administration expenses of 7% of the non-scheme employer's liability under section 105B(3) of the Act; and

(e) not include a prudential margin; and

(f) be based, to the extent practicable, on claims for compensation and damages made against the non-scheme employer; and

(g) be based on data that only relates to the period before the non-scheme employer's exit date.

75 Actuarial report

(1) Each appointed actuary must prepare an actuarial report under the actuarial standard of the appointed actuary's calculation of the estimated amount of the non-scheme employer's liability under section 105B(3) of the Act.

(2) The actuarial report must state the following—

(a) the estimated amount of the non-scheme employer's liability under section 105B(3) of the Act;

(b) the key assumptions made by the appointed actuary for the calculation;

(c) how the key assumptions made by the appointed actuary have been derived, including—

(i) the average amount of a claim for compensation against the non-scheme employer; and

(ii) the average amount of a claim for damages against the non-scheme employer; and

(iii) the amount anticipated to have been incurred by the non-scheme employer in potential claims for compensation or damages for which no claim has yet been made; and

(iv) the frequency of claims for compensation against the non-scheme employer; and

(v) the frequency of claims for damages against the non-scheme employer; and

(vi) the net amount of claims for compensation and damages against the non-scheme employer after allowing for future inflation (***inflated value***); and

(vii) the net present value of the inflated value after allowing for income from assets set aside by the non-scheme employer to pay the amount mentioned in paragraph (a); and

(viii) the rate of inflation used;

(d) the nature of the data used in the calculation;

(e) the appointed actuary's assessment of the data, including, for example, the accuracy of the data;

(f) how the appointed actuary interpreted the data;

(g) the actuarial model used in the calculation;

(h) the results of the calculation;

(i) the appointed actuary's confidence in the results of the calculation.

(3) Each appointed actuary must prepare the actuarial report within 35 days after the cancellation day.

76 Summary report

(1) The appointed actuaries must also jointly prepare a report (the ***summary report***) that—

(a) includes each appointed actuary's individual actuarial report; and

(b) states how the reports mentioned in paragraph (a) agree or differ and the reasons for any difference.

(2) The appointed actuaries must give a copy of the summary report to the Regulator, WorkCover and the non-scheme employer within 2 months after the cancellation day.

77 Agreement on amount

WorkCover and the non-scheme employer may agree on the estimated amount of the non-scheme employer's liability under section 105B(3) of the Act having regard to the summary report.

78 Referral to arbiter if no agreement on amount

(1) This section applies if WorkCover and the non-scheme employer do not agree on the estimated amount of the non-scheme employer's liability under section 105B(3) of the Act.

(2) WorkCover and the non-scheme employer must, by written notice, tell the Regulator that WorkCover and the non-scheme employer do not agree on the estimated amount of the non-scheme employer's liability under section 105B(3) of the Act.

(3) If the Regulator receives a written notice under subsection (2), the Regulator must refer the summary report to the arbiter to decide the estimated amount of the non-scheme employer's liability under section 105B(3) of the Act.

Note—

See sections 102 to 104 in relation to the arbiter's decision.

79 Payment of amount

(1) The non-scheme employer must pay to WorkCover the estimated amount of the non-scheme employer's liability under section 105B(3) of the Act (the ***final amount***)—

(a) agreed to by WorkCover and the non-scheme employer; or

(b) if there is no agreement—decided by the arbiter under section 102(2)(b)(ii).

(2) However, the final amount paid by the non-scheme employer must be adjusted by the non-scheme employer's appointed actuary to take into account—

(a) the amount of compensation and damages, if any, paid by the non-scheme employer during the final period; and

(b) claims for compensation and damages, if any, lodged against the non-scheme employer during the final period.

Note—

See section 105I(3)(b) of the Act for when the final amount must be paid.

(3) In this section—

assessment day means the last day of the financial quarter immediately before the cancellation day.

final period, in relation to a non-scheme employer, means the period that—

(a) starts on the assessment day; and

(b) ends on the cancellation day.

Subdivision 3 Finalising non-scheme employer's liability

80 Definitions for subdivision

In this subdivision—

appointed actuary see section 81(1).

summary report see section 85(1).

81 Appointment of actuaries

(1) WorkCover and the non-scheme employer must each appoint an actuary (each an ***appointed actuary***) to finalise the amount of the non-scheme employer's liability under section 105B(3) of the Act.

(2) The appointment must be made within 20 business days after the day that is 4 years after the cancellation day.

82 WorkCover to give appointed actuaries information

WorkCover must give each appointed actuary the information necessary to enable the appointed actuary to finalise the amount of the non-scheme employer's liability under section 105B(3) of the Act within the period mentioned in section 84(3).

83 Actuarial calculation

Each appointed actuary's calculation of the finalised amount of the non-scheme employer's liability under section 105B(3) of the Act must—

(a) be prepared under the actuarial standard; and

(b) apply a central estimate of the liability; and

(c) apply the same risk free rate of return that was used in estimating under subdivision 2 the non-scheme

employer's liability under section 105B(3) of the Act; and

(d) include claims administration expenses of 7% of the non-scheme employer's liability under section 105B(3) of the Act; and

(e) not include a prudential margin; and

(f) be based, to the extent practicable, on claims for compensation and damages made against the non-scheme employer; and

(h) have regard to payments for compensation and damages made in relation to the non-scheme employer's liability under section 105B(3) of the Act during the period (the ***4 year period***) that—

(i) starts on the cancellation day; and

(ii) ends 4 years after the cancellation day; and

(i) be based on data that—

(i) is up-to-date on the last day of the last financial quarter of the 4 year period for which data is available; and

(ii) only relates to the period before the non-scheme employer's exit date.

84 Actuarial report

(1) Each appointed actuary must prepare an actuarial report under the actuarial standard of the appointed actuary's calculation of the finalised amount of the non-scheme employer's liability under section 105B(3) of the Act.

(2) The actuarial report must state the following—

(a) the finalised amount of the non-scheme employer's liability under section 105B(3) of the Act;

(b) the key assumptions made by the appointed actuary for the calculation;

(c) how the key assumptions made by the appointed actuary have been derived, including—

(i) the average amount of a claim for compensation against the non-scheme employer; and

(ii) the average amount of a claim for damages against the non-scheme employer; and

(iii) the amount anticipated to have been incurred by the non-scheme employer in potential claims for compensation or damages for which no claim has yet been made; and

(iv) the frequency of claims for compensation against the non-scheme employer; and

(v) the frequency of claims for damages against the non-scheme employer; and

(vi) the net amount of claims for compensation and damages against the non-scheme employer after allowing for future inflation (***inflated value***); and

(vii) the net present value of the inflated value after allowing for income from assets set aside by the non-scheme employer to pay the amount mentioned in paragraph (a); and

(viii) the rate of inflation used;

(d) the nature of the data used in the calculation;

(e) the appointed actuary's assessment of the data, including, for example, the accuracy of the data;

(f) how the appointed actuary interpreted the data;

(g) the actuarial model used in the calculation;

(h) the results of the calculation;

(i) the appointed actuary's confidence in the results of the calculation.

(3) Each appointed actuary must prepare the actuarial report within 35 days after the day that is 4 years after the cancellation day.

85 Summary report

(1) The appointed actuaries must also jointly prepare a report (the ***summary report***) that—

(a) includes each appointed actuary's individual actuarial report; and

(b) states how the reports mentioned in paragraph (a) agree or differ and the reasons for any difference.

(2) The appointed actuaries must give a copy of the summary report to the Regulator, WorkCover and the non-scheme employer within 2 months after the day that is 4 years after the cancellation day.

86 Agreement on amount

WorkCover and the non-scheme employer may agree on the finalised amount of the non-scheme employer's liability under section 105B(3) of the Act having regard to the summary report.

87 Referral to arbiter if no agreement on amount

(1) This section applies if WorkCover and the non-scheme employer do not agree on the finalised amount of the non-scheme employer's liability under section 105B(3) of the Act.

(2) WorkCover and the non-scheme employer must, by written notice, tell the Regulator that WorkCover and the non-scheme employer do not agree on the finalised amount of the non-scheme employer's liability under section 105B(3) of the Act.

(3) If the Regulator receives a written notice under subsection (2), the Regulator must refer the summary report to the arbiter to decide the finalised amount of the non-scheme employer's liability under section 105B(3) of the Act.

Note—

See sections 102 to 104 in relation to the arbiter's decision.

88 Payment of amount

(1) This section applies if the finalised amount of the non-scheme employer's liability under section 105B(3) of the Act is—

(a) agreed to by WorkCover and the non-scheme employer under section 86; or

(b) if there is no agreement—decided by the arbiter under section 102(2)(b)(ii).

(2) If the finalised amount is more than the final amount paid under section 79 (the ***interim payment***), the non-scheme employer must, within 20 business days after the agreement or decision mentioned in subsection (1), pay WorkCover—

(a) the difference between the finalised amount and the interim payment; and

(b) interest on the difference, from the day the whole of the interim payment was paid, at the same risk free rate of return mentioned in section 83(c).

(3) If the finalised amount is less than the final amount paid under section 79 (the ***interim payment***), WorkCover must, within 20 business days after the agreement or decision mentioned in subsection (1), pay the non-scheme employer—

(a) the difference between the interim payment and the finalised amount; and

(b) interest on the difference, from the day the whole of the interim payment was paid, at the same risk free rate of return mentioned in section 83(c).

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

Subdivision 1 Preliminary

89 Definitions for division

In this division—

appointed actuary see section 91(1).

assessment day, in relation to a non-scheme member, means the last day of the financial quarter immediately before the final day.

final day, in relation to a non-scheme member, means the day the non-scheme member stopped being a member of the old self-insurer under section 105M of the Act.

old self-insurer, in relation to a non-scheme member, means the self-insurer of which the non-scheme member was a member immediately before becoming a non-scheme employer.

summary report see section 95(1).

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

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

Subdivision 2 Actuarial calculations and reports

91 Appointment of actuaries

(1) WorkCover and the old self-insurer must each appoint an actuary (each an ***appointed actuary***) to calculate the amount of the non-scheme member's total liability.

(2) The actuary appointed by the old self-insurer must be approved by the non-scheme member.

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

WorkCover and the old self-insurer must give each appointed actuary, in the approved form, the information necessary to enable the appointed actuary to calculate the amount of the non-scheme member's total liability within the period mentioned in section 94(3).

93 Actuarial calculation

Each appointed actuary's calculation of the amount of the non-scheme member's total liability must—

(a) be prepared under the actuarial standard; and

(b) apply a central estimate of the relevant liability; and

(c) apply the risk free rate of return; and

(d) include claims administration expenses of 7% of the non-scheme member's total liability; and

(e) not include a prudential margin; and

(f) be based, to the extent practicable, on claims for compensation and damages made against the non-scheme member; and

(g) be based on data that is up-to-date on the assessment day.

94 Actuarial report

(1) Each appointed actuary must prepare an actuarial report under the actuarial standard of the appointed actuary's calculation of the amount of the non-scheme member's total liability.

(2) The actuarial report must state the following—

(a) the amount of the non-scheme member's total liability;

(b) the key assumptions made by the appointed actuary for the calculation;

(c) how the key assumptions made by the appointed actuary have been derived, including—

(i) the average amount of a claim for compensation against the non-scheme member; and

(ii) the average amount of a claim for damages against the non-scheme member; and

(iii) the amount anticipated to have been incurred by the non-scheme member in potential claims for compensation or damages for which no claim has yet been made; and

(iv) the frequency of claims for compensation against the non-scheme member; and

(v) the frequency of claims for damages against the non-scheme member; and

(vi) the net amount of claims for compensation and damages against the non-scheme member after allowing for future inflation (***inflated value***); and

(vii) the net present value of the inflated value after allowing for income from assets set aside by the non-scheme member to pay the amount mentioned in paragraph (a); and

(viii) the rate of inflation used;

(d) the nature of the data used in the calculation;

(e) the appointed actuary's assessment of the data, including, for example, the accuracy of the data;

(f) how the appointed actuary interpreted the data;

(g) the actuarial model used in the calculation;

(h) the results of the calculation;

(i) the appointed actuary's confidence in the results of the calculation.

(3) Each appointed actuary must prepare the actuarial report within 35 days after the final day.

95 Summary report

(1) The appointed actuaries must also jointly prepare a report (the ***summary report***) that—

(a) includes each appointed actuary's individual actuarial report; and

(b) states how the reports mentioned in paragraph (a) agree or differ and the reasons for any difference.

(2) The appointed actuaries must give a copy of the summary report to the Regulator, WorkCover and the old self-insurer within 2 months after the final day.

96 Agreement on amount

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

97 Referral to arbiter if no agreement on amount

(1) This section applies if WorkCover and the old self-insurer do not agree on the amount of the non-scheme member's total liability.

(2) WorkCover and the old self-insurer must, by written notice, tell the Regulator that WorkCover and the old self-insurer do not agree on the amount of the non-scheme member's total liability.

(3) If the Regulator receives a written notice under subsection (2), the Regulator must refer the summary report to the arbiter to decide the amount of the non-scheme member's total liability.

Note—

See sections 102 to 104 in relation to the arbiter's decision.

98 Payment of amount

(1) The old self-insurer must pay to WorkCover the amount of the non-scheme member's total liability (the ***final amount***)—

(a) agreed to by the old self-insurer and WorkCover; or

(b) if there is no agreement—decided by the arbiter under section 102(2)(b)(ii).

(2) The old self-insurer must pay the final amount—

(a) within 3 months after the final day; or

(b) on or before a later day agreed to by the old self-insurer and WorkCover.

(3) However, the final amount paid by the old self-insurer must be adjusted by the old self-insurer's appointed actuary to take into account—

(a) the amount of compensation and damages, if any, paid by the non-scheme member during the final period; and

(b) claims for compensation and damages, if any, lodged against the non-scheme member during the final period.

(4) The old self-insurer must, by written notice, tell the Regulator the following information not later than the day the final amount is paid to WorkCover—

(a) the final amount paid, as adjusted under subsection (3);

(b) the name and contact details of the old self-insurer and the non-scheme member.

(5) In this section—

final period, in relation to a non-scheme member, means the period that—

(a) starts on the assessment day; and

(b) ends on the final day.

99 Transfer of claims information

The old self-insurer must, not later than the day the final amount is paid to WorkCover under section 98, give WorkCover all the information in the old self-insurer's possession about the claims for compensation and damages that relate to the non-scheme member's total liability.

Division 7 Actuarial arbiter

100 Appointment of arbiter

(1) The Regulator must appoint an actuarial arbiter (the ***arbiter***).

(2) The person appointed under subsection (1) must—

(a) be a Fellow or Accredited Member of the Actuaries Institute; and

(b) be selected by a selection panel consisting of—

(i) 2 individuals nominated by the Regulator; and

(ii) 2 individuals nominated by WorkCover; and

(iii) 2 individuals nominated by the Association of Self Insured Employers of Queensland.

(3) The arbiter is appointed on the terms and conditions, not provided for by this regulation, decided by the Regulator.

101 Functions of arbiter

The functions of the arbiter are—

(a) to consider reports referred to the arbiter under this part; and

(b) to decide on amounts of liability mentioned in this part.

102 Arbiter must decide amount of liability

(1) This section applies if—

(a) under section 34(3), 45(3), 56(3), 78(3), 87(3) or 97(3), the Regulator refers a summary report about an amount of liability to the arbiter; or

(b) under section 68(2), the Regulator refers an appointed actuary's actuarial report, the self-insurer's data and a second appointed actuary's actuarial report, if any, about an amount of liability to the arbiter.

(2) The arbiter must—

(a) for a referral mentioned in subsection (1)(a)—

(i) consider the individual reports included in the summary report; and

(ii) decide—

(A) the central estimate for the liability; and

(B) the amount of the liability; or

(b) for a referral mentioned in subsection (1)(b)—

(i) consider the documents mentioned in subsection (1)(b); and

(ii) decide—

(A) if an appointed actuary's actuarial report and a second appointed actuary's report is referred—the central estimate for the liability; and

(B) the amount of the liability.

(3) The amount of the liability decided under subsection (2)(a)(ii)(B) must not be—

(a) more than the higher of the amounts of liability stated in the individual reports; or

(b) less than the lower of the amounts of liability stated in the individual reports.

(4) The arbiter must give a written statement of the arbiter's decision, and the reasons for the decision, to the Regulator within 21 days after the referral to the arbiter is made.

103 Arbiter's decision is final

Unless the Supreme Court decides a decision of the arbiter under section 102 is affected by jurisdictional error, the decision—

(a) is final and conclusive; and

(b) can not be challenged, appealed against, reviewed, quashed, set aside or called in question in any other way under the *Judicial Review Act 1991* or otherwise (whether by the Supreme Court, another court, a tribunal or another entity); and

(c) is not subject to any declaratory, injunctive or other order of the Supreme Court, another court, a tribunal or another entity on any ground.

104 Arbiter's costs

The costs of an arbiter incurred in deciding an amount of liability under section 102 are to be paid in equal amounts by the following entities—

(a) for a decision about an amount of liability under division 1—WorkCover and the self-insurer;

(b) for a decision about an amount of liability under division 2—the old insurer and the new insurer;

(c) for a decision about an amount of liability under division 3—WorkCover and the former self-insurer;

(d) for a decision about an amount of liability under division 4—the Regulator and the self-insurer;

(e) for a decision about an amount of liability under division 5, subdivision 2 or 3—WorkCover and the non-scheme employer;

(f) for a decision about an amount of liability under division 6—WorkCover and the old self-insurer.

Part 4 Compensation

Division 1 Calculation of normal weekly earnings

105 Calculation of NWE—Act, s 106

This division prescribes, for section 106(3) of the Act, the way in which to calculate a worker's NWE in the 12 months immediately before the day the worker sustained an injury.

106 What amounts may be taken into account

(1) In calculating the worker's NWE, amounts paid to the worker by way of overtime, higher duties, penalties and allowances, in relation to work required by the worker's employer, may be taken into account but only if the amounts—

(a) are of a regular nature; and

(b) would have continued if not for the worker's injury.

(2) However, amounts mentioned in the Act, schedule 6, definition *wages*, paragraphs (a) to (d) must not be taken into account in calculating the worker's NWE.

107 NWE if impracticable to calculate worker's earnings

(1) This section applies if it is impracticable to calculate the worker's earnings in the 12 months immediately before the day the worker sustained the injury because of—

(a) the period for which the worker has been employed; or

(b) the terms of the worker's employment.

(2) In calculating the worker's NWE, regard must be had to—

(a) the NWE, in the 12 months immediately before the day the worker sustained the injury, of a person employed by the same employer who—

(i) is employed under the same or a comparable industrial agreement or the same or comparable terms and conditions as the worker; and

(ii) performs the same or comparable work as the worker; or

(b) if paragraph (a) does not apply—the NWE, in the 12 months immediately before the day the worker sustained the injury, of a person employed by another employer who—

(i) is employed under the same or a comparable industrial agreement or the same or comparable terms and conditions as the worker; or

(ii) performs the same or comparable work as the worker and receives the same or comparable earnings as the worker.

108 NWE if worker employed by 2 or more employers

(1) This section applies if, at the time the worker's injury was sustained, the worker was employed under concurrent contracts of service with 2 or more employers.

(2) The worker's NWE is to be calculated as if earnings under all the contracts were earnings in the employment of the employer for whom the worker was working when the injury was sustained.

109 NWE if insurer considers calculation unfair

(1) This section applies if an insurer considers that the calculation of a worker's NWE under this division would be unfair.

(2) The worker's NWE may be calculated in a way the insurer considers to be fair, and the calculation under this subsection is taken to be the worker's NWE.

Division 2 Application for compensation

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

For section 132(3)(b) of the Act, an application for compensation for a worker's injury must be accompanied by evidence and particulars of—

(a) the injury and its cause; and

(b) the nature, extent and duration of incapacity resulting from the injury; and

(c) if the injury is, or results in, the death of the worker—

(i) the identity of the worker; and

(ii) the worker's death; and

(iii) the relationship to the worker, and dependency, of persons claiming to be the worker's dependants; and

(d) if the injury is a latent onset injury that is a terminal condition and the worker has dependants—the relationship to the worker of persons claiming to be the worker's dependants.

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

For section 132A(3)(c)(ii) of the Act, an application to have a worker's injury assessed under section 179 of the Act must be accompanied by evidence and particulars of—

(a) the injury and its cause; and

(b) the nature, extent and duration of incapacity resulting from the injury.

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

For section 132B(3)(c)(ii) of the Act, an application for the issue of a certificate stating a person is a dependant of a deceased worker must be accompanied by evidence and particulars of—

(a) the injury and its cause; and

(b) the identity of the worker; and

(c) the worker's death; and

(d) the relationship to the worker, and dependency, of the person claiming to be the worker's dependant.

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

(1) This section applies if—

(a) a person (the ***applicant***) makes an application to an insurer under section 132, 132A or 132B of the Act; and

(b) the application is not accompanied by a medical certificate; and

(c) a doctor, nurse practitioner or registered dentist required or permitted to give the medical certificate was not available to attend the worker for the purpose of giving the certificate.

(2) The applicant must give the insurer a declaration in the approved form stating—

(a) that a doctor, nurse practitioner or registered dentist was not available to attend the worker for the purpose of giving the medical certificate; and

(b) the details of the worker's injury.

(3) For a non-fatal injury, the declaration—

(a) may be accepted by the insurer as proof of incapacity of the worker only once for injury to the worker in any 1 event; and

(b) is acceptable proof of incapacity of the worker for not more than 3 days.

(4) The declaration is taken to be a certificate in the approved form for section 132(3)(a), 132A(3)(c)(i) or 132B(3)(c)(i) of the Act.

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

(1) This section applies if—

(a) a person (the ***applicant***) makes an application to an insurer under section 132, 132A or 132B of the Act; and

(b) the application is not accompanied by a medical certificate; and

(c) the worker sustained the injury outside Queensland.

(2) The applicant may give the insurer a document, that is substantially to the same effect as the medical certificate, prepared by a person who holds a qualification corresponding to a doctor, nurse practitioner or registered dentist who attends the worker for the purpose of giving the document.

(3) The document is taken to be a certificate in the approved form for section 132(3)(a), 132A(3)(c)(i) or 132B(3)(c)(i) of the Act.

(4) Also, the insurer may—

(a) ask the person who gave the document to give a detailed report on the worker's condition to the insurer within 10 days after receiving the request; and

(b) pay an amount to the person who gave the document for the report that the insurer considers reasonable having regard to the table of costs.

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

(1) A requirement by an insurer under section 135 or 510 of the Act for a claimant or worker to submit to a personal examination by a registered person must be made by written notice.

(2) The notice must state—

(a) the name of the registered person engaged to make the examination; and

(b) if the registered person is a specialist—the field of specialty; and

(c) the day, time and place of the examination.

(3) The registered person stated under subsection (2)(a) must not be employed by the insurer giving the notice.

(4) A registered person who examines a claimant or worker under subsection (2) must, within 10 days after the examination, give the insurer—

(a) a written report of the examination; and

(b) an itemised account for the examination.

(5) The insurer must pay the registered person the costs of performing the examination, and giving the report, that the insurer considers reasonable having regard to the table of costs.

Division 3 Entitlement to compensation for permanent impairment—generally

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

For section 128B(2)(c) of the Act, the additional lump sum compensation, and graduated scale, stated in schedule 2 are prescribed.

117 Calculation of lump sum compensation—Act, s 180

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

Example—

A worker's DPI is assessed as 10%. The maximum statutory compensation is $422,295. The lump sum compensation is $42,229.50.

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

For section 192(2) of the Act, the additional lump sum compensation, and graduated scale, stated in schedule 3 are prescribed.

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

(1) This section prescribes—

(a) the way for assessing a worker's level of dependency for section 193(4) of the Act; and

(b) the way for assessing a worker's level of dependency and day to day care requirements for section 224(3) of the Act.

(2) The way is the way stated in the modified barthel index.

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

(1) This section prescribes—

(a) information to be included in an assessment report relating to a worker's level of dependency for section 193(5)(b) of the Act; and

(b) information to be included in an assessment report relating to a worker's level of dependency and day to day care requirements for section 224(4)(b) of the Act.

(2) The information is the following—

(a) whether day to day care of the same level was provided to the worker before the worker sustained the injury;

(b) whether day to day care of the same level would ordinarily be provided at the worker's home;

(c) whether day to day care of the same level is likely to continue to be provided at the worker's home;

(d) the number of hours of day to day care required by the worker.

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

(1) For section 193(6) of the Act, the additional lump sum compensation, and graduated scale, stated in schedule 4 are prescribed.

(2) 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

For section 193A of the Act, this division prescribes the following—

(a) the amount of section 193A compensation for an injury;

(b) the condition to which an entitlement to section 193A compensation is subject;

(c) the process for deciding whether the condition mentioned in paragraph (b) is satisfied for a worker to whom section 193A of the Act applies;

(d) the establishment of a panel to review decisions made by insurers about section 193A compensation.

123 Definitions for division

In this division—

injury means an injury mentioned in section 193A(1) of the Act.

panel means the panel established under section 141.

qualifying condition means the condition prescribed by section 126.

section 193A compensation, for an injury, means the additional lump sum compensation mentioned in section 193A(2) of the Act for the injury.

section 193A notice see section 129(1).

124 Application of division

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

For section 193A(2)(a) of the Act, the amount of section 193A compensation for an injury sustained by a worker in relation to whom the qualifying condition is satisfied is the amount under schedule 5.

126 Qualifying condition—Act, s 193A

(1) For section 193A(2)(b) of the Act, this section prescribes the condition applying to an entitlement to section 193A compensation for an injury sustained by a worker.

(2) The worker is entitled to section 193A compensation only if—

(a) the insurer is satisfied, on the balance of probabilities, that the worker's employer is, or would have been, liable to pay damages to the worker; but

(b) the worker can not seek damages because of the application of former section 237(1)(a)(i).

(3) In this section—

former section 237(1)(a)(i) means section 237(1)(a)(i) of the Act, as in force from 15 October 2013 until 31 January 2015.

Subdivision 3 Process for deciding qualifying condition

127 Application of subdivision

This subdivision applies if a worker's DPI has been decided.

Notes—

1 Section 193A of the Act applies only if a worker's DPI has been decided—see section 191 of the Act.

2 Also, see chapter 3, part 10 of the Act for provisions about—

- assessing a worker's injury to decide if the injury has resulted in a DPI; and
- giving the worker a notice of assessment stating the DPI for the injury; and
- an insurer making an offer of compensation to the worker.

128 Insurer to consider qualifying condition

An insurer must decide—

(a) whether the insurer has enough information to decide whether the qualifying condition is satisfied for the worker; and

(b) if the insurer decides it has enough information—whether the qualifying condition is satisfied for the worker.

129 Notification

(1) After deciding the matters mentioned in section 128, the insurer must give the worker a notice (a ***section 193A notice***) in the approved form.

(2) If the insurer decides the qualifying condition is satisfied for the worker, the section 193A notice must state the amount of section 193A compensation to which the worker is entitled for the worker's injury.

(3) If the insurer decides the qualifying condition is not satisfied for the worker, the section 193A notice must state—

(a) the insurer's decision; and

(b) that the worker may ask the insurer for written reasons for the decision; and

(c) that the worker may apply to the panel for a review of the decision only if the worker has asked the insurer for written reasons for the decision.

(4) If the insurer decides it does not have enough information to decide whether the qualifying condition is satisfied for the worker, the section 193A notice must state—

(a) the insurer's decision; and

(b) that the worker may, within the period mentioned in section 131(2)(a), give the insurer information to enable the insurer to decide whether the qualifying condition is satisfied for the worker; and

(c) that, if the worker does not give the insurer the information within the period mentioned in paragraph (b)—

(i) the qualifying condition will be taken not to be satisfied for the worker; and

(ii) the worker will not be entitled to section 193A compensation; and

(iii) the worker will not have a right to apply to the panel for a review of the matters mentioned in subparagraphs (i) and (ii).

130 Worker may request reasons

(1) This section applies if an insurer has given the worker a section 193A notice stating the insurer has decided the qualifying condition is not satisfied for the worker.

(2) The worker may, within 10 business days after receiving the notice, ask the insurer for written reasons for the decision.

(3) The insurer must give the worker the reasons for the decision within 10 business days after receiving the worker's request.

131 Giving information

(1) This section applies if the insurer has given the worker a section 193A notice stating the insurer does not have enough information to decide whether the qualifying condition is satisfied for the worker.

(2) The worker—

(a) may give the insurer information relevant to the decision—

(i) within 60 business days after receiving the section 193A notice; or

(ii) on or before a later day agreed to by the insurer and the worker; and

(b) if the worker gives information to the insurer under paragraph (a)—must tell the insurer whether the worker has engaged a lawyer and incurred legal costs in giving the information.

(3) The qualifying condition is taken not to be satisfied for the worker if the worker does not give the insurer information relevant to the decision within the period mentioned in subsection (2)(a).

132 Decision based on worker's information

(1) This section applies if the worker has given the insurer information under section 131.

(2) The insurer must consider the information and decide whether the qualifying condition is satisfied for the worker.

(3) The insurer must make the decision within the later of the following periods to end—

(a) 60 business days after receiving the information from the worker;

(b) if the insurer meets with the worker under section 133 within 60 business days after receiving the information from the worker—10 business days after the day of the meeting.

(4) If the insurer decides the qualifying condition is satisfied for the worker, the insurer must give the worker a written notice in the approved form stating the amount of section 193A compensation to which the worker is entitled for the worker's injury.

(5) If the insurer decides the qualifying condition is not satisfied for the worker, the insurer must give the worker written reasons for the decision.

(6) If the insurer does not make a decision within the period mentioned in subsection (3), the insurer is taken to have decided the qualifying condition is not satisfied for the worker.

133 Meeting before decision made

(1) This section applies if—

(a) the worker has given the insurer information under section 131; and

(b) the insurer proposes to decide the qualifying condition is not satisfied for the worker.

(2) Before making the decision, the insurer must—

(a) give the worker an opportunity to meet with the insurer to discuss the proposed decision; and

(b) if the worker agrees to meet with the insurer—give the worker any relevant information in the possession of the insurer at least 10 business days before the meeting.

(3) The insurer is not required to give the worker more than 1 opportunity to meet with the insurer.

(4) In this section—

relevant information, in relation to a worker, means information, other than information given to the insurer by the worker, that the insurer intends to consider for making the proposed decision.

Subdivision 4 Review of insurer's decision

134 Definition for subdivision

In this subdivision—

decision, of an insurer, includes a decision taken to have been made by the insurer under section 132(6).

135 Application of subdivision

This subdivision applies to a worker—

(a) who, under subdivision 3, has received written reasons for an insurer's decision that the qualifying condition is not satisfied for the worker; or

(b) in relation to whom an insurer is taken to have decided that the qualifying condition is not satisfied under section 132(6).

136 Application for review

(1) The worker may apply to the panel for a review of the decision within 20 business days after—

(a) the worker receives written reasons for the decision; or

(b) the day on which the worker becomes aware the insurer has failed to decide whether the qualifying condition is satisfied for the worker within the period mentioned in section 132(3).

(2) The application must include the following—

(a) the worker's reasons for asking for a review of the decision;

(b) if the worker has received written reasons for the decision—the reasons;

(c) if the worker has not already had an opportunity to give the insurer information about whether the qualifying condition is satisfied for the worker—any information the worker wants the panel to consider in support of the worker's application;

(d) if the worker has engaged a lawyer and incurred legal costs in relation to the application—a statutory declaration verifying the worker has engaged the lawyer and incurred legal costs.

(3) The worker must give the insurer a copy of the application.

137 Insurer to give information to panel

As soon as practicable after receiving a copy of the worker's application under section 136, the insurer must give the panel and the worker any information the insurer has considered in deciding whether the qualifying condition is satisfied for the worker.

138 Review by panel

(1) After considering the application and reviewing the insurer's decision, the panel must decide to—

(a) confirm the decision; or

(b) cancel the decision and substitute a new decision.

(2) The panel must give the worker and the insurer written notice of its decision and the reasons for its decision.

(3) If the panel decides to substitute a new decision, the new decision is taken to be the insurer's decision that the qualifying condition is satisfied for the worker.

(4) To remove any doubt, it is declared that the panel may review the insurer's decision without receiving oral submissions.

139 Panel's decision is final

Unless the Supreme Court decides a decision of the panel under section 138 is affected by jurisdictional error, the decision—

(a) is final and conclusive; and

(b) can not be challenged, appealed against, reviewed, quashed, set aside or called in question in any other way under the *Judicial Review Act 1991* or otherwise (whether by the Supreme Court, another court, a tribunal or another entity); and

(c) is not subject to any declaratory, injunctive or other order of the Supreme Court, another court, a tribunal or another entity on any ground.

140 Insurer must notify amount of entitlement

(1) This section applies if the insurer is notified by the panel that the insurer's decision is substituted with a new decision that the qualifying condition is satisfied for the worker.

(2) The insurer must give the worker a written notice in the approved form stating the amount of section 193A compensation to which the worker is entitled for the worker's injury.

Subdivision 5 Establishment of panel

141 Panel—Act, s 193A(3)

(1) For section 193A(3) of the Act, there is to be a panel made up of 1 chairperson and 2 other members.

(2) The function of the panel is to meet, as required, to review decisions under subdivision 4.

142 Appointment to panel

(1) The Minister must appoint a chairperson and 2 other members to the panel, on terms decided by the Minister.

(2) The Minister must ensure that each person appointed to the panel—

(a) is qualified, or eligible to qualify, as a lawyer; and

(b) has demonstrated significant experience relevant to the laws of personal injury and negligence.

143 Administrative matters

The Regulator may decide administrative matters about the panel that are not provided for under this subdivision, including, for example, the way in which the panel must meet.

Subdivision 6 Miscellaneous

144 Liability not affected

To remove any doubt, it is declared that a decision made by an insurer or the panel under this division does not impose liability on, or otherwise affect the liability of, the insurer or an employer for any other purpose or proceeding.

Division 5 Entitlement to compensation for pneumoconiosis

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

For section 36F(b) of the Act, the way stated in schedule 6 is prescribed.

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

(1) For section 128G(2) of the Act, the lump sum compensation, and graduated scale, stated in schedule 7 are prescribed.

(2) For section 128G(3) of the Act, the pneumoconiosis bands stated in schedule 7 are prescribed.

Division 6 Liability for caring allowance

147 Payment of caring allowance—Act, s 225

(1) For section 225(a) of the Act, if an insurer pays a caring allowance, the prescribed way of payment is for the insurer to—

(a) decide the number of hours of the day to day care required by the worker having regard to the occupational

therapist's assessment report under section 224(4) of the Act, and the graduated scale stated in schedule 8; and

(b) decide the allowance having regard to the information in the occupational therapist's report; and

(c) pay the allowance at an hourly rate equal to the carer pension rate divided by 35.

(2) In this section—

carer pension rate means the weekly amount of the maximum carer payment payable from time to time under a Commonwealth law, but does not include an amount for allowances such as rent assistance or family payment.

Part 5 Rehabilitation

Division 1 Rehabilitation and return to work coordinators

148 Functions—Act, s 41

For section 41(1)(b) of the Act, the following functions are prescribed for a rehabilitation and return to work coordinator—

(a) initiate early communication with an injured worker in order to clarify the nature and severity of the worker's injury;

(b) provide overall coordination of the worker's return to work;

(c) if a rehabilitation and return to work plan is developed under section 221 of the Act—

(i) consult with the worker and the worker's employer to develop the suitable duties program component of the plan; and

(ii) ensure the program is consistent with the current medical certificate or report for the worker's injury;

(d) liaise with—

(i) any person engaged by the employer to help in the worker's rehabilitation and return to work; and

(ii) the insurer for the purpose of providing information about the worker's progress and indicating, as early as possible, if there is a need for the insurer to assist or intervene.

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

(1) For section 226(1) of the Act, an employer must appoint a rehabilitation and return to work coordinator if—

(a) for an employer who employs workers at a workplace in a high risk industry—the wages of the employer in Queensland for the preceding financial year were more than 2,600 times QOTE; or

(b) otherwise—the wages of the employer in Queensland for the preceding financial year were more than 5,200 times QOTE.

(2) For the purpose of section 226(3)(a) of the Act, an employer is taken to have established a workplace, or started to employ workers at the workplace, only when the employer first meets the criteria prescribed under subsection (1).

(3) An employer may appoint a person as the rehabilitation and return to work coordinator for more than 1 workplace if the person can reasonably perform the person's functions as a rehabilitation and return to work coordinator for each workplace.

(4) In this section—

high risk industry means an industry specified by the Regulator by gazette notice as a high risk industry for the purpose of this section.

Division 2 Scheme directions

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

For section 329A(1)(b) of the Act, a scheme direction may provide for the standard for rehabilitation.

Part 6 Treatment, care and support payments

Division 1 Assessing entitlement

Subdivision 1 Preliminary

151 Definitions for division

In this division—

children's functional independence measure means the functional independence measure adapted for paediatrics and described on the department's website.

functional independence measure means a clinical tool used to assess the functional ability of a person by scoring motor and cognitive items against a scale and described on the department's website.

Subdivision 2 Eligibility criteria

152 Purpose of subdivision—Act, s 232M

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

153 Eligibility criteria for permanent spinal cord injury

(1) The eligibility criteria for a permanent spinal cord injury resulting in a permanent neurological deficit are—

(a) the permanent neurological deficit is classified as grade A, B, C or D on the ASIA impairment scale, as assessed under the ISNCSCI; and

(b) the injury has resulted in a residual significant impact on the function of the autonomic nervous system, evidenced by a score of 0 for an item relating to bladder, bowel or sexual function, as assessed under the ISAFSCI.

(2) In this section—

ASIA impairment scale means the scale, known as the American Spinal Injury Association impairment scale, used for measuring impairment resulting from a spinal cord injury and published by the American Spinal Injury Association.

ISAFSCI means the document called 'International standards to document autonomic function following spinal cord injury', published by the American Spinal Injury Association.

ISNCSCI means the document called 'International standards for neurological classification of spinal cord injury', published by the American Spinal Injury Association.

154 Eligibility criteria for traumatic brain injury

(1) The eligibility criteria for a traumatic brain injury resulting in a permanent impairment are—

(a) any or all of the following apply—

(i) the injury results in post-traumatic amnesia lasting 7 days or more as evidenced by an assessment using an approved scale;

(ii) the worker is or was in a coma, other than an induced coma, for 1 hour or more as a result of the injury;

(iii) brain imaging shows a significant brain abnormality as a result of the injury; and

(b) the worker's functional ability as a result of the injury is assessed as 5 or less for a motor or cognitive item using—

(i) for an adult—the functional independence measure; or

(ii) for a child—the children's functional independence measure.

(2) In this section—

approved scale, for assessing post-traumatic amnesia, means—

(a) the Westmead PTA scale; or

(b) a clinically accepted scale similar to the Westmead PTA scale approved by the Regulator for this definition.

Westmead PTA scale means the clinical tool, known as the Westmead Post Traumatic Amnesia Scale, used to assess the period a person suffers post-traumatic amnesia.

155 Eligibility criterion for amputation of leg through or above femur

(1) 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.

(2) For subsection (1), the percentage of the length of the femur lost must be worked out by—

(a) comparing the length of the femur before and after the amputation using X-rays taken before and after the amputation; or

(b) if X-rays of the femur are not available—comparing the length of the femur of the amputated leg with the length of the contralateral femur.

(3) To remove any doubt, it is declared that the eligibility criterion in subsection (1) may be satisfied even if the worker suffers from a personal injury that is the amputation of more than 1 limb or parts of different limbs.

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

(1) The eligibility criteria for the amputation of more than 1 limb or parts of different limbs are—

(a) the amputations involve the loss of 50% or more of the length of each of the worker's tibias; or

(b) both of the worker's upper limbs are amputated at or above the first metacarpophalangeal joint of the thumb and index finger of each hand; or

(c) the amputations involve—

(i) the loss of 50% or more of the length of 1 of the worker's tibias; and

(ii) 1 of the worker's upper limbs being amputated at or above the first metacarpophalangeal joint of the thumb and index finger of the same hand.

(2) For subsection (1), the percentage of the length of the tibia lost must be worked out by—

(a) comparing the length of the tibia before and after the amputation using X-rays taken before and after the amputation; or

(b) if X-rays of the tibia are not available—comparing the length of the tibia of the amputated leg with the length of the contralateral tibia; or

(c) if the length of the contralateral tibia can not be determined—using the estimated knee height based on overall height before the amputation.

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

The eligibility criteria for a full thickness burn to all or part of the body are—

(a) the full thickness burn is to—

(i) for a worker younger than 16 years—more than 30% of the total body surface area; or

(ii) for a worker 16 years or older—more than 40% of the total body surface area; or

(iii) both hands; or

(iv) the face; or

(v) the genital area; and

(b) the worker's functional ability as a result of the injury is assessed as 5 or less for a motor or cognitive item using—

(i) for an adult—the functional independence measure; or

(ii) for a child—the children's functional independence measure.

158 Eligibility criterion for inhalation burn resulting in permanent respiratory impairment

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—

(a) for an adult—the functional independence measure; or

(b) for a child—the children's functional independence measure.

159 Eligibility criterion for permanent blindness caused by trauma

(1) The eligibility criterion for permanent blindness caused by trauma is that the injured person has a visual defect, or a combination of visual defects, that result in visual loss that is, or is equivalent to—

(a) visual acuity of less than 6/60 in both eyes, assessed using the Snellen scale after correction by suitable lenses; or

(b) the constriction of the worker's field of vision to 10 degrees or less of the arc around central fixation in the worker's better eye, regardless of corrected visual acuity (equivalent to 1/100 white test object).

(2) In this section—

Snellen scale means the scale for measuring visual acuity using rows of letters printed in decreasing sizes.

Subdivision 3 Assessing eligibility criteria

160 Assessments using measures to be carried out by particular persons

An assessment using the functional independence measure or children's functional independence measure may be used for deciding whether a serious personal injury meets the eligibility criteria for the injury only if the assessment is carried out by a person who is—

(a) accredited by the Australasian Rehabilitation Outcomes Centre to carry out the assessment; and

(b) approved by the insurer to carry out the assessment.

Division 2 Assessing worker's needs

Subdivision 1 Assessment process

161 Assessments generally—Act, s 232O

(1) For section 232O(2)(a) of the Act, this section prescribes requirements for assessing a matter mentioned in section 232O(1)(a) of the Act.

(2) In carrying out the assessment, the insurer must, to the extent practicable, consult with the worker who has sustained the serious personal injury about the following matters—

(a) the treatment, care and support needs resulting from the serious personal injury the worker considers are necessary and reasonable;

(b) the treatment, care and support needed by the worker for any other injury resulting from the same event as the serious personal injury;

(c) the worker's abilities and limitations;

(d) the worker's individual goals.

(3) The insurer may also consult with any other person the insurer considers appropriate.

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

For section 232O(2)(a) of the Act, an assessment under section 232O(1)(a) of the Act relating to an eligible worker must be carried out—

(a) as soon as practicable after the insurer decides the worker is entitled to treatment, care and support payments; and

(b) if an assessment under section 232O(1)(a) of the Act relating to the worker has previously been carried out—within 1 year after the last assessment was carried out.

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

(1) For section 232O(2)(a) of the Act, this section prescribes requirements about assessing a matter mentioned in 232O(1)(a) of the Act if the insurer is assessing a worker's needs for, or relating to—

(a) a home modification; or

(b) transport modification; or

(c) workplace modification; or

(d) attendant care and support services that are personal assistance services or services to assist a person to participate in the community.

(2) In carrying out the assessment, the insurer must obtain and consider information about the needs mentioned in subsection (1) from a person who is appropriately qualified to give advice about the needs.

Example of appropriately qualified person—

an occupational therapist specialising in home or workplace modifications

Subdivision 2 Matters to be considered in assessing needs

164 Purpose of subdivision—Act, s 232N

(1) For section 232N(b) of the Act, this subdivision prescribes matters the insurer must consider in deciding whether an eligible worker's treatment, care and support needs resulting from the worker's serious personal injury are necessary and reasonable in the circumstances.

(2) This subdivision does not limit the matters the insurer may consider in making a decision mentioned in subsection (1).

165 Benefit to worker

(1) The insurer must consider whether providing treatment, care or support for, or relating to, the worker's treatment, care and support needs—

(a) is likely to maximise the worker's independence, participation in the community and employment; and

(b) will assist the worker in managing the injury.

(2) In considering the matters mentioned in subsection (1), the insurer must also have regard to the following matters—

(a) whether the treatment, care or support relates directly to the worker's individual goals;

(b) whether the treatment, care or support will improve or maintain the worker's ability to conduct daily activities or participate in the community or employment;

(c) whether the treatment, care or support has been provided to the worker previously, resulting in an improvement to, or assistance in managing, the worker's injury;

(d) whether the treatment, care or support has a measurable outcome;

(e) whether the worker has agreed or is likely to agree that the treatment, care or support will benefit the worker in the ways mentioned in subsection (1);

(f) any associated risks of the treatment, care or support to the worker, weighed against the expected benefit of the treatment, care or support to the worker.

166 Appropriateness of service

(1) The insurer must consider whether treatment, care or support for, or relating to, the worker's treatment, care and support needs—

(a) is consistent with other treatment, care or support being received by the worker; and

(b) is consistent with current clinical practice and other industry best practice for the treatment, care or support of persons with similar injuries.

(2) In considering the matters mentioned in subsection (1), the insurer must also have regard to the following matters—

(a) whether the treatment, care or support will be consistent with the worker's future treatment, care and support needs;

(b) whether the treatment, care or support relates directly to the worker's individual goals;

(c) whether the treatment, care or support could be harmful to the worker;

(d) whether similar treatment, care or support is already being, or is to be, provided to the worker for the injury;

(e) whether there is evidence that supports the effectiveness of the treatment, care or support.

Examples of evidence—

- peer-reviewed journal articles
- inclusion in clinical guidelines and frameworks
- successful clinical trials

- inclusion in the medical benefits schedule administered by the Commonwealth

167 Appropriateness of provider

(1) The insurer must consider whether treatment, care or support for, or relating to, the worker's treatment, care and support needs is provided by an appropriate provider.

(2) In considering the matter mentioned in subsection (1), the insurer must also have regard to the following matters—

(a) whether the provider, or the provider's staff, are appropriately qualified to provide the treatment, care or support;

(b) whether the provider is appropriate having regard to, for example, the worker's age, culture, ethnicity and location;

(c) whether the provider is acceptable to the worker;

(d) whether the provider has or may have a conflict of interest in providing the treatment, care or support to the worker;

(e) whether the provider's fee is reasonable;

(f) if, under section 232K(2) of the Act, the treatment, care or support must be provided by a registered provider—whether the provider is a registered provider.

168 Cost-effectiveness

(1) The insurer must consider whether treatment, care or support for, or relating to, the worker's treatment, care and support needs is cost-effective.

(2) In considering the matter mentioned in subsection (1), the insurer must also have regard to the following matters—

(a) the likely benefit to the worker of receiving the treatment, care or support weighed against the cost of providing the treatment, care or support to the worker;

(b) the cost of the treatment, care or support compared with the cost of the same or similar treatment, care or support provided by other suitable providers;

(c) whether there is a more cost-effective way to provide the treatment, care or support;

Examples—

- considering whether leasing equipment would be more cost-effective than purchasing new equipment
- considering whether the treatment, care or support can be more appropriately funded under another scheme

(d) whether the cost of the treatment, care or support is reasonable having regard to the period for which it is required;

(e) whether the cost of the treatment, care or support is more than an amount prescribed for the treatment, care or support under section 232R(4) of the Act.

Subdivision 3 Other requirements

169 Registered provider must provide particular needs

For section 232K(2)(b) of the Act, the following treatment, care or support is prescribed—

(a) a home modification;

(b) workplace modification;

(c) a service for the coordination of treatment, care and support.

Example for paragraph (c)—

a case manager engaged to coordinate a worker's treatment, care and support

Subdivision 4 Support plans and service requests

170 Support plans—Act, s 232O

(1) For section 232O(3) of the Act, this section prescribes requirements about an eligible worker's support plan.

(2) The support plan must state—

(a) the name of the worker; and

(b) the outcomes of the assessment under section 232O(1)(a) of the Act; and

(c) the matters mentioned in section 161(2), if known by the insurer; and

(d) any treatment, care and support needs resulting from the worker's serious personal injury the insurer considers are necessary and reasonable in the circumstances; and

(e) any treatment, care or support resulting from any other injury resulting from the same event as the serious personal injury that the insurer considers is necessary and reasonable in the circumstances; and

(f) any other treatment, care or support for the serious personal injury, or any other injury resulting from the same event as the serious personal injury, the insurer agrees to, wholly or partly, pay for under chapter 4A of the Act, having regard to the following matters—

(i) whether the treatment, care or support is needed by the worker as a result of the injury;

(ii) whether it would be fair and reasonable in the circumstances for the insurer to, wholly or partly, pay for the treatment, care or support;

(iii) whether providing the treatment, care or support will, or is likely to, reduce the worker's treatment, care and support needs for the injury;

(iv) whether the insurer considers paying, wholly or partly, for the treatment, care or support is more practical or cost-effective than the insurer paying for the worker's treatment, care and support needs for the injury, without compromising the level of treatment, care or support received by the worker under chapter 4A of the Act;

(v) whether the treatment, care or support is excluded treatment, care or support;

(vi) where the treatment, care or support is to be provided, including, for example, whether the treatment, care or support is to be provided outside Australia; and

(g) the intervals at which an assessment under section 232O(1)(a) of the Act will be carried out for the worker.

(3) The support plan must be consistent with an existing decision about a service request relating to the worker.

(4) However, subsection (3) applies only to the extent the support plan relates to the period covered by the existing decision.

171 Amending support plans—Act, s 232O

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

(2) An amendment of the support plan must be consistent with an existing decision about a service request relating to the worker.

(3) However, subsection (2) applies only to the extent the support plan relates to the period covered by the existing decision.

172 Deciding service request—Act, s 232P

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

(2) The insurer must consider the following matters—

(a) whether or not the requested service relates to—

(i) the worker's treatment, care and support needs resulting from the worker's serious personal injury; or

(ii) the worker's need for treatment, care or support resulting from another injury resulting from the same event as the worker's serious personal injury;

(b) if the requested service relates to the treatment, care and support needs mentioned in paragraph (a)(i)—whether or not the needs are necessary and reasonable in the circumstances;

(c) if the requested service relates to the treatment, care or support mentioned in paragraph (a)(ii)—whether or not the treatment, care or support is necessary and reasonable in the circumstances;

(d) if the requested service does not relate to treatment, care and support needs or treatment, care or support mentioned in paragraph (a)(ii), or the insurer does not consider the needs or the treatment, care or support mentioned in paragraph (a)(ii) are necessary and reasonable in the circumstances—whether or not the insurer should, wholly or partly, pay for the requested service under chapter 4A of the Act, having regard to the matters mentioned in section 170(2)(f).

Division 3 Payment options

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

(1) For section 232Q(3)(b) of the Act, this section prescribes the circumstances for making a payment request for the payment of all or part of an expense for the treatment, care or support of an eligible worker.

(2) A payment request may not be made by a person for the expense if—

(a) the person has entered into a funding agreement with the insurer for the treatment, care or support; and

(b) the expense was incurred in the period covered by the funding agreement.

(3) A payment request must be made within 6 months after the expense is incurred.

(4) However, the insurer may accept a later payment request if the insurer considers it is fair and reasonable in the circumstances to accept the request.

174 Deciding payment request—Act, s 232R

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

(2) If the insurer makes an information request for the payment request and the person of whom it is made does not provide the information requested by the stated day or a later day agreed to by the insurer and the person—

(a) the request lapses; and

(b) the insurer is not required to approve or refuse the request.

(3) The insurer must approve the payment request if—

(a) the expense is incurred in the eligibility period for the eligible worker; and

(b) the treatment, care or support to which the request relates is an approved service for the eligible worker.

(4) For subsection (3)(b), excluded treatment, care or support is an approved service only if the treatment, care or support—

(a) is specifically stated in a support plan for the worker to be—

(i) treatment, care or support resulting from the worker's serious personal injury that the insurer considers is necessary and reasonable in the circumstances; or

(ii) treatment, care or support resulting from another injury resulting from the same event as the worker's serious personal injury that the insurer considers is necessary and reasonable in the circumstances; or

(iii) treatment, care or support the insurer agrees to, wholly or partly, pay for under chapter 4A of the Act; or

(b) if a support plan has not been made for the worker—is specifically approved under an approval of a service request relating to the worker.

(5) To remove any doubt, it is declared that an insurer may approve a payment request even though the treatment, care or support to which the request relates is not an approved service for the eligible worker.

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

For section 232R(4) of the Act, the amount prescribed is—

(a) for medical treatment or rehabilitation—the amount stated in the table of costs; or

(b) for hospitalisation of the worker as an in-patient at a private hospital—the amount stated in section 217(3) of the Act; or

(c) for hospitalisation of the worker as an in-patient at a public hospital—the amount stated in section 218A(3) of the Act.

Division 4 Review of entitlement

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

(1) For section 232S(3) of the Act, this section prescribes matters for a review of a worker's entitlement to treatment, care and support payments under section 232S of the Act.

(2) The insurer must give the worker written notice of the review at least 20 business days before carrying out the review.

(3) In carrying out the review, the insurer may ask the worker to give the insurer information needed to make a decision about the worker's entitlement at the end of the review.

Part 7 Damages

Division 1 Particulars in notice of claim

177 Notice of claim for damages—Act, s 275

For section 275(3) of the Act, the particulars contained in this division are prescribed.

Note—

See section 276 of the Act if the claimant alleges an urgent need to start a proceeding for damages despite noncompliance with section 275 of the Act.

178 Particulars of claimant and worker

(1) A notice of claim must include—

(a) the worker's—

(i) full name and any other known names; and

(ii) residential address; and

(iii) date of birth; and

(iv) gender; and

(v) usual occupation and, if that differs from the nature of employment at the time the worker was injured, the nature of the employment at that time; and

(b) the name and address of every employer of the worker at the time the worker was injured.

(2) Also, if the claimant is not the worker, the notice of claim must include the claimant's—

(a) full name and any other known names; and

(b) residential address; and

(c) date of birth; and

(d) gender.

179 Particulars of event

A notice of claim must include the following—

(a) the date, time and place of the event;

(b) the claimant's description of the facts of the circumstances surrounding the worker's injury;

(c) the names and addresses of all witnesses to the injury, and their relationship, if any, to the worker;

(d) the name and address of any person on behalf of the claimant's employer to whom the claimant reported the injury and the details of the person's employment;

(e) the full particulars of the negligence alleged against the claimant's employer and any other party on which the claim is based;

(f) if a party other than the claimant's employer (the ***other party***) is involved—

(i) the liability expressed as a percentage for which the claimant holds the other party responsible; and

(ii) details of the notice of claim given to the other party.

180 Injury particulars

(1) A notice of claim must include full particulars of the nature and extent of—

(a) all injuries alleged to have been sustained by the claimant or worker because of the event; and

(b) the degree of permanent impairment that the claimant alleges has resulted from the injuries; and

(c) the amount of damages sought under each head of damage claimed by the claimant and the method of calculating each amount; and

(d) how the claimant or worker is currently affected by the injuries.

(2) Also, the notice of claim must include all personal injuries, illnesses and impairments of a medical, psychiatric or psychological nature sustained by the claimant or worker, either before or after the event that may affect—

(a) the extent of the permanent impairment resulting from the injury to which the claim relates; or

(b) the amount of damages in another way.

(3) In addition, if the claimant has claimed damages, compensation or benefits in relation to a personal injury, illness or impairment mentioned in subsection (2), the notice of claim must include—

(a) the name and address of any person against whom a claim for damages or compensation was made; and

(b) if an insurer or other insurance provider was involved in a claim mentioned in paragraph (a)—the name and address of that entity.

181 Particulars of hospital, treatment and rehabilitation

(1) A notice of claim must include the name and address of each of the following for each injury alleged to have been sustained by the claimant or worker—

(a) each hospital at which the claimant or worker has been treated for the injury;

(b) each doctor who treated the claimant or worker for the injury;

(c) each provider of treatment or rehabilitation services that assessed, treated, or provided treatment or rehabilitation services in relation to permanent impairment arising from the injury.

(2) Also, if section 180(2) applies, the notice of claim must include the name and address of—

(a) each hospital at which the claimant or worker has been treated for the personal injury, illness or impairment; and

(b) each doctor who treated the claimant for the personal injury, illness or impairment.

182 Particulars if claim for diminished income earning capacity

If a claimant claims damages for diminished income earning capacity, the notice of claim must include the following particulars of the claimant's employment for the 3 year period immediately before the event, and the period since the event—

(a) the name and address of each of the claimant's employers;

(b) the period of employment by each employer;

(c) the capacity in which the claimant was employed by each employer;

(d) the claimant's gross and net (after tax) earnings for each period of employment;

(e) the periods during which the claimant was receiving payments from Centrelink under the *Social Security Act 1991* (Cwlth);

(f) the periods during which the claimant received no income, and the reasons why the claimant was not receiving any income.

Note—

See also section 276 of the Act.

183 Particulars if injury causes death

(1) A notice of claim relating to an injury causing death must include the following additional particulars—

(a) if the claimant is the spouse of the deceased worker—

(i) the relevant date; and

(ii) the relevant place; and

(iii) the claimant's net (after tax) weekly income immediately before and after the worker's death; and

(iv) the age to which the claimant intended to work and whether the claimant intended the future employment to be full-time or part-time; and

(v) details of any current health problems of the claimant; and

(vi) the amount of average weekly financial benefit derived by the claimant from the deceased worker before the worker's death and the method of calculating the amount; and

(vii) the expected date of birth of a posthumous child of the relationship; and

(viii) details of any remarriage or start of a marriage-like relationship; or

(b) if the claimant is not the spouse of the deceased worker—

(i) the claimant's relationship to the deceased worker; and

(ii) the claimant's net (after tax) weekly income; and

(iii) the age to which the claimant would have been dependent on the deceased worker and the basis of the dependency; and

(iv) details of any current health problems of the claimant; and

(v) the amount of average weekly financial benefit derived by the claimant from the deceased worker immediately before the worker's death and the method of calculating the amount.

(2) In this section—

relevant date means—

(a) the date of marriage; or

(b) the date the civil partnership had effect; or

(c) the date on which the de facto relationship started.

relevant place means—

(a) the place of the marriage; or

(b) the place of registration of the civil partnership; or

(c) the residential address where the de facto relationship started.

184 Particulars of mitigation

A notice of claim must include 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

For section 278A(1) of the Act, the time prescribed is the later of the following—

(a) 30 business days after the insurer receives the notice of claim;

(b) 5 business days after the insurer identifies someone else as a contributor.

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

For section 278B(1)(a) of the Act, the following information is prescribed—

(a) the contributor's full name;

(b) the contributor's business address;

(c) the contributor's postal address;

(d) the name and contact details of the contributor's legal representatives, if any;

(e) the contributor's ABN, if any;

(f) if the contributor is a corporation—

(i) the corporation's ACN; and

(ii) the corporation's registered office.

Part 8 Assessment of damages

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

For section 306M(1)(b) of the Act, for an injury sustained during a period stated in an item of the following table, the amount stated in the item is prescribed.

Item	Period (dates inclusive)	Amount
1	1 July 2010 to 30 June 2011	$35,340
2	1 July 2011 to 30 June 2012	$36,350
3	1 July 2012 to 30 June 2013	$38,290
4	1 July 2013 to 30 June 2014	$39,430
5	1 July 2014 to 30 June 2015	$40,920
6	1 July 2015 to 30 June 2017	$41,920
7	1 July 2017 to 30 June 2018	$42,650
8	1 July 2018 to 30 June 2019	$43,960
9	1 July 2019 to 30 June 2020	$45,290
10	1 July 2020 and after	28.78 times QOTE

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

For section 306O(1)(c)(i) of the Act, a court must have regard to the following—

(a) for assessment of the ranges of injury scale value—the ranges mentioned in schedule 14;

(b) for matters to which a court is to have regard in the application of schedule 14—the rules mentioned in schedule 13;

(c) for the PIRS that must be used with schedule 14—the scales mentioned in schedule 16;

(d) for matters relevant to the application of schedule 16 and requirements with which a medical expert must comply in assessing a PIRS rating—the matters mentioned in schedule 15.

189 General damages calculation provisions—Act, s 306P

(1) For section 306P(2), definition *general damages calculation provisions*, for each period stated in a table in schedule 17, this section and that table are the general damages calculation provisions for the period.

(2) For an injury within the injury scale value stated in an item of any of tables 1 to 9, the general damages are the sum of—

(a) the base amount for the item (if any); and

(b) the variable amount for the item.

(3) For an injury within the injury scale value stated in an item of a table other than a table mentioned in subsection (2), the general damages are the amount worked out in the way stated in the column of the table with the heading 'general damages'.

(4) In this section—

variable amount means the amount worked out in the way stated in the column of a table with the heading 'variable amount'.

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

For section 306R(2) of the Act, for an injury sustained during a period stated in an item of the following table, the amount stated in the item is prescribed.

Item	Period (dates inclusive)	Amount
1	1 July 2010 to 30 June 2011	$117,800
2	1 July 2011 to 30 June 2012	$121,160
3	1 July 2012 to 30 June 2013	$127,620
4	1 July 2013 to 30 June 2014	$131,420
5	1 July 2014 to 30 June 2015	$136,400
6	1 July 2015 to 30 June 2017	$139,740
7	1 July 2017 to 30 June 2018	$142,160
8	1 July 2018 to 30 June 2019	$146,540
9	1 July 2019 to 30 June 2020	$150,970
10	1 July 2020 and after	95.92 times QOTE

Part 9 Costs

Division 1 Hearing before industrial magistrate or industrial commission

191 Costs of hearing before industrial magistrate or industrial commission

(1) A decision to award costs of a hearing before an industrial magistrate or the industrial commission is at the discretion of the magistrate or commission.

(2) If the magistrate or commission awards costs—

(a) costs in relation to counsel's or solicitor's fees are the costs stated in the *Uniform Civil Procedure Rules 1999*, schedule 2, part 2, scale C; and

(b) costs in relation to witnesses are the allowances stated in the *Uniform Civil Procedure (Fees) Regulation 2019*, part 3; and

(c) costs in relation to bailiffs are the fees stated in the *Uniform Civil Procedure (Fees) Regulation 2019*, schedule 2A.

(3) However, the magistrate or commission may award costs up to 1.5 times the amounts under subsection (2)(a), in total or in relation to any item, if the magistrate or commission is satisfied the amounts under subsection (2)(a) are inadequate having regard to—

(a) the work involved; or

(b) the importance, difficulty or complexity of the matter to which the proceeding relates.

192 Payment of additional amount for costs

(1) This section applies if—

(a) the Regulator or an insurer is required to pay costs in a proceeding in relation to a witness who—

(i) is a medical practitioner; or

(ii) gives evidence of a professional nature; and

(b) the amount of fees and expenses payable in relation to the witness by the party that called the witness is more than the amount of costs awarded by the industrial magistrate or the industrial commission.

(2) The Regulator or the insurer may, on the application of the party that called the witness, pay an additional amount for costs that the Regulator or the insurer is satisfied are

reasonable, having regard to the subject matter of the proceeding.

Division 2 Claim for damages

193 Application of division

This division applies to a claimant who is—

(a) a worker whose DPI is 20% or more; or

(b) a worker who has a terminal condition; or

(c) a dependant.

194 Costs before proceeding started

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

(2) If a claimant recovers net damages of $150,000 or more, the costs are—

(a) for pre-proceeding notification and negotiation if a compulsory conference was not held—120% of the amount in schedule 9, column A; and

(b) for pre-proceeding notification and negotiation if a compulsory conference was held—the amounts in schedule 9, columns A and B; and

(c) for investigation of liability by an expert—the amount in schedule 9, column C; and

(d) for an application to the court—the amount in schedule 9, column D.

(3) If a claimant recovers net damages of $50,000 or more but less than $150,000, the costs are 85% of the amount calculated under subsection (2).

(4) If a claimant recovers net damages of less than $50,000, the costs are 85% of the amount calculated under subsection (2)

multiplied by the proportion that the net damages bear to $50,000.

Example of subsection (4)—

If the net damages recovered are $30,000, the costs are (85% of the amount calculated under subsection (2)) x $^{3}/_{5}$.

(5) However, if the court in which the proceeding is started awards legal costs, the costs recoverable under subsections (2), (3) and (4) are multiplied by 120%.

(6) In this section—

net damages means the damages recovered less the compensation paid by an insurer.

195 Costs after proceeding started

(1) This section prescribes the legal professional costs of a claim incurred after a proceeding in a court is started.

(2) The costs are in accordance with the scale of costs for work done for or in a proceeding in the court.

Note—

See the *Uniform Civil Procedure Rules 1999*, chapter 17A.

(3) Despite subsection (2), the costs do not include counsel's fees.

(4) Also, the costs do not include—

(a) the cost of work performed before the proceeding was started; or

(b) the cost of work performed before the proceeding was started that is performed again after the proceeding was started.

196 Outlays

(1) In addition to the costs mentioned in section 194 or 195, the following outlays incurred by the claimant are allowed—

(a) 1 hospital report fee for each hospital that treated the worker's injury;

(b) 1 report fee for each doctor in general practice who treated the worker's injury;

(c) 1 medical specialist's report fee for each medical discipline reasonably relevant and necessary for understanding the worker's injury;

(d) 1 report fee of an expert investigating liability, of not more than $1,000, less any proportion of the fee agreed to be paid by the insurer;

(e) Australian Taxation Office or tax agents' fees for supplying copies of income tax returns;

(f) fees charged by the claimant's previous employers for giving information necessary for the claimant to complete the notice of claim, but not more than $50 for each employer;

(g) fees charged by a mediator of an amount previously agreed to by the insurer;

(h) filing fees or other necessary charges incurred in relation to an application to the court before the proceeding is started;

(i) reasonable fees for sundry items properly incurred, other than photocopying costs.

(2) The fees mentioned in subsection (1)(a) to (d) are allowable only for reports disclosed before the start of the proceeding.

(3) The fees mentioned in subsection (1)(a) to (c) are payable in accordance with the scale of fees recommended by the Australian Medical Association.

(4) Counsel's fees are not allowed under this section or under the *Uniform Civil Procedure Rules 1999*, chapter 17A.

Part 10 Medical assessment tribunals

197 Medical assessment tribunals—Act, s 492

For section 492 of the Act the following tribunals are prescribed—

(a) the General Medical Assessment Tribunal;

(b) the following specialty medical assessment tribunals—

(i) the Cardiac Assessment Tribunal;

(ii) the Orthopaedic Assessment Tribunal;

(iii) the Dermatology Assessment Tribunal;

(iv) the Ear, Nose and Throat Assessment Tribunal;

(v) the Neurology/Neurosurgical Assessment Tribunal;

(vi) the Ophthalmology Assessment Tribunal;

(vii) the Disfigurement Assessment Tribunal;

(viii) the Psychiatric Assessment Tribunal;

(c) the Composite Medical Assessment Tribunal.

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

(1) For section 494 of the Act, for deciding a matter referred to the General Medical Assessment Tribunal, the tribunal is constituted by—

(a) if the chairperson of the tribunal is a specialist—

(i) the chairperson; and

(ii) 2 appointees to the panel of doctors for the tribunal who are chosen by the chairperson; or

(b) if the chairperson of the tribunal is not a specialist and at least 1 deputy chairperson of the tribunal is a specialist—

(i) a deputy chairperson of the tribunal who is a specialist who is chosen by the chairperson; and

(ii) 2 appointees to the panel of doctors for the tribunal who are chosen by the deputy chairperson mentioned in subparagraph (i); or

(c) otherwise—

(i) the chairperson of the tribunal; and

(ii) 2 appointees to the panel of doctors for the tribunal, at least 1 of whom is a specialist, who are chosen by the chairperson of the tribunal.

(2) When choosing an appointee to the panel of doctors for the tribunal under subsection (1)(a)(ii), (b)(ii) or (c)(ii), the chairperson or deputy chairperson must consider the medical specialty that is relevant to the matter referred to the tribunal.

Note—

See also section 204 in relation to consulting the secretary of the tribunal.

(3) In this section—

specialist means a specialist in the medical specialty relevant to the matter referred to the tribunal.

199 Chairperson and deputy chairperson of General Medical Assessment Tribunal

(1) The chairperson of the General Medical Assessment Tribunal must preside over meetings of the tribunal.

(2) However, if a deputy chairperson of the tribunal is chosen under section 198(1)(b)(i) to constitute the tribunal for deciding a matter, the deputy chairperson must act as chairperson and preside over meetings of the tribunal for deciding the matter.

(3) Also, if the chairperson of the tribunal is not available to attend to the business of the tribunal, other than deciding a matter mentioned in subsection (2), a deputy chairperson of the tribunal chosen by the chairperson must act as chairperson of the tribunal.

(4) To remove any doubt, it is declared that a deputy chairperson of the tribunal may act as a member of the tribunal only if the deputy chairperson has been chosen for the purpose by the chairperson under subsection (3) or under section 198(1)(b)(i).

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

(1) For section 494 of the Act, for deciding a matter referred to a specialty medical assessment tribunal, the tribunal is constituted by—

(a) the chairperson of the tribunal; and

(b) 2 appointees to the panel of doctors for the tribunal, including appointees appointed as deputy chairpersons, who are chosen by the chairperson of the tribunal.

(2) When choosing an appointee to the panel of doctors for the tribunal under subsection (1)(b), the chairperson must consider the medical specialty that is relevant to the matter referred to the tribunal.

Note—

See also section 204 in relation to consulting the secretary of the tribunal.

201 Chairperson and deputy chairperson of specialty medical assessment tribunal

(1) The chairperson of a specialty medical assessment tribunal must preside over meetings of the tribunal.

(2) If the chairperson of the tribunal is not available to attend to the business of the tribunal—

(a) if the tribunal has only 1 deputy chairperson—the deputy chairperson of the tribunal must act as chairperson of the tribunal; or

(b) if the tribunal has more than 1 deputy chairperson—a deputy chairperson of the tribunal chosen by the chairperson of the tribunal must act as chairperson of the tribunal.

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

(1) For section 494 of the Act, for deciding a matter referred to the Composite Medical Assessment Tribunal, the tribunal is constituted by—

(a) the following chairperson—

(i) for a serious personal injury matter—the chairperson of the General Medical Assessment Tribunal;

Note—

The chairperson of the Composite Medical Assessment Tribunal and the General Medical Assessment Tribunal may be the same person.

(ii) otherwise—the chairperson of the tribunal; and

(b) at least 2 but not more than 4 appointees to the panel of doctors for the tribunal chosen by the chairperson under paragraph (a).

(2) When choosing an appointee to the panel of doctors for the tribunal under subsection (1)(b), the chairperson must—

(a) consider the medical specialty that is relevant to the matter referred to the tribunal; and

(b) consult with—

(i) if the chairperson of the tribunal is not the chairperson of the General Medical Assessment

Tribunal—the chairperson of the General Medical Assessment Tribunal; and

(ii) the chairperson of each specialty medical assessment tribunal relevant to the matter referred to the tribunal; and

Note—

See also section 204 in relation to consulting the secretary of the tribunal.

(c) ensure the chairperson chooses at least 1 specialist for each type of injury that is a subject of the matter referred to the tribunal.

(3) The number of specialists chosen under subsection (2)(c) for each type of injury must be equal.

Example—

A worker has a post-traumatic stress disorder and a fractured arm, leg, and ribs. The tribunal would be constituted by the chairperson and—

(a) 1 psychiatrist and 1 orthopaedic surgeon; or

(b) 2 psychiatrists and 2 orthopaedic surgeons.

(4) If, because of subsection (3), the tribunal would be constituted by an even number of members, the chairperson must also choose an appointee to the panel of doctors for the tribunal who is a physician to be a member of the tribunal.

Example—

A worker has 3 different types of injuries. The tribunal would be constituted by the chairperson and 3 specialists. A physician would also need to be chosen to constitute the tribunal, subject to subsection (5).

(5) However, subsection (4) does not apply if the chairperson is a physician.

(6) In this section—

serious personal injury matter means a matter referred to the tribunal under—

(a) section 500(1)(fa), (fb) or (fc) of the Act; or

(b) the *National Injury Insurance Scheme (Queensland) Act 2016*, section 113.

203 Chairperson and deputy chairperson of Composite Medical Assessment Tribunal

(1) The chairperson of the Composite Medical Assessment Tribunal under section 202(1)(a) must preside over meetings of the tribunal.

(2) If the chairperson of the tribunal under section 202(1)(a) is not available to attend to the business of the tribunal—

(a) if the tribunal has only 1 deputy chairperson—the deputy chairperson of the tribunal must act as chairperson of the tribunal; or

(b) if the tribunal has more than 1 deputy chairperson—a deputy chairperson of the tribunal chosen by the chairperson of the tribunal must act as chairperson of the tribunal.

204 Consultation with secretary of tribunal

The chairperson of a tribunal must consult with the secretary of the tribunal about the constitution of the tribunal.

205 Delegation by chairperson or deputy chairperson

(1) A chairperson of a tribunal may delegate to the Regulator a power under this part—

(a) to choose an appointee to the panel of doctors for the tribunal to constitute the tribunal; or

(b) to choose a deputy chairperson to act as chairperson of the tribunal.

(2) A deputy chairperson of the General Medical Assessment Tribunal may delegate to the Regulator a power under

section 198(1)(b)(ii) to choose an appointee to the panel of doctors for the tribunal to constitute the tribunal.

(3) The delegation may apply generally or be limited in its application to a particular matter.

Part 11 Miscellaneous

206 First responders—Act, s 36EB

For section 36EB(a) of the Act, each of the occupations or professions mentioned in schedule 10 is prescribed.

207 Eligible employees—Act, s 36EC

For section 36EC(1)(a) of the Act, each of the entities mentioned in schedule 11 is prescribed.

208 Presumption of injury—Act, s 36ED

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

(2) In this section—

DSM 5 means the 5th edition of the Diagnostic and statistical manual of mental disorders published by the American Psychiatric Association in 2013.

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

(1) For sections 46B(3) and 132AA(2) of the Act, a statement given by an employer to a worker, or an insurer to a worker or a worker's employer, providing information about the workers' compensation scheme (an ***information statement***) must be in the approved form.

(2) Without limiting the content of an information statement, the statement must include information about the provisions in the workers' compensation scheme for a worker—

(a) to make an application for compensation for an injury sustained by the worker; and

(b) to choose the registered person who will provide medical treatment for the injury; and

(c) to choose who is present during medical treatment for the injury; and

(d) to choose a different workplace rehabilitation provider if dissatisfied with a provider chosen by the insurer; and

(e) to be consulted in the preparation and review of a rehabilitation and return to work plan under section 221 of the Act; and

(f) to seek advice and support from a lawyer or a registered industrial organisation as the worker considers appropriate.

210 Declaration of designated courts—Act, s 114

(1) This section is made for section 114(4) of the Act, definition *designated court*, paragraph (b).

(2) Each court, tribunal or decision-making body stated in schedule 12, column 2, opposite the name of a State in schedule 12, column 1, is declared to be a designated court for the purposes of section 114 of the Act.

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

(1) This section is made for section 322(2) of the Act, definition *a State's legislation about damages for a work related injury*, paragraph (b).

(2) The provisions stated in schedule 12, column 3, opposite the name of a State in schedule 12, column 1, are declared to be the State's legislation about damages for a work related injury.

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

Each of the following entities is prescribed for section 385A(4) of the Act, definition *prescribed entity*—

(a) the chief inspector under the *Coal Mining Safety and Health Act 1999*;

(b) the chief inspector under the *Mining and Quarrying Safety and Health Act 1999*;

(c) the chief inspector under the *Petroleum and Gas (Production and Safety) Act 2004*;

(d) the general manager under the *Maritime Safety Queensland Act 2002*;

(e) the chief executive of the Office of the National Rail Safety Regulator under the Rail Safety National Law (Queensland);

(f) the chief executive officer of the National Heavy Vehicle Regulator under the Heavy Vehicle National Law (Queensland).

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

(1) For section 532D(1) of the Act, an employer or contractor (the ***person***) must keep the following documents—

(a) if the person must keep a time and wages record for an employee under the *Industrial Relations Act 2016*, section 339 or 340—the time and wages record;

(b) if the person must keep an employee's records under the *Fair Work Act 2009* (Cwlth), section 535—the employee record;

(c) documents, or accurate and complete copies of documents, required to be kept under a law of the Commonwealth for payments made to workers or contractors for the performance of work, including, for example—

(i) group certificates; and

(ii) group employer's reconciliation statements; and

(iii) tax invoices to claim a GST credit; and

(iv) invoices from a contractor received for work;

(d) the person's profit and loss account, to the extent the account relates to payments made to workers or contractors for the performance of work.

(2) However—

(a) subsection (1) does not apply to a document if the Regulator or WorkCover has given the person a notice stating that the document need not be kept by the person; and

(b) subsection (1) does not apply to an employer or contractor that is a corporation that has been wound up.

(3) For section 532D(1) of the Act, a document mentioned in subsection (1)(c) or (d) is not required to contain particulars the person reasonably believes are—

(a) confidential; and

(b) not necessary to enable the Regulator or WorkCover to calculate payments made to workers or contractors for the performance of work.

Examples—

- income and profit lines
- tax file numbers

(4) In this section—

employee record see the *Fair Work Act 2009* (Cwlth), section 12.

time and wages record see the *Industrial Relations Act 2016*, section 336.

worker does not include a household worker.

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

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 allowances and expenses to which a witness in a proceeding before the District Court is entitled.

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

(1) For sections 540(4)(a) and 546(3AA) of the Act, the reasons for a decision must address the following matters—

(a) citation of the provision of the Act under which the decision is made;

(b) a statement of—

(i) the evidence considered for the decision; and

(ii) the evidence that was accepted or rejected for the decision and why the evidence was accepted or rejected; and

(iii) the conclusions drawn from the evidence; and

(iv) the link between the evidence, the conclusions and the provision of the Act under which the decision is made; and

(v) the decision made.

(2) Also, the reasons for a decision must be written in plain English.

Part 12 Savings and transitional provisions

216 Definition for part

In this part—

expired regulation means the expired *Workers' Compensation and Rehabilitation Regulation 2014*.

217 Date fixed for annual levy before commencement

(1) The date fixed by the Regulator for the purpose of section 17(2) of the expired regulation, definition *estimated claims liability* before the commencement continues to apply to each financial year and is taken to be the specified date under section 18(2) for the financial year.

Note—

The date fixed by the Regulator was published in the gazette on 19 December 2014 at page 555 and is 1 February.

(2) Subsection (1) stops applying to a financial year starting after the commencement if the Regulator specifies a date under section 18(2) for the financial year.

218 Actuarial arbiter appointed before commencement

(1) This section applies to a person who, immediately before the commencement, held an appointment under section 93 of the expired regulation as the actuarial arbiter.

(2) The person continues to be the actuarial arbiter under section 100 on the same terms of appointment held by the person immediately before the commencement.

219 Chairperson and members of panel appointed before commencement

(1) This section applies to a person who, immediately before the commencement, held an appointment under section 112S of the expired regulation as the chairperson or a member of the panel.

(2) The person is taken to be the chairperson or a member of the panel established under section 141 on the same terms of appointment held by the person immediately before the commencement.

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

(1) Section 195 applies in relation to legal professional costs of a claim incurred in relation to a proceeding in a court only if the notice of claim given under section 275 of the Act in relation to the injury the subject of the proceeding is given after the commencement.

(2) Subsection (1) applies even if the injury the subject of the proceeding was sustained before the commencement.

(3) If the notice of claim given under section 275 of the Act in relation to the injury the subject of the proceeding was given before the commencement, section 136 of the expired regulation continues to apply in relation to the proceeding as if this regulation had not been made.

221 Outlays incurred in relation to claim

(1) Section 137 of the expired regulation continues to apply in relation to a current claim as if this regulation had not been made.

(2) Section 196 applies in relation to all other claims, even if the claim relates to an injury sustained before the commencement.

(3) In this section—

current claim means a claim in relation to which—

(a) a notice of claim was given under section 275 of the Act in relation to the injury the subject of the claim before the commencement; and

(b) costs and outlays have not been finalised before the commencement.

222 Saving of operation of transitional provision

Section 149 of the expired regulation is declared to be a law to which the *Acts Interpretation Act 1954*, section 20A applies.

223 Reference to provisions of expired regulation

A reference in a document to a particular provision (the ***former provision***) of the expired regulation may, to the extent necessary and if the context permits, be taken as a reference to a provision of this regulation all or part of which corresponds, or substantially corresponds, to the former provision.

Schedule 1 Additional premium

section 8

Day declaration of wages is given	Additional premium
on or after 1 September and not later than 31 October in 1 calendar year	the greater of— (a) 5% of assessed premium for the period of insurance to which the declaration relates; or (b) $5
on or after 1 November and not later than 30 November in 1 calendar year	the greater of— (a) 10% of assessed premium for the period of insurance to which the declaration relates; or (b) $10
on or after 1 December and not later than 31 December in 1 calendar year	the greater of— (a) 15% of assessed premium for the period of insurance to which the declaration relates; or (b) $15
on or after 1 January in the next calendar year	the greater of— (a) 20% of assessed premium for the period of insurance to which the declaration relates; or (b) $20

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

section 116

1 Graduated scale

(1) This schedule contains the graduated scale for additional lump sum compensation for a worker who has a terminal condition that is a latent onset injury.

(2) The maximum amount of additional lump sum compensation payable under this schedule is 216.15 times QOTE.

2 How to use the graduated scale

The worker's additional lump sum compensation entitlement is the amount stated in column 2 that corresponds to the age of the worker when the worker lodges the worker's application for compensation as stated in column 1.

Graduated scale

Column 1 Worker's age	Column 2 Additional lump sum compensation $
70 years or under	216.15 times QOTE
71 years	194.54 times QOTE
72 years	172.92 times QOTE
73 years	151.31 times QOTE
74 years	126.69 times QOTE
75 years	108.08 times QOTE

Column 1 Worker's age	Column 2 Additional lump sum compensation $
76 years	86.47 times QOTE
77 years	64.86 times QOTE
78 years	43.24 times QOTE
79 years	21.63 times QOTE
80 years or over	0

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

section 118

1 Graduated scale

(1) This schedule contains the graduated scale for additional lump sum compensation for a worker who sustains an injury that results in a DPI of 30% or more.

(2) The maximum amount of additional lump sum compensation payable under this schedule is 216.15 times QOTE.

2 How to use the graduated scale

A worker who sustains an injury that results in a DPI stated in column 1 is entitled to additional lump sum compensation in the amount stated in the corresponding entry in column 2.

Graduated scale

Column 1 DPI %	Column 2 Additional lump sum compensation $
30	8.15 times QOTE
31	12.77 times QOTE
32	17.39 times QOTE
33	22.01 times QOTE
34	26.63 times QOTE
35	31.26 times QOTE
36	35.88 times QOTE

Column 1 DPI %	Column 2 Additional lump sum compensation $
37	40.50 times QOTE
38	45.12 times QOTE
39	49.75 times QOTE
40	54.37 times QOTE
41	58.99 times QOTE
42	63.61 times QOTE
43	68.23 times QOTE
44	72.86 times QOTE
45	77.48 times QOTE
46	82.10 times QOTE
47	86.73 times QOTE
48	91.35 times QOTE
49	95.97 times QOTE
50	100.59 times QOTE
51	105.21 times QOTE
52	109.83 times QOTE
53	114.46 times QOTE
54	119.08 times QOTE
55	123.70 times QOTE
56	128.32 times QOTE
57	132.95 times QOTE
58	137.57 times QOTE
59	142.19 times QOTE

Column 1 DPI %	Column 2 Additional lump sum compensation $
60	146.82 times QOTE
61	151.44 times QOTE
62	156.06 times QOTE
63	160.68 times QOTE
64	165.31 times QOTE
65	169.93 times QOTE
66	174.55 times QOTE
67	179.17 times QOTE
68	183.80 times QOTE
69	188.42 times QOTE
70	193.04 times QOTE
71	197.66 times QOTE
72	202.28 times QOTE
73	206.91 times QOTE
74	211.53 times QOTE
75–100	216.15 times QOTE

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

section 121

1 Graduated scale

(1) This schedule contains the graduated scale for additional lump sum compensation for gratuitous care.

(2) The maximum amount of additional lump sum compensation payable under this schedule is 244.86 times QOTE.

2 How to use the graduated scale

(1) The DPI is stated in column 1.

(2) The range of dependency assessed under the modified barthel index is stated in column 2.

(3) In column 2—

(a) moderate is a modified barthel index total score of 50–74; and

(b) severe is a modified barthel index total score of 25–49; and

(c) total is a modified barthel index total score of 0–24.

(4) The worker's additional lump sum compensation entitlement is stated in the corresponding entry in column 3.

Graduated scale

Column 1 DPI %	Column 2 Range of dependency (modified barthel index)	Column 3 Additional lump sum compensation $
15–39	moderate	1.99 times QOTE
	severe	3.97 times QOTE
	total	5.94 times QOTE
40–49	moderate	3.70 times QOTE
	severe	7.52 times QOTE
	total	11.21 times QOTE
50–59	moderate	16.35 times QOTE
	severe	32.68 times QOTE
	total	49.00 times QOTE
60–69	moderate	40.84 times QOTE
	severe	73.49 times QOTE
	total	97.97 times QOTE
70–79	moderate	57.16 times QOTE
	severe	106.14 times QOTE
	total	146.93 times QOTE
80–89	moderate	65.32 times QOTE
	severe	132.00 times QOTE
	total	195.89 times QOTE
90–94	moderate	73.49 times QOTE
	severe	146.93 times QOTE
	total	228.53 times QOTE

Column 1 DPI %	Column 2 Range of dependency (modified barthel index)	Column 3 Additional lump sum compensation $
95–100	moderate	81.63 times QOTE
	severe	163.28 times QOTE
	total	244.86 times QOTE

Schedule 5 Section 193A compensation for particular workers

section 125

1 Amount of section 193A compensation

Section 193A compensation consists of the following amounts for an injury sustained by a worker in relation to whom the qualifying condition is satisfied—

(a) an amount of compensation (the ***DPI amount***)—

(i) payable under the graduated scale in section 2 of this schedule; and

(ii) applied to multiple injuries in the way provided for under section 3 of this schedule;

(b) an amount of compensation (the ***legal cost amount***) payable towards legal costs if the worker engages a lawyer and incurs legal costs for particular things done under part 4, division 4.

2 DPI amount generally

A worker who sustains a DPI stated in column 1 is entitled to the amount stated in column 2 opposite the DPI.

Graduated scale

Column 1 DPI %	Column 2 DPI amount $
1	6,298
2	12,596
3	18,894
4	25,192

Column 1 DPI %	Column 2 DPI amount $
5	31,490

3 DPI amount for multiple injuries

(1) This section prescribes the DPI amount if the worker—

(a) has sustained multiple injuries from 1 event; and

(b) receives a notice of assessment for the worker's physical injury and another notice of assessment for the worker's psychological injury.

(2) The worker is only entitled to 1 payment for the DPI amount, being the amount stated in section 2, column 2 opposite the DPI—

(a) stated in section 2, column 1; and

(b) that is the higher of the DPI percentages stated in the notices.

(3) However, subsection (4) applies if—

(a) a worker is paid the DPI amount based on a notice of assessment for an injury; and

(b) the worker later receives a second notice of assessment for a different type of injury; and

(c) the second notice of assessment states a DPI that is higher than the DPI stated in the first notice of assessment but is not more than 5%.

(4) The worker is entitled to another payment for the DPI amount, being the amount that is stated in section 2, column 2 opposite the DPI —

(a) stated in section 2, column 1; and

(b) that is equal to the difference between the DPI percentages stated in the notices.

Example of DPI amount if subsection (4) applies—

A worker with a DPI of 3% is paid a DPI amount of $18,894 for a physical injury. The worker later receives a notice of assessment stating a DPI of 5% for a psychological injury. The worker is entitled to be paid an additional DPI amount of $12,596 for the difference of 2% between the DPI percentages.

4 Legal cost amount

(1) This section applies if a worker has engaged a lawyer and incurs legal costs for doing 1 or more things mentioned in column 1.

(2) The worker is entitled to the amount stated in column 2 opposite each thing for which legal costs were incurred.

Column 1 Circumstance	Column 2 Legal cost amount $
The worker giving information to an insurer under section 131	1,700
The worker and the worker's lawyer attending a meeting mentioned in section 133	2,000
The worker, under section 136, applying to the panel to review an insurer's decision	1,000
Giving information to the panel under section 136(2)(c)	1,700

Example of when a legal cost amount is included in section 193A compensation—

A worker with a DPI of 5% who has engaged a lawyer to give information to an insurer, attended a meeting with the lawyer and the insurer, and applied to have the insurer's decision reviewed successfully, is entitled to section 193A compensation totalling $36,190, being $31,490 for the DPI amount and $4,700 for the legal cost amount.

Schedule 6 Pneumoconiosis score

section 145

1 Definitions for schedule

In this schedule—

category see section 2(1)(b).

consecutive categories see section 3.

corresponding score, for a category, means the score in section 2(1), table 1, column 2 that corresponds to the category.

reading, of a chest x-ray, see section 2.

2 Meaning of *reading* of chest x-ray

(1) A ***reading***, of a chest x-ray, is a process in which a qualified reader—

(a) assesses the x-ray for the appearance of opacities; and

(b) decides, in accordance with the ILO classification guidelines, the category in table 1, column 1 (the ***category***) that applies to the appearance of opacities in the x-ray; and

(c) records the category decided under paragraph (b).

Table 1

Column 1 Category	Column 2 Score
0/-	0
0/0	0
0/1	0
1/0	15

Column 1 Category	Column 2 Score
1/1	20
1/2	25
2/1	50
2/2	55
2/3	60
3/2	75
3/3	80
3/+	85
Category A	90
Category B	95
Category C	100

(2) In this section—

opacity means—

(a) a small opacity within the meaning of the ILO classification guidelines; or

(b) a large opacity within the meaning of the ILO classification guidelines.

qualified reader means a doctor who is qualified and competent to categorise, in accordance with the ILO classification guidelines, the appearance of opacities in a chest x-ray.

Example—

a doctor approved as a B Reader by the National Institute for Occupational Safety and Health

3 Meaning of *consecutive categories*

Two categories are ***consecutive categories*** if the categories—

(a) start with the same digit, other than 0; and

(b) appear in consecutive rows in section 2(1), table 1.

Examples of categories that are consecutive categories—

- 2/1 and 2/2
- 3/3 and 3/+

Examples of categories that are not consecutive categories—

- 0/0 and 0/1
- 1/2 and 2/1
- category B and category C

4 Requirement for 2 readings

(1) A worker's pneumoconiosis score is worked out by using 2 readings of the same chest x-ray of the worker in the way provided under subsection (2) or (3).

(2) If each reading records the same category, the worker's pneumoconiosis score is the corresponding score for that category.

(3) If each reading records a different category, the worker's pneumoconiosis score is—

(a) if the 2 categories are any combination of 0/-, 0/0 or 0/1—0; or

(b) if the 2 categories are consecutive categories—the higher of the corresponding scores for the consecutive categories; or

Example for paragraph (b)—

One reading records the category as 2/2, which has a corresponding score of 55. The other reading records the category as 2/3, which has a corresponding score of 60. The worker's pneumoconiosis score is 60, being the higher of the corresponding scores for the consecutive categories.

(c) if the 2 categories are any combination of category A, category B or category C—the higher of the corresponding scores for the 2 categories.

Example for paragraph (c)—

One reading records the category as category A, which has a corresponding score of 90. The other reading records the category as category C, which has a corresponding score of 100. The worker's pneumoconiosis score is 100, being the higher of the corresponding scores for the 2 categories.

5 Requirement for third reading

(1) This section applies if the worker's pneumoconiosis score can not be worked out under section 4.

(2) The worker's pneumoconiosis score is worked out by—

(a) obtaining a third reading of the same chest x-ray; and

(b) using that reading, with the first 2 readings, in the way provided under subsection (3) or (4).

(3) If the third reading records the same category as either of the first 2 readings, the worker's pneumoconiosis score is the corresponding score for that category.

(4) If the third reading records a different category from both of the first 2 readings, the worker's pneumoconiosis score is—

(a) if 2 of the 3 categories are consecutive categories—the higher of the corresponding scores for the consecutive categories; or

Example for paragraph (a)—

The first 2 readings record the categories as 1/2 and 2/1. The third reading records the category as 2/2. Because the categories of 2/1 and 2/2 are consecutive categories, the worker's pneumoconiosis score is 55, being the higher of the corresponding scores for the consecutive categories.

(b) if 2 of the 3 categories are any combination of category A, category B or category C—the higher of the corresponding scores for the 2 categories.

Example for paragraph (b)—

The first 2 readings record the categories as 3/+ and category A. The third reading records the category as category B. The worker's pneumoconiosis score is 95, being the higher of the corresponding scores for category A and category B.

6 Requirement for fourth and fifth readings

(1) This section applies if the worker's pneumoconiosis score can not be worked out under section 4 or 5.

(2) The worker's pneumoconiosis score is worked out by—

(a) obtaining a fourth and fifth reading of the same chest x-ray; and

(b) using those readings, with the other 3 readings, in the way provided under subsection (3).

(3) The worker's pneumoconiosis score is the corresponding score for the median category of the categories recorded in each of the 5 readings.

Example—

The first 3 readings record the categories as 1/2, 2/1 and 2/3. The fourth and fifth readings record the categories as 1/2 and 2/1. The 5 categories, in ascending order, are 1/2, 1/2, 2/1, 2/1 and 2/3. The median category is 2/1, and the worker's pneumoconiosis score is 50.

Schedule 7 Lump sum compensation for workers with pneumoconiosis

section 146

1 Graduated scale

(1) This schedule contains the graduated scale for lump sum compensation for a worker to whom chapter 3, part 3, division 5 of the Act applies.

(2) The maximum amount of lump sum compensation payable under chapter 3, part 3, division 5 of the Act is 80.97 times QOTE.

2 How to use the graduated scale

(1) A pneumoconiosis band stated in column 1 comprises the pneumoconiosis scores in the corresponding entry in column 2.

(2) A worker who has a pneumoconiosis score stated in column 2 is entitled to lump sum compensation in the amount stated for the corresponding entry in column 3.

(3) However, the amount of the lump sum compensation under subsection (2) is subject to any reduction required under section 3.

Graduated scale

Column 1 Pneumoconiosis band	Column 2 Pneumoconiosis scores	Column 3 Lump sum compensation $
1	0	0

Column 1 Pneumoconiosis band	Column 2 Pneumoconiosis scores	Column 3 Lump sum compensation $
2	15	12.15 times QOTE
	20	16.20 times QOTE
	25	20.25 times QOTE
3	50	40.49 times QOTE
	55	44.53 times QOTE
	60	48.59 times QOTE
4	75	60.73 times QOTE
	80	64.78 times QOTE
5	85	68.83 times QOTE
6	90	72.87 times QOTE
7	95	76.92 times QOTE
8	100	80.97 times QOTE

3 Effect of worker's lodgement age

(1) This section applies if the worker's lodgement age is 71 years or more.

(2) For each whole year by which the worker's lodgement age is more than 70 years, the amount (the ***prescribed amount***) to which the worker would otherwise be entitled under section 2(2) must be reduced by an amount equal to 5% of the prescribed amount.

Example—

A worker with a pneumoconiosis score of 100 has a lodgement age of 72 years. The worker is entitled under section 2(2) to the amount of $149,365. However, that amount must be reduced under this subsection by $6,000 for each of the 2 years by which the worker's lodgement age is more than 70 years. The amount of the worker's entitlement under this schedule is therefore $137,365.

(3) However, the maximum reduction that may be made under subsection (2) is an amount equal to 50% of the prescribed amount.

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

section 147(1)(a)

1 Graduated scale

This schedule contains the graduated scale for the payment of caring allowance.

2 How to use the graduated scale

(1) The range of dependency assessed under the modified barthel index is stated in column 1.

(2) In column 1—

(a) minimal is a modified barthel index total score of 91–99; and

(b) mild is a modified barthel index total score of 75–90; and

(c) moderate is a modified barthel index total score of 50–74; and

(d) severe is a modified barthel index total score of 25–49; and

(e) total is a modified barthel index total score of 0–24.

(3) The maximum number of hours of care required in a week is stated in the corresponding entry in column 2.

Graduated scale

Column 1 Range of dependency (modified barthel index)	Column 2 Maximum hours of care required in a week
minimal	10

Column 1 Range of dependency (modified barthel index)	Column 2 Maximum hours of care required in a week
mild	13.0
moderate	20.0
severe	23.5
total	27.0

Schedule 9 Legal professional costs

section 194(2)

Column A Pre-proceeding notification and negotiation	Column B Compulsory conference	Column C Investigation by expert	Column D Pre-proceeding court application
$2,000	$135 for the first hour or part of an hour $105 for each additional hour or part of an hour	$270	$400

Schedule 10 First responders

section 206

1 an ambulance officer under the *Ambulance Service Act 1991* who is classified by the Queensland Ambulance Service as a paramedic of any type

2 an authorised officer under the *Child Protection Act 1999*

3 a corrective services officer under the *Corrective Services Act 2006*

4 a fire service officer under the *Fire Services Act 1990*

5 a member of the State Emergency Service under the *State Emergency Service Act 2024*

6 a member of a rural fire brigade registered under the *Fire Services Act 1990*, section 135

7 a volunteer firefighter or volunteer fire warden engaged by the authority responsible for the management of the fire services under the *Fire Services Act 1990*

8 a police officer or police recruit under the *Police Service Administration Act 1990*

9 a youth justice staff member within the meaning of the *Youth Justice Act 1992*, section 59B

10 a doctor or nurse employed in any of the following areas—

- emergency and trauma care
- acute care
- critical care
- high-dependency care

11 an occupation or profession performed in the private sector that corresponds to an occupation or profession mentioned in item 1, 3 or 4

12 an occupation or profession performed by a local government employee within the meaning of the *Local Government Act*

2009 that corresponds to an occupation or profession mentioned in item 1 or 4

13 a coal mine worker within the meaning of the *Coal Mining Safety and Health Act 1999* who is appropriately qualified to perform a rescue function at a coal mine

14 a worker within the meaning of the *Mining and Quarrying Safety and Health Act 1999* who is appropriately qualified to perform a rescue function at a mine

15 a member of Marine Rescue Queensland under the *Marine Rescue Queensland Act 2024*

Schedule 11 Eligible employees

section 207

1 the department in which the *Ambulance Service Act 1991* is administered

2 the department in which the *Child Protection Act 1999* is administered

3 the department in which the *Corrective Services Act 2006* is administered

4 the department in which the *Fire Services Act 1990* is administered

5 the department in which the *Police Service Administration Act 1990* is administered

6 the department in which the *Youth Justice Act 1992* is administered

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

sections 210(2) and 211(2)

Column 1 State	Column 2 Designated court	Column 3 the State's legislation about damages for work related injury
Australian Capital Territory	Magistrates Court	the provisions of the *Workers Compensation Act 1951* (ACT)
New South Wales	District Court of New South Wales Personal Injury Commission of New South Wales	the provisions of the *Workers Compensation Act 1987* (NSW) and the *Workplace Injury Management and Workers Compensation Act 1998* (NSW)
Northern Territory	Work Health Court	the provisions of the *Return to Work Act 1986* (NT)
South Australia	South Australian Employment Tribunal	the provisions of the *Return to Work Act 2014* (SA)
Tasmania	Tasmanian Civil and Administrative Tribunal	the provisions of the *Workers Rehabilitation and Compensation Act 1988* (Tas)
Victoria	County Court Magistrates' Court of Victoria	the provisions of the *Workplace Injury Rehabilitation and Compensation Act 2013* (Vic)
Western Australia	District Court of Western Australia	the provisions of the *Workers Compensation and Injury Management Act 2023* (WA)

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

section 188(b)

Part 1 Objectives of sch 14 (Ranges of injury scale values)

1 Objectives of sch 14

The objectives of schedule 14 include promoting—

(a) consistency of assessments of general damages awarded by courts for similar injuries; and

(b) similarity of assessments of general damages awarded by courts for different types of injury that have a similar level of adverse impact on an injured worker.

Part 2 How to use sch 14

Division 1 Injury

2 Injury mentioned in sch 14

(1) In assessing the injury scale value (***ISV***) for an injury mentioned in the injury column of schedule 14, a court must consider the range of injury scale values stated in schedule 14 for the injury.

(2) The range of ISVs for the injury reflects the level of adverse impact of the injury on the injured worker.

3 Multiple injuries

(1) Subject to section 9, in assessing the ISV for multiple injuries, a court must consider the range of ISVs for the dominant injury of the multiple injuries.

(2) To reflect the level of adverse impact of multiple injuries on an injured worker, the court may assess the ISV for the multiple injuries as being higher in the range of ISVs for the dominant injury of the multiple injuries than the ISV the court would assess for the dominant injury only.

Note—

This section acknowledges that—

- the effects of multiple injuries commonly overlap, with each injury contributing to the overall level of adverse impact on the injured worker; and
- if each of the multiple injuries were assigned an individual ISV and these ISVs were added together, the total ISV would generally be too high.

4 Multiple injuries and maximum dominant ISV inadequate

(1) This section applies if a court considers the level of adverse impact of multiple injuries on an injured worker is so severe that the maximum dominant ISV is inadequate to reflect the level of impact.

(2) To reflect the level of impact, the court may make an assessment of the ISV for the multiple injuries that is higher than the maximum dominant ISV.

(3) However, the ISV for the multiple injuries—

(a) must not be more than 100; and

Note—

Under section 306O(1)(a) of the Act, an ISV is assessed on a scale running from 0 to 100.

(b) should rarely be more than 25% higher than the maximum dominant ISV.

(4) If the increase is more than 25% of the maximum dominant ISV, the court must give detailed written reasons for the increase.

(5) In this section—

maximum dominant ISV, in relation to multiple injuries, means the maximum ISV in the range for the dominant injury of the multiple injuries.

5 Adverse psychological reaction

(1) This section applies if a court is assessing an ISV where an injured worker has an adverse psychological reaction to a physical injury.

(2) The court must treat the adverse psychological reaction merely as a feature of the injury.

6 Mental disorder

(1) This section applies if—

(a) a court is assessing an ISV; and

(b) a PIRS rating for a mental disorder of an injured worker is relevant under schedule 14.

(2) The PIRS rating for the mental disorder of the injured worker is the PIRS rating accepted by the court.

(3) A PIRS rating is capable of being accepted by the court only if it is—

(a) assessed by a medical expert as required under schedules 15 and 16; and

(b) provided to the court in a PIRS report as required under schedule 15, section 12.

7 Aggravation of pre-existing condition

(1) This section applies if an injured worker has a pre-existing condition that is aggravated by an injury for which a court is assessing an ISV.

(2) In considering the impact of the aggravation of the pre-existing condition, the court may have regard only to the

extent to which the pre-existing condition has been made worse by the injury.

Division 2 Other matters

8 Court must have regard to particular provisions of sch 14

(1) In addition to providing ranges of ISVs for particular injuries, schedule 14 sets out provisions relevant to using schedule 14 to assess an ISV for particular injuries.

Examples of relevant provisions—

- examples of the injury
- examples of factors affecting ISV assessment
- comments about appropriate level of ISV

(2) In assessing an ISV, a court must have regard to those provisions to the extent they are relevant in a particular case.

(3) The fact that schedule 14 provides examples of factors affecting an ISV assessment is not intended to discourage a court from having regard to other factors it considers are relevant in a particular case.

9 Court may have regard to other matters

In assessing an ISV, a court may have regard to other matters to the extent they are relevant in a particular case.

Examples of other matters—

- the injured worker's age, degree of insight, life expectancy, pain, suffering and loss of amenities of life
- the effects of a pre-existing condition of the injured worker
- difficulties in life likely to have emerged for the injured worker whether or not the injury happened
- in assessing an ISV for multiple injuries, the range for, and other provisions of schedule 14 in relation to, an injury other than the dominant injury of the multiple injuries

10 DPI

The extent of DPI is an important consideration, but not the only consideration, affecting the assessment of an ISV.

11 Medical report stating DPI

(1) If a medical report states a DPI, it must state how the DPI is decided, including—

(a) the clinical findings; and

(b) how the impairment is calculated; and

(c) if the DPI is based on criteria provided under AMA 5—

(i) the provisions of AMA 5 setting out the criteria; and

(ii) if a range of percentages is available under AMA 5 for an injury of the type being assessed—the reason for assessing the injury at the selected point in the range.

(2) However, the medical report must not identify—

(a) an item in schedule 14 to which the injury belongs; or

(b) an ISV for the injury.

Note—

For requirements about tendering a medical report into evidence in a proceeding for a claim for personal injury damages, see the *Uniform Civil Procedure Rules 1999*, chapter 11, part 5.

12 Greater weight to assessments based on AMA 5

(1) This section does not apply to a medical assessment of scarring or of a mental disorder.

(2) In assessing an ISV, a court must give greater weight to a medical assessment of a DPI based on the criteria for the assessment of a DPI provided under AMA 5 than to a medical assessment of a DPI not based on the criteria.

13 Greater weight to assessments of PIRS rating

In assessing an ISV, a court must give greater weight to a PIRS report provided as required under schedule 15 than to another medical assessment of the permanent impairment caused by a mental disorder.

14 ISV must be a whole number

An ISV assessed by a court must be a whole number.

Note—

Under section 306O(1)(a) of the Act, an ISV is assessed on a scale running from 0 to 100.

Schedule 14 Ranges of injury scale values

section 188(a)

Item no.	Injury	Other provisions	Range of injury scale values (ISVs)

Part 1 Central nervous system and head injuries

1 Quadriplegia

		Examples of factors affecting ISV assessment • presence and extent of pain • extent of any residual movement • degree of insight • adverse psychological reaction • level of function and pre-existing function • degree of independence • ability to participate in daily activities, including employment	75 to 100

		• presence and extent of secondary medical complications **Comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate only if the injured worker has assisted ventilation, full insight, extreme physical limitation and gross impairment of ability to communicate.	

2 Paraplegia

	Examples of factors affecting ISV assessment • presence and extent of pain • extent of any residual movement • adverse psychological reaction • level of function and pre-existing function • degree of independence • ability to participate in daily activities, including employment • loss of reproductive or sexual function • bowel or bladder incontinence • presence and extent of secondary medical complications	60 to 80

3 Hemiplegia or severe paralysis of more than 1 limb

	Comment Incomplete paralysis causing a DPI of less than 40% must be assessed under part 6 if it is the only injury or the dominant injury of multiple injuries. **Examples of factors affecting ISV assessment for item 3** The same examples apply as for item 2.	
3.1	***Complete or nearly complete paralysis***	60 to 80
3.2	***Other paralysis, causing whole person impairment of at least 40%***	45 to 60

4 Monoplegia

	Comment See items 5, 6 and 7 and part 6.	

5 Extreme brain injury

	Comment The injury will involve major trauma to the brain with severe permanent impairment.	
5.1	***Substantial insight remaining*** **Comment about appropriate level of ISV for item 5.1**	71 to 100

	• An ISV at or near the top of the range will be appropriate only if the injured worker needs full-time nursing care and has the following—
	  • substantial insight despite gross disturbance of brain function
	  • significant physical limitation and destruction of pre-existing lifestyle
	  • epileptic seizures
	  • double incontinence
	  • little or no language function
	  • little or no meaningful response to environment.
	• An injured worker with an injury for which an ISV at or near the top of the range is appropriate may have some ability to follow basic commands, recovery of eye opening, return of postural reflex movement and return to pre-existing sleep patterns.
	Examples of factors affecting ISV assessment for item 5.1
	• degree of insight
	• life expectancy
	• extent of bodily impairment	

5.2	***Substantially reduced insight*** **Comment for items 5.2.1 and 5.2.2**	

	• The injured worker will have major trauma to the brain with severe permanent impairment. • The injured worker's insight of his or her condition may change. • Insight may be impaired in the degree, or continuity of, appreciation of the injured worker's condition. **Examples of factors affecting ISV assessment for items 5.2.1 and 5.2.2** The same examples apply as for an item 5.1 injury, but reducing levels of insight progressively reduce the level of suffering and the appropriate level of ISV.	
5.2.1	***The injured worker will have partial or complete insight (as evidenced by appropriate responses to physical or emotional stimuli) for not more than half of the person's waking hours.***	36 to 70
5.2.2	***The injured worker will have infrequent periods of partial insight and will show unreliable, rare or limited responses to physical or emotional stimuli.***	16 to 35
5.3	***Grossly reduced insight*** **Comment for item 5.3** The injured worker will be in a persistent vegetative state and have little or no insight.	10 to 15

	Comment about appropriate level of ISV for item 5.3 If some minor awareness of loss remains, an ISV at or near the top of the range may be appropriate.	

6 Serious brain injury

	Comment The injured worker will be very seriously disabled. **Example of the injury** serious brain damage causing— (a) physical impairment, for example, limb paralysis; or (b) cognitive impairment with marked impairment of intellect and personality **Examples of factors affecting ISV assessment** • degree of insight • life expectancy • extent of physical limitations • extent of cognitive limitations • extent of sensory limitation, for example, limitation of hearing or sense of taste or smell • level of function and pre-existing function • degree of independence	56 to 70

	• ability to communicate • behavioural or psychological changes • epilepsy or a high risk of epilepsy • presence of and extent of secondary medical complications **Comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate only if the injured worker substantially depends on others and needs substantial professional and other care.	

7 Moderate brain injury

	Comment The injured worker will be seriously disabled, but the degree of the injured worker's dependence on others, although still present, is lower than for an item 6 injury. **Examples of factors affecting ISV assessment** • degree of insight • life expectancy • extent of physical limitations • extent of cognitive limitations	21 to 55

	• extent of sensory limitation, for example, limitation of hearing or sense of taste or smell
	• level of function and pre-existing function
	• degree of independence
	• ability to communicate
	• behavioural or psychological changes
	• epilepsy or a high risk of epilepsy
	• presence of, and extent of, secondary medical complications
	Comment about appropriate level of ISV
	• An ISV of 21 to 25 will be appropriate if there is reduced concentration and memory, or reduced mood control, and either or both—
	  • reduced capacity for employment
	  • a noticeable interference with lifestyle and leisure.
	• An ISV of 26 to 40 will be appropriate if there is an increased risk of epilepsy and either or both—
	  • a moderate cognitive impairment
	  • loss of, or greatly reduced capacity for, employment.	

	• An ISV of 41 to 55 will be appropriate if there is no capacity for employment, and 1 or more of the following— • moderate to severe cognitive impairment • marked personality change • dramatic effect on speech, sight or other senses • epilepsy or a high risk of epilepsy.	

8 Minor brain injury

	Comment The injured worker will make a good recovery and be able to take part in normal social life and to return to work. There may be minor problems persisting that prevent a restoration of normal function. **Examples of factors affecting ISV assessment** • severity of any physical injury causing the brain damage, having regard to— (a) any medical assessment made immediately after the injury was caused, for example, CT or MRI scans, an ambulance officer's assessment or hospital emergency unit assessment; and	6 to 20

	(b) any post-traumatic amnesia • extent of any ongoing, and possibly permanent, disability • extent of any personality change • depression • degree of insight • life expectancy • extent of physical limitations • extent of cognitive limitations • extent of sensory limitation, for example, limitation of hearing or sense of taste or smell • level of function and pre-existing function • degree of independence • ability to communicate • behavioural or psychological changes • epilepsy or a high risk of epilepsy • presence of, and extent of, secondary medical complications **Comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if the injured worker has—	

	• an increased risk of epilepsy; and • ongoing reduced concentration and memory, or reduced mood control, that does not significantly interfere with the person's ability to take part in normal social life or return to work.	

9 Minor head injury, other than an injury mentioned in pt 3

	Comment Brain damage, if any, is minimal. **Examples of the injury** • uncomplicated skull fracture • concussion with transitory loss of consciousness and no residual effect **Examples of factors affecting ISV assessment** • severity of any physical injury causing brain damage • length of time to recover from any symptoms • extent of ongoing symptoms • presence of, or absence of, headaches **Comment about appropriate level of ISV**	0 to 5

	• An ISV at or near the bottom of the range will be appropriate for an injury from which the injured worker fully recovers within a few weeks. • An ISV at or near the top of the range will be appropriate if there is an uncomplicated skull fracture and there are associated concussive symptoms of dizziness, headache and memory loss persisting for less than 6 months.	

Part 2 Mental disorders

	General comment for items 10 to 13 This part includes references to ratings on the psychiatric impairment rating scale stated in schedule 16 (***PIRS ratings***). Under schedule 13, section 6 of this regulation, a PIRS rating is capable of being accepted by a court only if it is assessed by a medical expert as required under schedules 15 and 16 and provided to the court in a PIRS report. **Examples of factors affecting ISV assessment for items 10 to 13** • PIRS rating • degree of insight	

	• age and life expectancy • pain and suffering • loss of amenities of life • likelihood difficulties would have emerged in any event • if there is extreme psychological trauma, for example, intense helplessness or horror, the immediate adverse psychological reaction	

10 Extreme mental disorder

	Example of the injury a mental disorder with a PIRS rating between 31% and 100% **Comment about appropriate level of ISV** Despite a very high PIRS rating, an ISV at or near the bottom of the range may be appropriate if the injured worker has reduced insight.	41 to 65

11 Serious mental disorder

	Example of the injury a mental disorder with a PIRS rating between 11% and 30%	11 to 40

12 Moderate mental disorder

	Comment	2 to 10

	There is generally only moderate impairment. **Example of the injury** a mental disorder with a PIRS rating between 4% and 10%	

13 Minor mental disorder

	Comment For many persons who have suffered the injury there will be little or no impact on their lives. **Example of the injury** a mental disorder with a PIRS rating between 0% and 3%	0 to 1

Part 3 Facial injuries

Division 1 Skeletal injuries of the facial area

	Examples of factors affecting ISV assessment for items 14 to 22 • extent of skeletal or functional damage • degree of cosmetic damage or disfigurement • adverse psychological reaction • availability of cosmetic repair	

14 Extreme facial injury

	Comment The injury will involve severe traumatic injury to the face requiring substantial reconstructive surgery. **Examples of the injury** • a Le Fort I fracture or Le Fort II fracture if the degree of incapacity and disfigurement after reconstructive surgery will be very severe • a Le Fort III fracture causing incapacity in daily activities *Note—* Le Fort I fracture, Le Fort II fracture and Le Fort III fracture are defined in schedule 18. **Additional example of factor affecting ISV assessment** the extent of any neurological impairment or effect on the airway	26 to 45

15 Serious facial injury

	Comment The injury will involve serious traumatic injury to the face requiring reconstructive surgery that is not substantial. **Examples of the injury**	14 to 25

	• a Le Fort I fracture or Le Fort II fracture if the degree of incapacity and disfigurement after reconstructive surgery will not be very severe • a Le Fort III fracture if no serious deformity will remain after reconstructive surgery • a serious or multiple fracture of the nasal complex either or both— (a) requiring more than 1 operation; and (b) causing 1 or more of the following— • permanent damage to the airway • permanent damage to nerves or tear ducts • facial deformity • a serious cheekbone fracture that will require surgery and cause serious disfigurement and permanent effects despite reconstructive surgery, for example, hyperaesthesia or paraesthesia • a very serious multiple jaw fracture that will— (a) require prolonged treatment; and	

	(b) despite reconstructive surgery, cause permanent effects, for example, severe pain, restriction in eating, paraesthesia or a risk of arthritis in the joints • a severed trunk of the facial nerve (7th cranial nerve), causing total paralysis of facial muscles on 1 side of the face **Additional examples of factors affecting ISV assessment** • any neurological impairment or effect on the airway • permanent cosmetic deformity **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if the injury causes permanent cosmetic deformity, asymmetry of 1 side of the face and limited adverse psychological reaction. • An ISV at or near the top of the range will be appropriate if the injury causes serious bilateral deformity and significant adverse psychological reaction.	

16 Moderate facial injury

	Examples of the injury	6 to 13

	• a simple cheekbone fracture, requiring minor reconstructive surgery, from which the injured worker will fully recover with little or no cosmetic damage • a fracture of the jaw causing— (a) permanent effects, for example, difficulty in opening the mouth or in eating; or (b) hyperaesthesia or paraesthesia in the area of the fracture • a displaced fracture of the nasal complex from which the injured worker will almost fully recover after surgery • severed branches of the facial nerve (7th cranial nerve) with paralysis of some of the facial muscles • a severed sensory nerve of the face with minor permanent paraesthesia	

17 Minor facial injury

	Examples of the injury • a simple cheekbone fracture, for which surgery is not required and from which the injured worker will fully recover	0 to 5

	• a simple jaw fracture, requiring immobilisation and from which the injured worker will fully recover • a stable fracture of the joint process of the jaw • a displaced fracture of the nasal complex requiring only manipulation • a simple undisplaced fracture of the nasal complex, from which the injured worker will fully recover • a severed sensory nerve of the face, with good repair causing minimal or no paraesthesia	

18 Injury to teeth or gums

	Comment There will generally have been a course of treatment as a result of the injury. **Additional examples of factors affecting ISV assessment** • extent and degree of discomfort during treatment • difficulty with eating **Comment about appropriate level of ISV** If protracted dentistry causes the injury, the ISV may be higher than the ISV for the same injury caused by something else.	

18.1	***Loss of or serious damage to more than 3 teeth, serious gum injury or serious gum infection***	6 to 10
18.2	***Loss of or serious damage to 2 or 3 teeth, moderate gum injury or moderate gum infection***	3 to 5
18.3	***Loss of or serious damage to 1 tooth, minor gum injury or minor gum infection***	0 to 2

Division 2 Scarring to the face

	General comment for items 19 to 22 This division will usually apply to an injury involving skeletal damage only if the skeletal damage is minor.	

19 Extreme facial scarring

	Examples of the injury • widespread area scarring, for example, over the side of the face or another whole area • severe contour deformity • significant deformity of the mouth or eyelids with muscle paralysis or tic **Comment about appropriate level of ISV**	21 to 45

	• An ISV in the upper half of the range may be appropriate if the injured worker is relatively young, the cosmetic damage is very disfiguring and the adverse psychological reaction is severe. • An ISV at or near the top of the range will be appropriate if the injury is caused by burns that resulted in loss of the entire nose, eyelids or ears.	

20 Serious facial scarring

	Examples of the injury • substantial disfigurement and significant adverse psychological reaction • severe linear scarring • discoloured hypertrophic (keloid) scarring • atrophic scarring • serious contour defects	11 to 20

21 Moderate facial scarring

	Comment Any adverse psychological reaction is small, or having been considerable at the outset, has greatly diminished. **Examples of the injury**	6 to 10

	• scarring, the worst effects of which will be reduced by plastic surgery that will leave minor cosmetic damage • scars crossing lines of election with discoloured, indurated, hypertrophic or atrophic scarring, of moderate severity	

22 Minor facial scarring

	Examples of the injury • a single scar able to be camouflaged • more than 1 very small scar if the overall effect of the scars is to mar, but not to markedly affect, appearance and adverse psychological reaction is minor • almost invisible linear scarring, in lines of election, with normal texture and elevation	0 to 5

Part 4 Injuries affecting the senses

Division 1 General comment

	General comment for items 23 to 35 Injuries mentioned in this part are commonly symptoms of brain or nervous system injury.	

Division 2 Injuries affecting the eyes

23 Total sight and hearing impairment

	Comment The injury ranks with the most devastating injuries. **Examples of factors affecting ISV assessment** • degree of insight • age and life expectancy	90 to 100

24 Total sight impairment

	Examples of factors affecting ISV assessment • degree of insight • age and life expectancy	50 to 80

25 Complete sight impairment in 1 eye with reduced vision in the other eye

	Comment about appropriate level of ISV An ISV at or near the top of the range will be appropriate if there is serious risk of further significant deterioration in the remaining eye.	25 to 50

26 Complete sight impairment in 1 eye or total loss of 1 eye

	Examples of factors affecting ISV assessment • the extent to which the injured worker's activities are adversely affected by the impairment or loss • associated scarring or cosmetic damage **Comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there is a minor risk of sympathetic ophthalmia.	26 to 30

27 Serious eye injury

	Examples of the injury • a serious but incomplete loss of vision in 1 eye without significant risk of loss or reduction of vision in the other eye • an injury causing double vision that is not minor and intermittent	11 to 25

28 Moderate eye injury

	Example of the injury	6 to 10

	minor but permanent impairment of vision in 1 eye, including if there is double vision that is minor and intermittent	

29 Minor eye injury

	Example of the injury a minor injury, for example, from being struck in the eye, exposed to smoke or other fumes or being splashed by liquids— (a) causing initial pain and temporary interference with vision; and (b) from which the injured worker will fully recover within a relatively short time	0 to 5

Division 3 Injuries affecting the ears

	Comment for items 30 to 33 The injuries commonly, but not always, involve hearing loss. If the injury is to a single ear, the binaural loss must be assessed. **Examples of factors affecting ISV assessment for item 30 to 33 injuries**	

	• whether the injury has an immediate effect, allowing the injured worker no opportunity to adapt, or whether it occurred over a period of time, for example, from exposure to noise • whether the injury was suffered at an early age so that it has affected or will affect speech • whether the injury will affect balance • the extent to which former activities will be affected • presence of tinnitus	

30 Extreme ear injury

	Definition of injury The injury involves a binaural hearing loss of at least 80%. **Additional examples of factors affecting ISV assessment** • associated problems, for example, severe tinnitus, moderate vertigo, a moderate vestibular disturbance or headaches • availability of hearing aids or other devices that may reduce the hearing loss **Comment about appropriate level of ISV**	36 to 55

	An ISV at or near the top of the range will be appropriate if the injury happened at an early age so as to prevent or to seriously affect the development of normal speech.	

31 Serious ear injury

	Definition of injury The injury involves— (a) a binaural hearing loss of at least 50% but less than 80%; or (b) severe permanent vestibular disturbance. **Comment about appropriate level of ISV** • An ISV in the lower half of the range will be appropriate if there is no speech impairment or tinnitus. • An ISV in the upper half of the range will be appropriate if there is speech impairment and tinnitus.	26 to 35

32 Moderate ear injury

	Definition of injury The injury involves— (a) a binaural hearing loss of at least 20% but less than 50%; or (b) significant permanent vestibular disturbance.	11 to 25

	Comment about appropriate level of ISV An ISV at or near the top of the range will be appropriate if there are problems associated with the injury, for example, severe tinnitus, moderate vertigo, a moderate vestibular disturbance or headaches.	

33 Minor ear injury

	Definition of injury The injury involves a binaural hearing loss of less than 20%. **Comment** • This item covers the bulk of hearing impairment cases. • The injury is not to be judged simply by the degree of hearing loss. • There will often be a degree of tinnitus present. • There may also be minor vertigo or a minor vestibular disturbance causing loss of balance. • A vestibular disturbance may increase the level of ISV.	
33.1	***Moderate tinnitus or hearing loss, or both***	6 to 10
33.2	***Mild tinnitus with some hearing loss***	4 to 5

33.3	***Slight or occasional tinnitus with slight hearing loss or an occasional vestibular disturbance, or both***	0 to 3

Division 4 Impairment of taste or smell

34 Total loss of taste or smell, or both

	Comment about appropriate level of ISV • An ISV at or near the bottom of the range will be appropriate if there will be a total loss of either taste or smell. • An ISV at or near the top of the range will be appropriate if there will be a total loss of both taste and smell.	6 to 9

35 Partial loss of taste or smell, or both

	Comment about appropriate level of ISV • An ISV at or near the bottom of the range will be appropriate if there will be a partial loss of either taste or smell. • An ISV at or near the top of the range will be appropriate if there will be a partial loss of both taste and smell.	0 to 5

Part 5 Injuries to internal organs

Division 1 Chest injuries

	Example of factor affecting ISV assessment for items 36 to 39 the level of any reduction in the capacity for employment and enjoyment of life	

36 Extreme chest injury

	Comment The injury will involve severe traumatic injury to the chest, or a large majority of the organs in the chest cavity, causing a high level of disability and ongoing medical problems. **Comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there will be total removal of 1 lung or serious heart damage, or both, with serious and prolonged pain and suffering and significant permanent scarring.	46 to 65

37 Serious chest injury

	Comment	21 to 45

	The injury will involve serious traumatic injury to the chest or organs in the chest cavity, causing serious disability and ongoing medical problems.
	
	Examples of the injury
	
	• a trauma to 1 or more of the following, causing permanent damage, physical disability and impairment of function—
	  • the chest
	  • the heart
	  • 1 or both of the lungs
	  • the diaphragm
	• an injury that causes the need for oxygen therapy for about 16 to 18 hours a day
	
	Example of factors affecting ISV assessment
	
	the need for a permanent tracheostomy
	
	Comment about appropriate level of ISV
	
	An ISV at or near the top of the range will be appropriate if, after recovery, there are both of the following—
	
	(a) serious impairment to cardio-pulmonary function;
	
	(b) a DPI for the injury of, or of nearly, 40%.	

38 Moderate chest injury

	Example of the injury the injury will involve serious traumatic injury to the chest or organs in the chest cavity, causing moderate disability and ongoing medical problems **Examples of factors affecting ISV assessment** • duration and intensity of pain and suffering • the DPI of lung or cardiac function, as evidenced by objective test results • the need for a temporary tracheostomy for short-term airway management **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there will be the loss of a breast without significant adverse psychological reaction. • An ISV in the lower half of the range will be appropriate if there was a pneumothorax, or haemothorax, requiring intercostal catheter insertion. • An ISV at or near the top of the range will be appropriate if there are multiple rib fractures causing—	11 to 20

	(a) a flail segment (flail chest) requiring mechanical ventilation in the acute stage; and (b) moderate permanent impairment of cardio-pulmonary function.	

39 Minor chest injury

	Examples of factors affecting ISV assessment for items 39.1 and 39.2 • complexity of any fractures • extent of injury to underlying organs • extent of any disability • duration and intensity of pain and suffering	
39.1	***Complicated or significant fracture, or internal organ injury, that substantially resolves*** **Comment** The injury will involve significant or complicated fractures, or internal injuries, that cause some tissue damage but no significant long-term effect on organ function. **Examples of the injury** • multiple fractures of the ribs or sternum, or both, that may cause cardio-pulmonary contusion	5 to 10

	• internal injuries that cause some tissue damage but no significant long-term effect on organ function **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is a fractured sternum that substantially resolves, and there is some ongoing pain and activity restriction. • An ISV at or near the top of the range will be appropriate if the injury causes significant persisting pain and significant activity restriction.	
39.2	***Soft tissue injury, minor fracture or minor internal organ injury*** **Comment** • The injury will involve a soft tissue injury, minor fracture, or minor and non-permanent injury to internal organs. • There may be persistent pain from the chest, for example, from the chest wall or sternocostal or costochondral joints. **Examples of the injury** • a single penetrating wound, causing some tissue damage but no long-term effect on lung function	0 to 4

	• an injury to the lungs caused by the inhalation of toxic fumes or smoke that will not permanently interfere with lung function • a soft tissue injury to the chest wall, for example, a laceration or serious seatbelt bruising • fractured ribs or a minor fracture of the sternum causing serious pain and disability for weeks, without internal organ damage or permanent disability **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is a soft tissue injury from which the injured worker will fully recover. • An ISV at or near the top of the range will be appropriate if there is an injury causing a small pneumothorax that does not require intercostal catheter insertion, and from which the injured worker will fully recover.	

Division 2 Lung injuries other than asthma

	General comment for items 40 to 43	

	The level of an ISV for lung disease often reflects the fact that the disease is worsening and there is a risk of the development of secondary medical consequences. **Examples of factors affecting ISV assessment for items 40 to 43** • a history of smoking tobacco will reduce the level of ISV • adverse psychological reaction may increase the level of ISV	

40 Extreme lung injury

	Examples of the injury • diagnosed lung cancer • lung disease involving serious disability causing severe pain and dramatic impairment of function and quality of life • a recurrent pulmonary embolism resulting in failure of the right side of the heart requiring a lung transplant, heart transplant or both **Additional examples of factors affecting ISV assessment** • age • likelihood of progressive worsening • duration and intensity of pain and suffering	46 to 65

41 Serious lung injury

41.1	***Serious lung injury if progressive worsening of lung function*** **Example of item 41.1** lung disease, for example, emphysema, causing— • significantly reduced and worsening lung function • prolonged and frequent coughing • disturbance of sleep • restriction of physical activity, employment and enjoyment of life **Additional examples of factors affecting ISV assessment for item 41.1** • the possibility of lung cancer developing may increase the level of ISV • the need for continuous oxygen therapy	25 to 45
41.2	***Serious lung injury if no progressive worsening of lung function*** **Examples of item 41.2** • lung disease causing breathing difficulties, short of disabling breathlessness, requiring frequent use of an inhaler	11 to 24

	• lung disease causing a significant effect on employment and social life, including inability to tolerate a smoky environment, with an uncertain prognosis • a recurrent pulmonary embolism causing pulmonary hypertension and cor pulmonale	

42 Moderate lung injury

	Examples of the injury • bronchitis that does not cause serious symptoms, with little or no serious or permanent effect on employment or social life • a pulmonary embolism requiring anticoagulant therapy for at least 1 year or pulmonary endarterectomy	6 to 10

43 Minor lung injury

	Examples of the injury • lung disease causing slight breathlessness, with— (a) no effect on employment; and (b) the likelihood of substantial and permanent recovery within a few years after the injury is caused	0 to 5

	• a pulmonary embolism requiring anticoagulant therapy for less than 1 year **Comment about appropriate level of ISV** An ISV at or near the bottom of the range will be appropriate if there is lung disease causing temporary aggravation of bronchitis, or other chest problems, that will resolve within a few months.	

Division 3 Asthma

44 Extreme asthma

	Comment The most serious cases may confine a person to the home and destroy capacity for employment. **Example of the injury** severe and permanent disabling asthma causing— • prolonged and frequent coughing • disturbance of sleep • severe restriction of physical activity and enjoyment of life • gross reduction of capacity for employment	31 to 55

45 Severe asthma

	Example of the injury chronic asthma, with a poor prognosis, causing— • breathing difficulties • the need to frequently use an inhaler • significantly reduced capacity for employment	11 to 30

46 Moderate asthma

	Example of the injury asthma, with symptoms that include bronchitis and wheezing, affecting employment or social life	6 to 10

47 Minor asthma

	Example of the injury asthma with minor symptoms that has no effect on employment or social life **Comment about appropriate level of ISV** An ISV at or near the bottom of the range will be appropriate if there is asthma treated by a general practitioner that will resolve within 1 year after the injury is caused.	0 to 5

Division 4 Injuries to male reproductive system

	General comment for items 48 to 51 • This division applies to injuries caused by physical trauma rather than as a secondary result of a mental disorder. • For a mental disorder that causes loss of reproductive system function, see part 2 (Mental disorders). • Sterility is usually either— (a) caused by surgery, chemicals or disease; or (b) caused by a traumatic injury that is often aggravated by scarring. **Examples of factors affecting ISV assessment for items 48 to 51** • adverse psychological reaction • effect on social and domestic life	

48 Impotence and sterility

	Additional examples of factors affecting ISV assessment • age	5 to 37

	• whether the injured worker has children • whether the injured worker intended to have children or more children **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if the sterility has little impact. • An ISV in the lower half of the range will be appropriate if an injured worker with children may have intended to have more children and has uncomplicated sterility, without impotence or any aggravating features. • An ISV in the upper half of the range will be appropriate if a young injured worker without children has uncomplicated sterility, without impotence or any aggravating features. • An ISV at or near the middle of the range will be appropriate if a middle-aged injured worker with children has sterility and permanent impotence. • An ISV at or near the top of the range will be appropriate if a young injured worker has total impotence and loss of sexual function and sterility.	

49 Loss of part or all of penis

	Additional examples of factors affecting ISV assessment • extent of the penis remaining • availability of a prosthesis • extent to which sexual activity will be possible	5 to 25

50 Loss of both testicles

	Comment See item 48 because sterility results. **Additional example of factor affecting ISV assessment** level of any pain or residual scarring	

51 Loss of 1 testicle

	Additional examples of factors affecting ISV assessment age, cosmetic damage or scarring **Comment about appropriate level of ISV** An ISV at or near the bottom of the range will be appropriate if the injury does not reduce reproductive capacity.	2 to 10

Division 5 Injuries to female reproductive system

	General comment for items 52 and 53 • This division applies to injuries caused by physical trauma rather than as a secondary result of a mental disorder. • For a mental disorder that causes loss of reproductive system function, see part 2 (Mental disorders). **Examples of factors affecting ISV assessment for items 52 and 53** • extent of any physical trauma • whether the injured worker has children • whether the injured worker intended to have children or more children • age • scarring • depression or adverse psychological reaction • effect on social and domestic life	

52 Infertility

52.1	***Infertility causing severe effects***	16 to 35

	Example of item 52.1 infertility with severe depression, anxiety and pain	
52.2	***Infertility causing moderate effects*** **Example of item 52.2** infertility without any medical complication if the injured worker has a child or children **Comment about appropriate level of ISV for item 52.2** An ISV at or near the top of the range will be appropriate if there is significant adverse psychological reaction.	9 to 15
52.3	***Infertility causing minor effects*** **Example of item 52.3** infertility if— (a) the injured worker was unlikely to have had children, for example, because of age; and (b) there is little or no adverse psychological reaction	0 to 8

53 Any other injury to the female reproductive system

53.1	***Post-menopausal hysterectomy***	5 to 15
53.2	***Female impotence*** **Comment for item 53.2** The injury may be correctable by surgery.	5 to 15

	Additional examples of factors affecting ISV assessment for item 53.2 the level of sexual function or the extent of any corrective surgery	
53.3	***An injury causing an inability to give birth by normal vaginal delivery, for example, because of pelvic ring disruption or deformity*** **Comment for item 53.3** The injury may be correctable by surgery.	4 to 15
53.4	***Injury to female genitalia or reproductive organs, or both*** **Comment about appropriate level of ISV for item 53.4** • An ISV at or near the bottom of the range will be appropriate if there is a laceration or tear with good repair. • An ISV at or near the middle of the range will be appropriate if the injury causes development of a prolapse or fistula. • An ISV at or near the top of the range will be appropriate if the injury causes the early onset of menopause or irregular hormonal activity.	3 to 25
53.5	***Reduced fertility, caused by, for example, trauma to ovaries or fallopian tubes*** **Comment about appropriate level of ISV for item 53.5**	3 to 8

	An ISV in the lower half of the range will be appropriate if the injury is caused by a delay in diagnosis of an ectopic pregnancy.	

Division 6 Injuries to digestive system

Subdivision 1 Injuries caused by trauma

54 Extreme injury to the digestive system caused by trauma

	Examples of the injury • severe permanent damage to the digestive system, with ongoing debilitating pain and discomfort, diarrhoea, nausea and vomiting that— (a) are not controllable by drugs; and (b) cause weight loss of at least 20% *Note—* ***Digestive system*** is defined in schedule 18. • an injury to the throat requiring a permanent gastrostomy **Comment about appropriate level of ISV**	19 to 40

	• An ISV at or near the bottom of the range will be appropriate if there is an injury to the throat requiring a temporary gastrostomy for more than 1 year and permanent dietary changes, for example, a requirement for a soft food diet. • An ISV at or near the top of the range will be appropriate if there is an injury to the throat requiring a permanent gastrostomy, with significant ongoing symptoms. **Examples of factors affecting ISV assessment** • the extent of any voice or speech impairment • need for ongoing endoscopic procedures	

55 Serious injury to the digestive system caused by trauma

	Examples of the injury • a serious injury causing long-term complications aggravated by physical strain • an injury requiring a feeding tube for between 3 and 12 months **Examples of factors affecting ISV assessment** • the extent of any ongoing voice or speech impairment	11 to 18

	• whether a feeding tube was required, and if so, for how long it was required	

56 Moderate injury to the digestive system caused by trauma

	Examples of the injury • a simple penetrating stab wound, causing some permanent tissue damage, but with no significant long-term effect on digestive function • an injury requiring a feeding tube for less than 3 months **Examples of factors affecting ISV assessment** • whether a feeding tube was required, and if so, for how long it was required • whether dietary changes are required to reduce the risk of aspiration because of impaired swallowing	6 to 10

57 Minor injury to the digestive system caused by trauma

	Examples of the injury • a soft tissue injury to the abdomen wall, for example, a laceration or serious seatbelt bruising to the abdomen or flank, or both	0 to 5

	• a minor injury to the throat or tongue causing temporary difficulties with swallowing or speech • a laceration of the tongue requiring suturing	

Subdivision 2 Injuries not caused by trauma

	General comment for items 58 to 61 There is a marked difference between those comparatively rare cases having a long-term or even permanent effect on quality of life and cases in which the only ongoing symptom is an allergy, for example, to specific foods, that may cause short-term illness.	

58 Extreme injury to the digestive system not caused by trauma

	Example of the injury severe toxicosis— (a) causing serious acute pain, vomiting, diarrhoea and fever, requiring hospitalisation for days or weeks; and (b) also causing 1 or more of the following— • ongoing incontinence	13 to 35

	• haemorrhoids • irritable bowel syndrome; and (c) having a significant impact on the capacity for employment and enjoyment of life **Comment about appropriate level of ISV** An ISV in the lower half of the range will be appropriate if the injury causes a chronic infection, that requires prolonged hospitalisation, that will not resolve after antibiotic treatment for 1 year.	

59 Serious injury to the digestive system not caused by trauma

	Examples of the injury • serious but short-term food poisoning causing diarrhoea and vomiting— (a) diminishing over 2 to 4 weeks; and (b) with some remaining discomfort and disturbance of bowel function and impact on sex life and enjoyment of food, over a few years • constant abdominal pain, causing significant discomfort, for up to 18 months caused by a delay in diagnosis of an injury to the digestive system	6 to 12

	Comment about appropriate level of ISV • An ISV at or near the top of the range will be appropriate if there is an adverse response to the administration of a drug that— (a) requires admission to an intensive care unit; and (b) does not cause any permanent impairment; and (c) causes the need for ongoing drug therapy for life. • An ISV in the upper half of the range will be appropriate if a chronic infection— (a) requires prolonged hospitalisation and additional treatment; and (b) will be resolved by antibiotic treatment within 1 year. • An ISV at or near the bottom of the range will be appropriate if there is an adverse response to the administration of a drug that— (a) requires admission to an intensive care unit; and (b) does not cause any permanent impairment; and	

	(c) does not cause the need for ongoing drug therapy for life.	

60 Moderate injury to the digestive system not caused by trauma

	Examples of the injury • food poisoning— (a) causing significant discomfort, stomach cramps, change of bowel function and fatigue; and (b) requiring hospitalisation for days; and (c) with symptoms lasting a few weeks; and (d) from which the injured worker will fully recover within 1 or 2 years • an infection that is resolved by antibiotic treatment, with or without additional treatment in hospital, within 3 months after the injury is caused • an adverse response to the administration of a drug, causing any of the following continuing over a period of more than 7 days, and requiring hospitalisation— (a) vomiting; (b) shortness of breath; (c) hypertension;	3 to 5

	(d) skin irritation	

61 Minor injury to the digestive system not caused by trauma

	Examples of the injury • disabling pain, cramps and diarrhoea, ongoing for days or weeks • a localised infection, requiring antibiotic treatment, that heals within 6 weeks after the start of treatment • an adverse response to the administration of a drug, causing any of the following continuing over a period of not more than 7 days, and not requiring hospitalisation— (a) vomiting; (b) shortness of breath; (c) hypertension; (d) skin irritation • intermittent abdominal pain for up to 6 months caused by a delay in diagnosis of an injury to the digestive system	0 to 2

Division 7 Kidney or ureter injuries

	General comment for items 62 to 65 An injury to a ureter or the ureters alone, without loss of, or serious damage to, a kidney will generally be assessed under item 64 or 65. **Examples of factors affecting ISV assessment for items 62 to 65** • age • risk of ongoing kidney or ureter problems, complications or symptoms • need for future medical procedures	

62 Extreme injury to kidneys or ureters

62.1	***Loss of both kidneys causing loss of renal function and requiring permanent dialysis or transplant***	56 to 75
62.2	***Serious damage to both kidneys, requiring temporary or intermittent dialysis*** **Examples of factors affecting ISV assessment** • the effect of dialysis and loss of kidney function on activities of daily living	31 to 55

	• the length of time for which dialysis was required or the frequency of intermittent dialysis • ongoing requirement for medication, for example, to control blood pressure • whether the injury caused the need for dietary changes, and if so, for how long **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if dialysis was required for an initial 3-month period, with intermittent dialysis required after that. • An ISV at or near the top of the range will be appropriate if the injury required dialysis for about 1 year and ongoing dietary changes and medication.	

63 Serious injury to kidneys or ureters

	Comment The injury may require temporary dialysis for less than 3 months. **Example of the injury** loss of 1 kidney if there is severe damage to, and a risk of loss of function of, the other kidney	19 to 30

	Comment about appropriate level of ISV The higher the risk of loss of function of the other kidney, the higher the ISV.	

64 Moderate injury to kidneys or ureters

	Examples of the injury • loss of 1 kidney, with no damage to the other kidney • an injury to a ureter or the ureters that requires surgery or placement of stents	11 to 18

65 Minor injury to kidneys or ureters

	Example of the injury a laceration or contusion to 1 or both of the kidneys **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is an injury to a kidney causing a contusion. • An ISV at or near the top of the range will be appropriate if a partial removal of a kidney is required.	0 to 10

Division 8 Liver, gall bladder or biliary tract injuries

	Examples of factors affecting ISV assessment for items 66 to 69 • whether there are recurrent episodes of infection or obstruction • whether there is a risk of developing biliary cirrhosis	

66 Extreme injury to liver, gall bladder or biliary tract

	Example of the injury loss, or injury causing effective loss, of liver function, requiring constant substitutional therapy **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there are recurrent episodes of liver failure that require hospital admission and medical management but do not require liver transplantation. • An ISV at or near the top of the range will be appropriate if the injury requires liver transplantation.	51 to 70

67 Serious injury to liver, gall bladder or biliary tract

	Example of the injury serious damage causing loss of over 30% of the tissue of the liver, but with some functional capacity of the liver remaining	36 to 50

68 Moderate injury to liver, gall bladder or biliary tract

	Example of the injury a laceration or contusion to the liver, with a moderate effect on liver function **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if the injury causes impaired liver function with symptoms of intermittent nausea and vomiting. • An ISV at or near the bottom of the range will also be appropriate if there is a gall bladder injury with recurrent infection or symptomatic stone disease, the symptoms of which may include, for example, pain or jaundice. • An ISV at or near the middle of the range will be appropriate if the injury involves removal of the gall bladder causing a bile duct injury.	16 to 35

	• An ISV at or near the top of the range will be appropriate if— (a) surgery is required to remove not more than 30% of the liver; or (b) bile ducts require repair, for example, placement of stents. • An ISV at or near the top of the range will also be appropriate if there is an injury to the gall bladder, that despite biliary surgery, causes ongoing symptoms, infection or the need for further endoscopic surgery.	

69 Minor injury to liver, gall bladder or biliary tract

	Comment An injury within this item should not require surgery to the liver. **Example of the injury** a laceration or contusion to the liver, with a minor effect on liver function **Comment about appropriate level of ISV** An ISV in the lower half of the range will be appropriate if there is an uncomplicated removal of the gall bladder with no ongoing symptoms.	3 to 15

Division 9 Bowel injuries

	Examples of factors affecting ISV assessment for items 70 to 73 • age • risk of ongoing bowel problems, complications or symptoms • need for future surgery • the degree to which dietary changes are required to manage chronic pain or diarrhoea caused by the injury	

70 Extreme bowel injury

	Example of the injury an injury causing a total loss of natural bowel function and dependence on colostomy	41 to 60

71 Serious bowel injury

	Example of the injury a serious abdominal injury causing either or both of the following— (a) impairment of bowel function (which often requires permanent or long-term colostomy, leaving disfiguring scars);	19 to 40

	(b) restrictions on employment and diet	

72 Moderate bowel injury

	Comment about appropriate level of ISV • An ISV at or near the bottom of the range will be appropriate if— (a) the injury requires an ileostomy or colostomy for less than 3 months; and (b) bowel function returns to normal; and (c) there are no ongoing symptoms. • An ISV at or near the top of the range will be appropriate if— (a) the injury requires temporary surgical diversion of the bowel, for example, an ileostomy or colostomy; and (b) there is ongoing intermittent abnormal bowel function requiring medication.	7 to 18

73 Minor bowel injury

	Example of the injury	3 to 6

	an injury causing tears to the bowel, with minimal ongoing bowel problems	

Division 10 Bladder, prostate or urethra injuries

	Examples of factors affecting ISV assessment for items 74 to 77 • age • risk of ongoing bladder, prostate or urethra problems, complications or symptoms • need for future surgery	

74 Extreme bladder, prostate or urethra injury

	Example of the injury an injury causing a complete loss of bladder function and control, with permanent dependence on urostomy	40 to 60

75 Serious bladder, prostate or urethra injury

	Example of the injury an injury causing serious impairment of bladder control, with some incontinence **Comment about appropriate level of ISV**	19 to 39

	An ISV in the upper half of the range will be appropriate if there is serious ongoing pain.	

76 Moderate bladder, prostate or urethra injury

	Example of the injury an injury causing continued impairment of bladder control, with minimal incontinence and minimal pain **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is a laceration of the urethra, that required surgical repair and caused intermittent infection or bladder dysfunction. • An ISV at or near the top of the range will be appropriate if there is— (a) increased urinary frequency of more than once every 2 hours throughout the day and more than 3 times at night that is unresponsive to treatment; or (b) an ongoing requirement for minor surgery, for example, cystoscopy or urethral dilation.	7 to 18

77 Minor bladder, prostate or urethra injury

	Example of the injury a bladder injury, from which the injured worker will fully recover, with some relatively long-term interference with natural bladder function	3 to 6

Division 11 Pancreas and spleen injuries

78 Injury to the pancreas

	Comment about appropriate level of ISV • An ISV at or near the bottom of the range will be appropriate if there is a contusion to the pancreas that heals. • An ISV at or near the middle of the range will be appropriate if there are chronic symptoms, for example, pain or diarrhoea. • An ISV at or near the top of the range will be appropriate if— (a) there are chronic symptoms with significant weight loss of between 10% and 20% of body weight, and pancreatic enzyme replacement is required; or (b) an injury to the pancreas causes diabetes.	10 to 35

	Examples of factors affecting ISV assessment • the extent of any ongoing risk of internal infection and disorders, for example, diabetes • the need for, and outcome of, further surgery, for example, surgery to manage pain caused by stone disease, infection or an expanding pseudocyst	

79 Loss of spleen (complicated)

	Example of the injury loss of spleen if there will be a risk, that is not minor, of ongoing internal infection and disorders caused by the loss **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if the injury leads to a splenectomy, with intermittent symptoms of pain, nausea and vomiting that settle. • An ISV at or near the middle of the range will be appropriate if— (a) the injury leads to a splenectomy, with serious infection after the splenectomy; and	8 to 20

	(b) the infection requires surgical or radiological intervention. • An ISV at or near the top of the range will be appropriate if the injury leads to a splenectomy, with portal vein thrombosis after the splenectomy.	

80 Injury to the spleen or uncomplicated loss of spleen

	Example of the injury laceration or contusion to the spleen that— (a) has been radiologically confirmed; and (b) has no ongoing bleeding; and (c) is managed conservatively; and (d) resolves fully **Comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there has been removal of the spleen (splenectomy), with little or no risk of ongoing infections and disorders caused by the loss of the spleen.	0 to 7

Division 12 Hernia injuries

81 Severe hernia

	Example of the injury	11 to 20

	a hernia if after repair there is either or both— (a) ongoing pain; or (b) a restriction on physical activities, sport or employment	

82 Moderate hernia

	Example of the injury a hernia that after repair has some real risk of recurring in the short-term	6 to 10

83 Minor hernia

	Example of the injury an uncomplicated inguinal hernia, whether or not repaired	0 to 5

Part 6 Orthopaedic injuries

Division 1 Cervical spine injuries

	General comment for items 84 to 88 • This division does not apply to the following injuries (that are dealt with in items 1 to 3)— • quadriplegia	

	• paraplegia • hemiplegia or severe paralysis of more than 1 limb. • Cervical spine injuries, other than those dealt with in items 1 to 3, range from cases of very severe disability to cases of a minor strain, with no time off work and symptoms only suffered for 2 or 3 weeks. • Symptoms associated with nerve root compression or damage can not be taken into account in assessing an ISV under item 84, 85 or 86 unless objective signs are present of nerve root compression or damage, for example— • CT or MRI scans or other radiological evidence • muscle wasting • clinical findings of deep tendon reflex loss, motor weakness and loss of sensation.	

84 Extreme cervical spine injury

	Comment • These are extremely severe injuries that cause gross limitation of movement and serious interference with performance of daily activities.	41 to 75

	• The injury will involve significant upper or lower extremity impairment and may require the use of an adaptive device or prosthesis. **Examples of the injury** • a total neurological loss at a single level • severe multilevel neurological dysfunction • structural compromise of the spinal canal with extreme upper or lower extremity motor and sensory impairments • fractures involving more than 50% compression of a vertebral body with neural compromise **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is a DPI of about 29%. • An ISV at or near the top of the range will be appropriate if there is a cervical spine injury causing monoplegia of the dominant upper limb and a DPI of at least 60%.	

85 Serious cervical spine injury

	Comment	16 to 40

	• The injury will cause serious upper extremity impairment or serious permanent impairment of the cervical spine. • The injury may involve— (a) a change of motion segment integrity; or (b) bilateral or multilevel nerve root compression or damage. **Examples of the injury** • loss of motion in a motion segment because of a surgical or post-traumatic fusion • a fracture involving more than 25% compression of 1 vertebral body • an injury showing objective signs of nerve root damage after surgery **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if— (a) the injured worker has had surgery and symptoms persist; or (b) there is a fracture involving 25% compression of 1 vertebral body.	

	• An ISV in the middle of the range will be appropriate if there is a fracture involving about 50% compression of a vertebral body, with ongoing pain. • An ISV at or near the top of the range will be appropriate if— (a) the injured worker has had a fusion of vertebral bodies that has failed, leaving objective signs of significant residual nerve root damage and ongoing pain, affecting 1 side of the body; and (b) there is a DPI of about 28%.	

86 Moderate cervical spine injury—fracture, disc prolapse or nerve root compression or damage

	Comment about appropriate level of ISV • An ISV at or near the top of the range will be appropriate if— (a) there is a disc prolapse for which there is radiological evidence at an anatomically correct level; and	5 to 15

	(b) there are symptoms of pain and 3 or more of the following objective signs that are anatomically localised to an appropriate spinal nerve root distribution— (i) sensory loss; (ii) loss of muscle strength; (iii) loss of reflexes; (iv) unilateral atrophy; and (c) the impairment has not improved after non-operative treatment. • An ISV of about 10 will be appropriate if there is a fracture of a vertebral body with up to 25% compression, and ongoing pain. • An ISV at or near the bottom of the range will be appropriate for an uncomplicated fracture of a posterior element of 1 or more of the vertebral segments, for example, spinous or transverse processes, without neurological impairment.	

87 Moderate cervical spine injury—soft tissue injury

	Comment	5 to 10

	The injury will cause moderate permanent impairment, for which there is objective evidence, of the cervical spine. **Comment about appropriate level of ISV** An ISV of not more than 10 will be appropriate if there is a DPI of 8% caused by a soft tissue injury for which there is no radiological evidence.	

88 Minor cervical spine injury

	Comment • Injuries within this item include a whiplash injury with no ongoing symptoms, other than symptoms that are merely a nuisance, remaining more than 18 months after the injury is caused. • There will be no objective signs of neurological impairment. **Example of the injury** a soft tissue or whiplash injury if symptoms are minor and the injured worker recovers, or is expected to recover, from the injury to a level where the injury is merely a nuisance within 18 months after the injury is caused **Comment about appropriate level of ISV**	0 to 4

	• An ISV at or near the bottom of the range will be appropriate if the injury will resolve without any ongoing symptoms within months after the injury is caused. • An ISV at or near the top of the range will be appropriate if the injury, despite improvement, causes headaches and some ongoing pain.	

Division 2 Thoracic or lumbar spine injuries

	General comment for items 89 to 93
	• This division does not apply to the following injuries (that are dealt with in items 1 to 3)—
	  • quadriplegia
	  • paraplegia
	  • hemiplegia or severe paralysis of more than 1 limb.
	• Thoracic or lumbar spine injuries, other than those dealt with in items 1 to 3, range from cases of very severe disability to cases of a minor strain, with no time off work and symptoms suffered only for 2 or 3 weeks.	

	• Symptoms associated with nerve root compression or damage can not be taken into account in assessing an ISV under item 89, 90 or 91 unless objective signs are present of nerve root compression or damage, for example— • CT or MRI scans or other radiological evidence • muscle wasting • clinical findings of deep tendon reflex loss, motor weakness and loss of sensation.	

89 Extreme thoracic or lumbar spine injury

	Comment These are extremely severe injuries causing gross limitation of movement and serious interference with performance of daily activities. There may be some motor or sensory loss, and some impairment of bladder, ano-rectal or sexual function. **Example of the injury** a fracture involving compression of a thoracic or lumbar vertebral body of more than 50%, with neurological impairment **Comment about appropriate level of ISV**	36 to 60

	• An ISV at or near the bottom of the range will be appropriate if there is a DPI for the injury of 25%. • An ISV at or near the top of the range will be appropriate if there is a DPI for the injury of at least 45%.	

90 Serious thoracic or lumbar spine injury

	Comment • The injury will cause serious permanent impairment in the thoracic or lumbar spine. • The injury may involve— (a) bilateral or multilevel nerve root damage; or (b) a change in motion segment integrity, for example, because of surgery. **Example of the injury** a fracture involving at least 25% compression of 1 thoracic or lumbar vertebral body **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if— (a) the injured worker has had surgery and symptoms persist; or	16 to 35

	(b) there is a fracture involving 25% compression of 1 vertebral body. • An ISV in the middle of the range will be appropriate if there is a fracture involving 50% compression of a vertebral body, with ongoing pain. • An ISV at or near the top of the range will be appropriate if the injured worker has had a fusion of vertebral bodies that has failed— (a) leaving objective signs of significant residual nerve root damage and ongoing pain, affecting 1 side of the body; and (b) causing a DPI of 24%.	

91 Moderate thoracic or lumbar spine injury—fracture, disc prolapse or nerve root compression or damage

	Comment about appropriate level of ISV • An ISV at or near the top of the range will be appropriate if— (a) there is a disc prolapse for which there is radiological evidence at an anatomically correct level; and	5 to 15

	(b) there are symptoms of pain and 3 or more of the following objective signs, that are anatomically localised to an appropriate spinal nerve root distribution— (i) sensory loss; (ii) loss of muscle strength; (iii) loss of reflexes; (iv) unilateral atrophy; and (c) the impairment has not improved after non-operative treatment. • An ISV of about 10 will be appropriate if there is a fracture of a vertebral body with up to 25% compression, and ongoing pain. • An ISV at or near the bottom of the range will be appropriate for an uncomplicated fracture of a posterior element of 1 or more of the vertebral segments, for example, spinous or transverse processes, without neurological impairment.	

92 Moderate thoracic or lumbar spine injury—soft tissue injury

	Comment	5 to 10

	The injury will cause moderate permanent impairment, for which there is objective evidence, of the thoracic or lumbar spine. **Comment about appropriate level of ISV** An ISV of not more than 10 will be appropriate if there is a DPI of 8% caused by a soft tissue injury for which there is no radiological evidence.	

93 Minor thoracic or lumbar spine injury

	Example of the injury a soft tissue injury of the thoracic or lumbar spine with no— • significant clinical findings • fractures • documented neurological impairment • significant loss of motion segment integrity • other objective signs of impairment relating to the injury **Comment about appropriate level of ISV**	0 to 4

	• An ISV at or near the top of the range will be appropriate, whether or not the injured worker continues to suffer some ongoing pain, if the injury will substantially reach maximum medical improvement, with only minor symptoms, within about 18 months after the injury is caused. • An ISV at or near the bottom of the range will be appropriate if the injury will resolve without any ongoing symptoms within months after the injury is caused.	

Division 3 Shoulder injuries

	General comment for items 94 to 97 • Injuries under items 94 to 97 include subluxations or dislocations of the sternoclavicular joint, acromioclavicular joint or glenohumeral joint. • Soft tissue injuries may involve the musculoligamentous supporting structures of the joints. • Fractures may involve the clavicle, the scapula (shoulder blade) and the humerus.	

	Comment about appropriate level of ISV for items 94 to 97 An ISV at or near the top of the range will generally only be appropriate if the injury is to the shoulder of the dominant upper limb.	

94 Extreme shoulder injury

	Comment These are the most severe traumatic injuries causing gross permanent impairment. **Examples of the injury** • a severe fracture or dislocation, with secondary medical complications • joint disruption with poor outcome after surgery • degloving • permanent nerve palsies **Additional comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there is a DPI of 45% and complete loss of all shoulder function of the dominant upper limb.	31 to 50

95 Serious shoulder injury

	Comment	16 to 30

	The injury will involve serious trauma to the shoulder causing serious permanent impairment. **Examples of the injury** • a crush injury • a serious fracture with secondary arthritis • nerve palsies from which the injured worker will partially recover • established non-union of a clavicular or scapular fracture despite open reduction and internal fixation (ORIF) • established non-union of a clavicular or scapular fracture if surgery is not appropriate or not possible, and there is significant functional impairment **Additional comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there is a DPI for the injury of 25% and the injury is to the dominant upper limb.	

96 Moderate shoulder injury

	Examples of the injury • traumatic adhesive capsulitis with discomfort, limitation of movement and symptoms persisting or expected to persist for about 2 years	6 to 15

	• permanent and significant soft tissue disruption, for example, from tendon tears or ligament tears • a fracture, from which the injured worker has made a reasonable recovery, requiring open reduction and internal fixation • nerve palsies from which the injured worker has made a good recovery • painful persisting dislocation of the acromioclavicular joint • an injury to the sternoclavicular joint causing permanent, painful instability **Additional comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is a DPI for the injury of 6%. • An ISV at or near the top of the range will be appropriate if there is a DPI for the injury of 12% and the injury is to the dominant upper limb.	

97 Minor shoulder injury

	Examples of the injury	0 to 5

	• soft tissue injury with considerable pain from which the injured worker makes an almost full recovery in less than 18 months • fracture from which the injured worker has made an uncomplicated recovery • strain injury of the acromioclavicular joint or sternoclavicular joint	

Division 4 Amputation of upper limbs

	Comment about appropriate level of ISV for items 98 to 99.3 An ISV at or near the top of the range will generally only be appropriate if the amputation is of the dominant upper limb.	

98 Loss of both upper limbs, or loss of 1 arm and extreme injury to the other arm

	Comment The effect of the injury is to reduce the injured worker to a state of considerable helplessness. **Examples of factors affecting ISV assessment**	55 to 85

	• whether the amputations are above or below the elbow (the loss of the elbow joint adds greatly to the disability) • the length of any stump suitable for use with a prosthesis • severity of any phantom pains **Additional comment about appropriate level of ISV** • An ISV of 70 to 85 will be appropriate if— (a) both upper limbs are amputated at the shoulder; or (b) 1 arm is amputated at the shoulder, and there is a loss of function in the other arm, causing a DPI of 60%. • An ISV of 65 to 80 will be appropriate if— (a) both upper limbs are amputated through the elbow or above the elbow but below the shoulder; or (b) 1 arm is amputated through the elbow or above the elbow but below the shoulder, and there is a loss of function in the other arm, causing a DPI of 57%. • An ISV of 55 to 75 will be appropriate if—	

	(a) both upper limbs are amputated below the elbow; or (b) 1 arm is amputated below the elbow, and there is a loss of function in the other arm, causing a DPI of 54%.	

99 Loss of 1 upper limb

	Examples of factors affecting ISV assessment • whether the amputation is above or below the elbow (the loss of the elbow joint adds greatly to the disability) • whether the amputation was of the dominant arm • the length of any stump suitable for use with a prosthesis • severity of any phantom pains • extent of any disability in the other arm	
99.1	***An upper limb amputation at the shoulder***	50 to 65
99.2	***An upper limb amputation through the elbow or above the elbow but below the shoulder*** **Additional comment about appropriate level of ISV for item 99.2**	40 to 65

	• An ISV at or near the bottom of the range will generally be appropriate if there is an amputation through the elbow. • An ISV at or near the top of the range will be appropriate if there is a short stump because a short stump may create difficulties in the use of a prosthesis.	
99.3	***An upper limb amputation below the elbow*** **Additional comment about appropriate level of ISV for item 99.3** An ISV at or near the top of the range will be appropriate if there is an amputation through the forearm with residual severe pain in the stump and phantom pains.	35 to 60

Division 5 Elbow injuries

	Comment about appropriate level of ISV for items 100 to 103 An ISV at or near the top of the range will generally only be appropriate if the injury is to the elbow of the dominant upper limb.	

100 Extreme elbow injury

	Comment The injury will involve an extremely severe elbow injury, falling short of amputation, leaving little effective use of the elbow joint. **Examples of the injury** • a DPI for the injury of between 24% and 42% • a complex elbow fracture, or dislocation, with secondary complications • joint disruption, with poor outcome after surgery • degloving • permanent nerve palsies • an injury causing severe limitation of elbow movement with the joint constrained in a non-functional position	26 to 50

101 Serious elbow injury

	Comment The injury will involve significant disability and require major surgery. **Examples of the injury** • a serious fracture with secondary arthritis • a crush injury	13 to 25

	• nerve palsies from which the injured worker will partially recover • permanent, poor restriction of range of motion with the elbow constrained in a satisfactory functional position **Additional comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there is a DPI for the injury of 23% and the injury is to the elbow of the dominant upper limb.	

102 Moderate elbow injury

	Comment The injury will cause moderate long-term disability but does not require protracted surgery. **Examples of the injury** • soft tissue disruption, for example, a ligament or tendon tear • a fracture, from which the injured worker has made a reasonable recovery, requiring open reduction and internal fixation • nerve palsies from which the injured worker has made a good recovery	6 to 12

	Additional comment about appropriate level of ISV • An ISV at or near the bottom of the range will be appropriate if there is a DPI for the injury of 5%. • An ISV at or near the top of the range will be appropriate if there is a moderately severe injury to the elbow of the dominant upper limb— (a) requiring prolonged treatment; and (b) causing a DPI of 10%.	

103 Minor elbow injury

	Comment The injury will cause no permanent damage and no permanent impairment of function. **Examples of the injury** • a fracture with an uncomplicated recovery • a soft tissue injury with pain, minor tennis elbow syndrome or laceration	0 to 5

Division 6 Wrist injuries

	Comment about appropriate level of ISV for items 104 to 107 An ISV at or near the top of the range will generally only be appropriate if the injury is to the wrist of the dominant upper limb.	

104 Extreme wrist injury

	Comment The injury will involve severe fractures, or a dislocation, causing a high level of permanent impairment. **Examples of the injury** • a severe fracture or dislocation with secondary joint complications • joint disruption with poor outcome after surgery • degloving • permanent nerve palsies **Additional comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there is a DPI for the injury of 36% and the injury is to the wrist of the dominant upper limb.	25 to 40

105 Serious wrist injury

	Examples of the injury • an injury causing significant permanent loss of wrist function, for example, severe problems with gripping or pushing objects, but with some useful movement remaining • non-union of a carpal fracture • severe carpal instability **Additional comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there is a DPI for the injury of 20% and the injury is to the wrist of the dominant upper limb.	16 to 24

106 Moderate wrist injury

	Examples of the injury • a wrist injury that is not serious and causes some permanent disability, for example, some persisting pain and stiffness • persisting radio-ulnar instability • recurrent tendon subluxation or entrapment **Additional comment about appropriate level of ISV**	6 to 15

	• An ISV at or near the bottom of the range will be appropriate if there is a DPI for the injury of 6%. • An ISV at or near the top of the range will be appropriate if there is a DPI for the injury of 12%.	

107 Minor wrist injury

	Examples of the injury • a fracture from which the injured worker almost fully recovers • a soft tissue injury, for example, severe bruising • continued pain following carpal tunnel release	0 to 5

Division 7 Hand injuries

	General comment for items 108 to 119 Hands are cosmetically and functionally the most important part of the upper limbs. **Comment about appropriate level of ISV for items 108 to 119**	

	• The appropriate ISV for loss of a hand is only a little less than the appropriate ISV for the loss of the relevant arm. • An ISV at or near the top of the range will generally be appropriate if the injury is to the dominant hand.	

108 Total or effective loss of both hands

	Example of the injury a serious injury causing extensive damage to both hands making them little more than useless **Examples of factors affecting ISV assessment** • the level of residual capacity left in either hand • severity of any phantom pains if there has been an amputation or amputations **Additional comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if both hands remain attached to the forearms and are of some cosmetic importance. • An ISV at or near the top of the range will be appropriate if both hands are amputated through the wrist.	51 to 75

109 Serious injury to both hands

	Comment The injury will involve significant loss of function in both hands, for example, loss of 50% or more of the use of each hand.	40 to 50

110 Total or effective loss of 1 hand

	Examples of the injury • a crushed hand that has been surgically amputated • traumatic amputation of all fingers and most of the palm **Example of factor affecting ISV assessment** severity of any phantom pain if there has been an amputation **Additional comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there has been an amputation of the fingers at the metacarpophalangeal joints, but the thumb remains, and there is a DPI for the injury of 32%. • An ISV at or near the top of the range will be appropriate if— (a) there has been amputation of the dominant hand at the wrist; and	35 to 60

	(b) there is residual severe pain in the stump and ongoing complications, for example, chronic regional pain syndrome or neuroma formation.	

111 Amputation of the thumb or part of the thumb

	Examples of factors affecting ISV assessment • the level of amputation, for example, at carpo metacarpal (CMC) joint, through the distal third of the thumb metacarpal, at the metacarpophalangeal (MCP) joint or thumb interphalangeal (IP) joint • whether the injury is to the dominant hand • the extent of any damage to the fingers **Additional comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if— (a) there has been an amputation through the interphalangeal joint of the thumb; and (b) there is a DPI for the injury of 11%.	15 to 28

	• An ISV at or near the middle of the range will be appropriate if there has been an amputation through the proximal phalanx. • An ISV at or near the top of the range will be appropriate if— (a) there has been an amputation at the base of the thumb at the carpometacarpal (CMC) joint level of the dominant hand; and (b) there are ongoing debilitating complications.	

112 Amputation of index, middle and ring fingers, or any 2 of them

	Comment The amputation will cause complete loss or nearly complete loss of 2 or all of the following fingers of the hand— • index finger • middle finger • ring finger. **Example of factor affecting ISV assessment** the level of the amputation, for example, whether the hand has been made to be of very little use and any remaining grip is very weak **Additional comment about appropriate level of ISV**	15 to 30

	• An ISV at or near the bottom of the range will be appropriate if 2 fingers, whether index, middle or ring fingers, are amputated at the level of the proximal interphalangeal joints. • An ISV at or near the middle of the range will be appropriate if there is a DPI for the injury of 19%. • An ISV at or near the top of the range will be appropriate if— (a) the index, middle and ring fingers are amputated at the level of the metacarpophalangeal joint (MCP joint) or there is a DPI for the injury of at least 27%; and (b) the injury is to the dominant hand.	

113 Amputation of individual fingers

	Examples of factors affecting ISV assessment • whether the amputation was of the index or middle finger • the level of the amputation • any damage to other fingers short of amputation **Additional comment about appropriate level of ISV**	5 to 20

	• An ISV at or near the bottom of the range will be appropriate if— (a) there has been an amputation at the level of the distal interphalangeal joint of the little or ring finger; or (b) there is a DPI for the injury of 3%. • An ISV of not more than 11 will be appropriate if— (a) there has been an amputation of the index or middle finger at the proximal interphalangeal joint (PIP joint); or (b) there is a DPI for the injury of 8%. • An ISV at or near the top of the range will be appropriate if there is complete loss of the index or middle finger of the dominant hand, and serious impairment of the remaining fingers causing a DPI of at least 15%.	

114 Amputation of thumb and all fingers

	Comment As the injury will cause effective loss of the hand, see item 110.	

115 Any other injury to 1 or more of the fingers or the thumb

	Comment about appropriate level of ISV for items 115.1 to 115.4 An ISV of not more than 5 will be appropriate if substantial function of the hand remains. **Examples of factors affecting ISV** • whether the injury is to the thumb, or index or middle finger • any damage to other fingers • whether the injury is to the dominant hand	
115.1	***Extreme injury to 1 or more of the fingers or the thumb*** **Example of the injury** total loss of function of 1 or more of the fingers, with the joints ankylosed in non-functional positions **Additional comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is a DPI for the injury of 14%. • An ISV at or near the top of the range will be appropriate if there is an injury to the thumb of the dominant hand causing total loss of function of the thumb.	16 to 25
115.2	***Serious injury to 1 or more of the fingers or the thumb***	11 to 15

	Examples of the injury • a severe crush injury causing ankylosis of the fingers • a bursting wound, or an injury causing severe finger damage, causing residual scarring and dysfunction • an injury leaving a digit that interferes with the remaining function of the hand • division of 1 or more of the long flexor tendons of the finger, with unsuccessful repair	
115.3	***Moderate injury to 1 or more of the fingers or the thumb*** **Comment** There will be permanent discomfort, pain or sensitive scarring. **Examples of the injury** • moderate injury to the thumb or index finger causing loss of movement or dexterity • a crush injury causing multiple fractures of 2 or more fingers • division of 1 or more of the long flexor tendons of the finger, with moderately successful repair **Additional comment about appropriate level of ISV**	6 to 10

	An ISV at or near the top of the range will be appropriate if there is a DPI for the injury of 8% and the injury is to the dominant hand.	
115.4	***Minor injury to 1 or more of the fingers or the thumb*** **Example of the injury** an uncomplicated fracture or soft tissue injury that has healed with minimal residual symptoms **Additional comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is a straightforward fracture of 1 or more of the fingers, with complete resolution within a short time. • An ISV at or near the top of the range will be appropriate if there has been— (a) a fracture causing minor angular or rotational malunion of the thumb, or index or middle finger, of the dominant hand; or (b) some adherence of a tendon following surgical repair, limiting full function of the digit.	0 to 5

116 Extreme hand injury

	Comment	31 to 45

	• The injury will involve a severe traumatic injury to the hand, that may include amputation of part of the hand, causing gross impairment of the hand. • A hand injury causing a DPI for the injury of 35% will generally fall within this item. **Examples of the injury** • an injury reducing a hand's capacity to 50% or less • an injury involving the amputation of several fingers that are rejoined to the hand leaving it clawed, clumsy and unsightly • an amputation of some fingers and part of the palm causing grossly reduced grip and dexterity and gross disfigurement **Additional comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if the injured hand has some residual usefulness for performing activities of daily living. • An ISV at or near the top of the range will be appropriate if the injured hand— (a) has little or no residual usefulness for performing activities of daily living; and	

	(b) is the dominant hand.	

117 Serious hand injury

	Examples of the injury • a severe crush injury causing significantly impaired function despite surgery • serious permanent tendon damage **Additional comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there is a DPI for the injury of 20%.	16 to 30

118 Moderate hand injury

	Examples of the injury • a crush injury, penetrating wound or deep laceration, requiring surgery • moderately serious tendon damage • a hand injury causing a DPI for the injury of between 5% and 12%	6 to 15

119 Minor hand injury

	Examples of the injury	0 to 5

	a soft tissue injury, or an injury that does not require surgery, with nearly full recovery of hand function	

Division 8 Upper limb injuries, other than injuries mentioned in divs 3 to 7

	Comment about appropriate level of ISV for items 120 to 123 An ISV at or near the top of the range will generally only be appropriate if the injury is to the dominant upper limb.	

120 Extreme upper limb injury, other than an injury mentioned in divs 3 to 7

	Comment The injury will involve an extremely serious upper limb injury, falling short of amputation, leaving the injured worker little better off than if the whole arm had been lost. **Examples of the injury** • a serious brachial plexus injury affecting peripheral nerve function • a non-union of a fracture, with peripheral nerve damage to the extent that an arm is nearly useless	36 to 65

	Additional comment about appropriate level of ISV • An ISV at or near the bottom of the range will be appropriate if there is a DPI for the injury of 31%. • An ISV at or near the top of the range will be appropriate if— (a) there is a complete brachial plexus lesion shown by a flail arm and paralysis of all muscles of the hand; and (b) the injury is to the dominant limb. • An ISV at or near the top of the range will also be appropriate if there is a serious crush injury that causes a DPI for the injury of 55%.	

121 Serious upper limb injury, other than an injury mentioned in divs 3 to 7

	Examples of the injury • a serious fracture of the humerus, radius or ulna, or any combination of the humerus, radius and ulna, if there is significant permanent residual impairment of function • a brachial plexus injury requiring nerve grafts with partial recovery of shoulder and elbow function and normal hand function	21 to 35

	Additional comment about appropriate level of ISV • An ISV at or near the bottom of the range will be appropriate if there is a DPI for the injury of 16%. • An ISV at or near the top of the range will be appropriate if there is an injury to the dominant limb causing a DPI of 30%.	

122 Moderate upper limb injury, other than an injury mentioned in divs 3 to 7

	Examples of the injury • a fracture that causes impairment of associated soft tissues, including nerves and blood vessels • a fracture with delayed union or infection • multiple fractures of the humerus, radius or ulna, or multiple fractures of any combination of the humerus, radius and ulna **Additional comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is a DPI for the injury of 6%.	6 to 20

	• An ISV in the lower half of the range will be appropriate if there is a complicated fracture of the humerus, radius or ulna, or any combination of the humerus, radius and ulna— (a) requiring open reduction and internal fixation; and (b) from which the injured worker has recovered or is expected to recover. • An ISV at or near the top of the range will be appropriate if there is a crush injury causing significant skin or muscle loss with permanent residual impairment. • An ISV at or near the top of the range will also be appropriate if there is a DPI for the injury of 15%.	

123 Minor upper limb injury, other than an injury mentioned in divs 3 to 7

	Example of the injury an uncomplicated fracture of the humerus, radius or ulna, or any combination of the humerus, radius and ulna, from which the injured worker has fully recovered within a short time **Additional comment about appropriate level of ISV**	0 to 5

	• An ISV at or near the bottom of the range will be appropriate if there are soft tissue injuries, lacerations, abrasions and contusions, from which the injured worker will fully or almost fully recover. • An ISV at or near the top of the range will be appropriate if there is a brachial plexus injury from which the injured worker has substantially recovered within a few weeks, leaving some minor functional impairment.	

Division 9 Pelvis or hip injuries

	General comment for items 124 to 127 • The most serious injuries to the pelvis or hips can be as devastating as a leg amputation and will have similar ISVs. • However, the appropriate ISV for other injuries to the pelvis or hips will generally be no higher than about 20. **Examples of factors affecting ISV assessment for items 124 to 127** • exceptionally severe specific sequelae will increase the level of ISV	

	• the availability of remedies, for example, a total hip replacement is an important factor in assessing an ISV • age	

124 Extreme pelvis or hip injury

	Examples of the injury • an extensive pelvis fracture • degloving • permanent nerve palsies **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is a DPI for the injury of 40%. • An ISV at or near the top of the range will be appropriate if the injured worker is not able to mobilise without a wheelchair and is relatively young.	46 to 65

125 Serious pelvis or hip injury

	Comment There will be substantial residual disability, for example, severe lack of bladder and bowel control, sexual dysfunction, or deformity making the use of 2 canes or crutches routine.	26 to 45

	Examples of the injury • a fracture dislocation of the pelvis involving both ischial and pubic rami • traumatic myositis ossificans with formation of ectopic bone around the hip • a fracture of the acetabulum leading to degenerative changes and leg instability requiring an osteotomy, with the likelihood of future hip replacement surgery **Comment about appropriate level of ISV** An ISV at or near the bottom of the range will be appropriate for an injury causing a DPI for the injury of 20%.	

126 Moderate pelvis or hip injury

	Examples of the injury • a significant pelvis or hip injury, with no major permanent disability • a hip fracture requiring a hip replacement • a fracture of the sacrum extending into the sacro-iliac joint causing ongoing significant symptoms and a DPI of at least 10% **Comment about appropriate level of ISV**	11 to 25

	• An ISV at or near the bottom of the range will be appropriate if there is a DPI for the injury of 10%. • An ISV at or near the top of the range will be appropriate if there is a fracture requiring a hip replacement that is only partially successful, so that there is a clear risk of the need for revision surgery.	

127 Minor pelvis or hip injury

	Examples of the injury • an uncomplicated fracture of 1 or more of the bones of the pelvis or hip that does not require surgery or cause permanent impairment • undisplaced coccygeal fractures • undisplaced or healed pubic rami fractures • an injury to the coccyx for which surgery is required and is successfully performed **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is a soft tissue injury from which the injured worker fully recovers.	0 to 10

	• An ISV at or near the middle of the range will be appropriate if there is a DPI for the injury of 5%. • An ISV at or near the top of the range will be appropriate if the person has ongoing coccydynia and difficulties with sitting.	

Division 10 Amputation of lower limbs

Subdivision 1 Amputation of both lower limbs

	Examples of factors affecting ISV assessment for items 128 and 129 • the level of each amputation • severity of any phantom pain • pain in the stumps • extent of any ongoing symptoms	

128 Loss of both lower limbs above or through the knee

	Comment about appropriate level of ISV An ISV at or near the top of the range will be appropriate if each amputation is near the hips so neither stump can be used with a prosthesis.	55 to 70

129 Below the knee amputation of both lower limbs

	Comment about appropriate level of ISV • An ISV at or near the bottom of the range will be appropriate if there is a DPI for the injury of 48%. • An ISV at or near the top of the range will be appropriate if— (a) both legs are amputated just below the knees leaving little or no stumps for use with prostheses; and (b) there is poor quality skin cover; and (c) there is a chronic regional pain syndrome.	50 to 65

Subdivision 2 Amputation of 1 lower limb

	Examples of factors affecting ISV assessment for items 130 and 131 • the level of the amputation • severity of any phantom pain • whether there have been problems with a prosthesis, for example, pain and further damage to the stump	

130 Above or through the knee amputation of 1 lower limb

	Comment about appropriate level of ISV • An ISV at or near the bottom of the range will be appropriate if the amputation is through or just above the knee. • An ISV at or near the top of the range will be appropriate if the amputation is near the hip and a prosthesis can not be used.	35 to 50

131 Below the knee amputation of 1 lower limb

	Comment about appropriate level of ISV • An ISV at or near the bottom of the range will be appropriate in a straightforward case of a below-knee amputation with no complications. • An ISV at or near the top of the range will be appropriate if there is an amputation close to the knee joint, leaving little or no stump for use with a prosthesis.	31 to 45

Division 11 Lower limb injuries, other than injuries mentioned in division 9 or 10 or divs 12 to 15

132 Extreme lower limb injury, other than an injury mentioned in division 9 or 10 or divs 12 to 15

	Comment These are the most severe injuries short of amputation, leaving the injured worker little better off than if the whole leg had been lost. **Examples of the injury** • extensive degloving of the lower limb • an injury causing gross shortening of the lower limb • a fracture that has not united despite extensive bone grafting • serious neurovascular injury • a lower limb injury causing a DPI of 40%	31 to 55

133 Serious lower limb injury, other than an injury mentioned in division 9 or 10 or divs 12 to 15

	Comment • Removal of extensive muscle tissue and extensive scarring may have a significant enough impact to fall within this item.	21 to 30

	• An injury to multiple joints or ligaments causing instability, prolonged treatment and a long period of non-weight-bearing may have a significant enough impact to fall within this item, but generally only if those results are combined. **Example of the injury** multiple complex fractures of the lower limb that are expected to take years to heal and cause serious deformity and serious limitation of mobility **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is a DPI for the injury of 16%. • An ISV at or near the top of the range will be appropriate if there is a DPI for the injury of 25%.	

134 Moderate lower limb injury, other than an injury mentioned in division 9 or 10 or divs 12 to 15

	Examples of the injury • a fracture causing impairment of associated soft tissues, including nerves and blood vessels • a fracture with delayed union or infection	11 to 20

	• multiple fractures of the femur, tibia or fibula, or multiple fractures of any combination of the femur, tibia and fibula **Examples of factors affecting ISV assessment** • period of non-weight-bearing • presence or risk of degenerative change • imperfect union of a fracture • muscle wasting • limited joint movement • unsightly scarring • permanently increased vulnerability to future damage **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is a DPI for the injury of 10%. • An ISV at or near the middle of the range will be appropriate if there is a deep vein thrombosis requiring treatment for life. • An ISV at or near the top of the range will be appropriate if there is a DPI for the injury of 15%.	

135 Minor lower limb injury, other than an injury mentioned in division 9 or 10 or divs 12 to 15

	Example of the injury an uncomplicated fracture of the femur, tibia or fibula, from which the injured worker has fully recovered **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is a deep vein thrombosis requiring treatment for less than 6 months, from which the injured worker will fully recover. • An ISV at or near the bottom of the range will also be appropriate if— (a) there are soft tissue injuries, lacerations, cuts, bruising or contusions, from which the injured worker will fully or almost fully recover; and (b) any residual disability will be minor. • An ISV at or near the top of the range will be appropriate if there is a deep vein thrombosis requiring treatment for at least 1 year.	0 to 10

	• An ISV at or near the top of the range will also be appropriate if the injured worker is left with impaired mobility or a defective gait. • An ISV at or near the top of the range will also be appropriate if there is a DPI for the injury of 9%.	

Division 12 Knee injuries

	General comment for items 136 to 139 The availability of remedies, for example, a total knee replacement, is an important factor in assessing an ISV under this division.	

136 Extreme knee injury

	Example of the injury a severe knee injury if there is a disruption of the joint, gross ligamentous damage, loss of function after unsuccessful surgery, lengthy treatment and considerable pain **Comment about appropriate level of ISV**	25 to 40

	• An ISV at or near the bottom of the range will be appropriate if there is a DPI for the injury of 20%. • An ISV at or near the top of the range will be appropriate if a total knee replacement was needed and— (a) it is very likely that the knee replacement will need to be repeated; or (b) there are ongoing severe symptoms, poor function and a DPI for the injury of more than 30%.	

137 Serious knee injury

	Comment The injury may involve— (a) ongoing pain, discomfort, limitation of movement, instability or deformity; and (b) a risk, in the long-term, of degenerative changes caused by damage to the joint surfaces, muscular wasting or ligamentous or meniscal injury. **Example of the injury** a leg fracture extending into the knee joint, causing pain that is constant, permanent and limits movement or impairs agility **Comment about appropriate level of ISV**	11 to 24

	An ISV at or near the middle of the range will be appropriate if there is a ligamentous injury, that required surgery and prolonged rehabilitation, causing a DPI of 15% and functional limitation.	

138 Moderate knee injury

	Examples of the injury a dislocation or torn cartilage or meniscus causing ongoing minor instability, wasting and weakness **Comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there is a DPI for the injury of 8%.	6 to 10

139 Minor knee injury

	Examples of the injury • a partial cartilage, meniscal or ligamentous tear • a laceration • a twisting or bruising injury	0 to 5

Division 13 Ankle injuries

	Comment about appropriate level of ISV for items 140 to 143 The appropriate ISV for the vast majority of ankle injuries is 1 or 2.	

140 Extreme ankle injury

	Examples of the injury • a transmalleolar fracture of the ankle with extensive soft tissue damage causing 1 or more of the following— (a) severe deformity with varus or valgus malalignment; (b) a risk that any future injury to the relevant leg may lead to a below-knee amputation of the leg; (c) marked reduction in walking ability with constant dependence on walking aids; (d) inability to place the relevant foot for even load-bearing distribution • an ankylosed ankle in a severely misaligned position with severe ongoing pain and other debilitating complications	21 to 35

	• a DPI for the injury of more than 20% **Examples of factors affecting ISV assessment** • a failed arthrodesis • regular disturbance of sleep • need for an orthosis for load bearing and walking	

141 Serious ankle injury

	Example of the injury an injury requiring a long period of treatment, a long time in plaster or insertion of pins and plates, if— (a) there is permanent significant ankle instability; or (b) the ability to walk is severely limited on a permanent basis **Examples of factors affecting ISV assessment** • unsightly scarring • the significance of any malunion • a requirement for modified footwear • whether, and to what degree, there is swelling following activity **Additional comment about appropriate level of ISV**	11 to 20

	• An ISV at or near the bottom of the range will be appropriate if there is a DPI for the injury of 10%. • An ISV at or near the top of the range will be appropriate if a major tendon controlling foot or ankle movement is severed.	

142 Moderate ankle injury

	Example of the injury a fracture, ligamentous tear or similar injury causing moderate disability, for example— • difficulty in walking on uneven ground • awkwardness on stairs • irritation from metal plates • residual scarring **Additional comment about appropriate level of ISV** An ISV at or near the bottom of the range will be appropriate if there is a DPI for the injury of 6%.	6 to 10

143 Minor ankle injury

	Example of the injury a sprain, ligamentous or soft tissue injury or minor or undisplaced fracture	0 to 5

	Examples of factors affecting ISV assessment • whether the injured worker has fully recovered from the injury, and if not, whether there is any tendency for the ankle to give way • whether there is scarring, aching or discomfort	

Division 14 Foot injuries

Subdivision 1 Amputations

144 Amputation of both feet

	Examples of factors affecting ISV assessment • severity of any phantom pain • pain in the stumps • extent of any ongoing symptoms **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there are amputations of both feet at the forefoot (transmetatarsal level amputations).	32 to 65

	• An ISV of about 40 will be appropriate if there are amputations of both feet at the mid foot (tarsometatarsal level or Lisfranc amputations). • An ISV at or near the top of the range will be appropriate if each amputation is at the level of the ankle (Syme's amputation) and the stumps can not be used with prostheses.	

145 Amputation of 1 foot

	Examples of factors affecting ISV assessment • severity of any phantom pain • pain in the stump • extent of any ongoing symptoms **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if the amputation is at the forefoot (transmetatarsal level amputation). • An ISV of about 26 will be appropriate if the amputation is at the mid foot (tarsometatarsal level or Lisfranc amputation).	20 to 35

	• An ISV at or near the top of the range will be appropriate if the amputation is at the level of the ankle (Syme's amputation) and the stump can not be used with a prosthesis.	

Subdivision 2 Other foot injuries

146 Extreme foot injury that is not an amputation

	Comment There will be permanent and severe pain or very serious permanent disability. **Example of the injury** an unusually severe foot injury causing a DPI of 15% or more, for example, a heel fusion or loss of the tibia-calcaneum angle **Comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there is subtalar fibrous ankylosis in a severely malaligned position, ongoing pain and a DPI for the injury of 24%.	13 to 25

147 Serious foot injury

	Examples of the injury • a severe midfoot deformity causing a DPI of 8%	9 to 12

	• a lower level loss of the tibia-calcaneum angle	

148 Moderate foot injury

	Example of the injury a displaced metatarsal fracture causing permanent deformity, with ongoing symptoms of minor severity, for example, a limp that does not prevent the injured worker engaging in most daily activities	4 to 8

149 Minor foot injury

	Example of the injury a simple metatarsal fracture, ruptured ligament, puncture wound or similar injury **Comment about appropriate level of ISV** An ISV of 2 or less will be appropriate if there is a straightforward foot injury, for example, a fracture, laceration or contusions, from which the injured worker will fully recover.	0 to 3

Division 15 Toe injuries

150 Extreme toe injury

	Examples of factors affecting ISV assessment for items 150.1 to 150.3 • whether the amputation was traumatic or surgical • extent of the loss of the forefoot • residual effects on mobility	
150.1	***Amputation of all toes*** **Comment about appropriate level of ISV** • An ISV at or near the middle of the range will be appropriate if the amputation is through the metatarsophalangeal joints (MTP joints) of all toes. • An ISV at or near the top of the range will be appropriate if there is complete amputation of all toes and amputation of a substantial part of the forefoot.	8 to 20
150.2	***Amputation of the great toe*** **Example of factor affecting ISV assessment for item 150.2** the level at which the amputation happens or any ongoing symptoms **Comment about appropriate level of ISV**	6 to 12

	An ISV at or near the top of the range will be appropriate if there is complete loss of the great toe and ball of the foot caused by an amputation through the first metatarsal bone.	
150.3	***Amputation of individual lesser toes*** **Example of factor affecting ISV assessment for item 150.3** the level at which the amputation happens or any ongoing symptoms **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is an amputation of 1 lesser toe and— (a) there is no ongoing pain; and (b) there is little or no loss of function of the foot; and (c) the cosmetic effect of the amputation is minor. • An ISV at or near the top of the range will be appropriate if there is complete amputation of all lesser toes and part of the forefoot.	3 to 5

151 Serious toe injury

	Comment	8 to 12

	The injury will cause serious and permanent disability. **Examples of the injury** • a severe crush injury causing ankylosis of the toes • a bursting wound, or an injury causing severe toe damage, with significant symptoms	

152 Moderate toe injury

	Comment There will be permanent discomfort, pain or sensitive scarring. **Examples of the injury** • a moderate injury to the great toe • a crush injury causing multiple fractures of 2 or more toes **Comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there has been more than 1 unsuccessful operation, or there are persisting stabbing pains, impaired gait or similar effects.	4 to 7

153 Minor toe injury

	Example of the injury	0 to 3

	a relatively straightforward fracture or soft tissue injury **Comment about appropriate level of ISV** An ISV of 1 will be appropriate if there is a straightforward fracture of 1 or more toes with complete resolution within a short time.	

Division 16 Limb disorders

	General comment The ISV for a limb disorder must be assessed having regard to the item of this schedule that— (a) relates to the part of the body affected by the disorder; and (b) is for an injury that has a similar level of adverse impact to the disorder. **Examples of a limb disorder** • tenosynovitis (inflammation of synovial sheaths of tendons usually resolving with rest over a short period and sometimes leading to ongoing symptoms of loss of grip and dexterity)	

	• peripheral nerve injury (the constriction of the motor or sensory nerves or thickening of surrounding tissue, for example, carpal tunnel syndrome or sciatica) • epicondylitis (inflammation around the elbow joint, for example, medially (golfer's elbow) or laterally (tennis elbow)) • vascular disorders, for example, deep vein thrombosis **Examples of factors affecting ISV assessment** • whether the disorder is bilateral or one-sided • the level of pain, swelling, tenderness or crepitus or other symptoms • the capacity to avoid a recurrence of symptoms • the ability to engage in daily activities • the availability and likely benefit of surgery • whether the disorder is to a dominant or non-dominant limb	

Part 7 Scarring to parts of the body other than the face

	General comment • This part applies to external appearance and physical condition of the skin only, and includes scarring to the scalp, trunk and limbs. • Facial scarring must be assessed under part 3, division 2. • This part does not apply to adhesions, or scarring, of internal organs. • This part will usually apply to an injury involving skeletal damage only if the skeletal damage is minor. • Many of the physical injuries mentioned in this schedule involve some scarring from the initial injury and subsequent surgery, including skin grafting, to repair the injury and this has been taken into account in fixing the range of ISVs for the injuries. *Example—* The ISV range for an injury causing a closed fracture of a limb takes into account the potential need for open reduction and internal fixation of the fracture and the resulting surgical wound and scar.	

	Examples of factors affecting ISV assessment for items 154.1 to 154.4 • location of a scar • age • adverse psychological reaction • likelihood of a scar fading or becoming less noticeable over time	

154 Scarring to a part of the body other than the face

154.1	***Extreme scarring to a part of the body other than the face*** **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is— (a) extensive scarring to 1 or more of the limbs and significant cosmetic disfigurement; and (b) either— (i) the need to keep the limb or limbs covered or wear special clothing; or	14 to 25

	(ii) ongoing limitation in the ability to participate in activities because of cosmetic disfigurement or functional impairment. • An ISV at or near the top of the range will be appropriate if there is gross permanent scarring over an extensive area or areas of the body, with ongoing pain and other symptoms.	
154.2	***Serious scarring to a part of the body other than the face*** **Comment** There is serious scarring— (a) requiring extensive medical treatment or surgery; and (b) causing significant ongoing limitation in the ability to participate in activities because of cosmetic disfigurement or functional impairment. **Examples of the injury** • significant scarring over the upper and lower arm requiring skin grafting if— (a) there are post-operative complications requiring additional medical treatment for up to 18 months; and	9 to 13

	(b) there is maximum medical improvement within 2 years after the scarring is caused • hypertrophic (keloid) scarring caused by a burn to the front of the neck, with an intermittent sensation of burning, itching or irritation	
154.3	***Moderate scarring to a part of the body other than the face*** **Examples of the injury** • several noticeable scars that are hypertrophic (keloid) • a significant linear scar in an area of cosmetic importance, for example, the front of the neck	4 to 8
154.4	***Minor scarring to a part of the body other than the face*** **Examples of the injury** • scarring caused by a superficial burn that heals within a few weeks and causes some minor change of pigmentation in a noticeable area • a single noticeable scar, or several superficial scars, to 1 or both of the legs, arms or hands, with some minor cosmetic damage	0 to 3

Part 8 Burn injuries

	General comment • The ISV for a burn injury must be assessed having regard to the item of this schedule that— (a) relates to the part of the body affected by the burn injury; and (b) is for an injury that has a similar level of adverse impact to the burn injury. • Burns to the face must be assessed under part 3, division 2. • In burns cases, the ISV for an injury to a part of the body causing functional impairment will generally be at or near the top of the range for an injury to that part of the body. • In serious burns cases, the effects of scarring are more comprehensive and less able to be remedied than the effects of scarring from other causes.	

Part 9 Injuries affecting hair

155 Extreme injury affecting head hair

	Example of the injury	11 to 15

	total permanent loss of head hair	

156 Serious injury affecting head hair

	Example of the injury damage to head hair, caused by, for example, defective waving or tinting, if— (a) the physical effect of the damage is— (i) dermatitis; or (ii) tingling or burning of the scalp, causing dry, brittle hair that breaks off or falls out, or both; and (b) the physical effect leads to depression, loss of confidence and inhibited social life **Comment about appropriate level of ISV** An ISV in the upper half of the range will be appropriate if— (a) thinning continues and prospects of regrowth are poor; or (b) there is a partial loss of areas of hair and regrowth is slow.	4 to 10

157 Moderate injury affecting head hair or loss of body hair

	Examples of the injury • hair that has been pulled out leaving bald patches	0 to 3

	• the same example mentioned in item 156 but with fewer or only moderate symptoms **Example of factor affecting ISV assessment** length of time before regrowth	

Part 10 Dermatitis

158 Extreme dermatitis

	Example of the injury permanent dermatitis having a severe effect on employment and domestic capability, with some mental disorder	11 to 20

159 Serious dermatitis

	Example of the injury dermatitis that— (a) lasts for years or indefinitely; and (b) involves cracking and soreness; and (c) affects employment and domestic capability; and (d) causes marked adverse psychological reaction	8 to 10

160 Moderate dermatitis

	Example of the injury dermatitis lasting for a significant period, but settling with treatment or a change of personal conduct, or both	3 to 7

161 Minor dermatitis

	Example of the injury itching, skin irritation or a rash, alone or in combination, that resolves with treatment within a few months of the start of treatment	0 to 2

Schedule 15 Matters relevant to PIRS assessment by medical expert

section 188(d)

Part 1 Explanation of the PIRS

1 PIRS rates permanent impairment caused by mental disorder

The PIRS stated in schedule 16 rates permanent impairment caused by a mental disorder.

Note—

PIRS ratings are referred to in schedule 14, part 2. A PIRS rating is capable of being accepted by a court under schedule 13, section 6 only if it is—

(a) assessed by a medical expert as required under this schedule and schedule 16; and

(b) provided to the court in a PIRS report as required under section 12.

2 Areas of functional impairment

(1) The PIRS consists of 6 scales, each of which rates permanent impairment in an area of function.

(2) Each scale has 5 classes of impairment, ranging from little or no impairment to total impairment.

Part 2 Assessment of PIRS rating

3 Medical expert must comply with requirements

(1) A medical expert must comply with this schedule and schedule 16 in assessing a PIRS rating for a mental disorder of an injured worker.

(2) The medical expert may give an assessment only if the medical expert has examined the injured worker.

4 How to assess a PIRS rating

(1) To assess a PIRS rating for a mental disorder of an injured worker, a medical expert must follow the steps stated in this section.

Note—

Section 8 provides an example completed worksheet that could be used to assess a PIRS rating.

(2) Step 1—for each area of functional impairment stated in the PIRS, the medical expert must—

(a) decide which level of impairment stated in the PIRS describes the level of impairment caused by the mental disorder of the injured worker; and

(b) read off from the PIRS the class, for example, class 1, that corresponds to the level that has been decided.

(3) In deciding which level to choose for an area of functional impairment, the medical expert—

(a) must have regard to—

(i) the examples of indicators of the level of impairment stated in the PIRS for the area to the extent they are relevant in a particular case; and

(ii) all factors the medical expert considers relevant to the injured worker's level of impairment, including, for example, the injured worker's age and pre-existing functional capacity for the area; and

(b) may have regard to the range of percentages of impairment stated in the PIRS for the area as a guide to the level of impairment.

Note—

The examples of impairment stated in the PIRS assume a full pre-existing functional capacity for the area which may not be appropriate in a particular case.

(4) Step 2—the medical expert must list the class number of the 6 classes read off under step 1 in ascending order.

(5) Step 3—the medical expert must work out the median of the class numbers (the ***median class score***) under section 6.

(6) Step 4—the medical expert must work out the total of the class numbers (the ***total class score***) by adding together all of the class numbers.

(7) Step 5—from the conversion table in section 7, the medical expert must read off the percentage impairment that corresponds to the particular median class score when found in conjunction with the particular total class score.

(8) Subject to section 5, the percentage impairment is the PIRS rating assessed by the medical expert for the mental disorder of the injured worker.

5 Assessment if pre-existing mental disorder

(1) If an injured worker has a pre-existing mental disorder, a medical expert must—

(a) work out a percentage impairment for the pre-existing mental disorder at the time immediately before the injury using the steps stated in section 4 (the ***pre-injury rating***); and

(b) work out a percentage impairment for the current mental disorder using the steps stated in section 4 (the ***post-injury rating***); and

(c) subtract the pre-injury rating from the post-injury rating.

(2) The remaining percentage impairment is the PIRS rating assessed by the medical expert for the mental disorder of the injured worker.

Note—

See also section 11.

6 How to work out a median class score

(1) A median class score is the number that would fall at the middle point between the third class number and the fourth class number if all the class numbers are listed in ascending order.

(2) If the median class score under subsection (1) is not a whole number, the median class score must be rounded up to the nearest whole number.

Note—

A median class score, as opposed to a mean class score or average class score, has the advantage of not being too influenced by 1 extreme score.

7 Conversion table

This section sets out the conversion table for use under section 4.

Conversion table for percentage impairment
Median class score

Total class score	1	2	3	4	5
6	0%				
7	0%				
8	1%				
9	1%	4%			
10	2%	5%			
11	2%	5%			
12	2%	6%			
13	3%	7%	11%		
14	3%	7%	13%		
15		8%	15%		
16		9%	17%		

Conversion table for percentage impairment
Median class score

17		9%	19%	31%	
18		10%	22%	34%	
19			24%	37%	
20			26%	41%	
21			28%	44%	61%
22			30%	47%	65%
23				50%	70%
24				54%	74%
25				57%	78%
26				60%	83%
27					87%
28					91%
29					96%
30					100%

8 Example worksheet

This section sets out an example of a completed worksheet that could be used to assess a PIRS rating for a mental disorder.

Area of functional impairment		**Class**				
1	**Self-care and personal hygiene**	1				
2	**Social and recreational activities**		2			
3	**Travel**			3		

4 Social functioning					5
5 Concentration, persistence and pace					5
6 Adaptation					5
List of class numbers in ascending order: 1 2 3 5 5					5
Median class score (using section 6):					4
Total class score:					21
Percentage impairment (using conversion table in section 7):					44%
PIRS rating (if no pre-existing mental disorder):					44%

Part 3 Particular cases

9 Refusal of treatment

(1) This section applies if an injured worker refuses treatment that could lead to a significant improvement in the level of permanent impairment caused by a mental disorder of the injured worker.

(2) Despite the injured worker's refusal of treatment, a medical expert may assess a PIRS rating for the mental disorder of the injured worker.

(3) The refusal of treatment must not affect the medical expert's assessment of the PIRS rating.

(4) The medical expert must note the refusal of treatment in the PIRS report and state in the report the likely effect of treatment and any reasons known to the medical expert for the refusal of treatment.

(5) Subsection (6) applies if a PIRS report given to a court states that the injured worker refuses treatment that could lead to a significant improvement in the level of permanent impairment caused by the mental disorder of the injured worker.

(6) The court may, in assessing the ISV for an injury or multiple injuries of the injured worker, take into account the refusal of treatment and the matters stated in the PIRS report under subsection (4).

(7) In this section—

PIRS report means a report under section 12.

10 Cognitive impairment

If a medical expert assessing a PIRS rating for a mental disorder of an injured worker suspects the injured worker has a cognitive impairment, the medical expert must take into account the following factors—

(a) the relevant medical history of the injured worker;

(b) any medical treatment, and progress towards rehabilitation, for the cognitive impairment;

(c) any results of radiological scans, including CT and MRI scans, electroencephalograms and psychometric tests made available to the medical expert.

11 Pre-existing mental disorder

If a medical expert assessing a PIRS rating for a mental disorder of an injured worker considers the injured worker had a pre-existing mental disorder, the medical expert must—

(a) make appropriate enquiry into the pre-existing mental disorder; and

(b) consider any psychiatric or psychological reports made available to the medical expert.

Part 4 Report of PIRS rating

12 Court to be given PIRS report

(1) This section applies if a party to a proceeding wants a court to accept a PIRS rating assessed by a medical expert for a mental disorder of an injured worker.

(2) The party must give the court a written report from the medical expert stating the following matters—

(a) the mental disorder diagnosed by the medical expert;

(b) the PIRS rating assessed by the medical expert for the mental disorder of the injured worker;

(c) how the PIRS rating was assessed, including—

(i) for each area of functional impairment stated in the PIRS—

(A) the relevant clinical findings; and

(B) the level of impairment stated in the PIRS that the medical expert decided described the level of impairment caused by the mental disorder of the injured worker; and

(C) the class stated in the PIRS that corresponds to the level that was decided; and

(ii) the median class score and total class score worked out under section 4; and

(iii) if the injured worker had a pre-existing mental disorder, the information mentioned in subparagraphs (i) and (ii) in relation to the pre-injury rating and the post-injury rating as defined under section 5;

(d) details of any cognitive impairment of the injured worker.

Schedule 16 Psychiatric impairment rating scale

section 188(c)

Area of functional impairment: self-care and personal hygiene

Class	Level of impairment	Examples of indicators of level of impairment *Note—* These examples must be had regard to under schedule 15, section 4(3)(a)(i).	Percentage impairment ranges *Note—* These ranges may be had regard to under schedule 15, section 4(3)(b).
Class 1	Little or no impairment		0 to 3%
Class 2	Mild impairment	• can live independently • looks after himself or herself adequately, although may look unkempt occasionally • sometimes misses a meal or relies on takeaway food	4 to 10%
Class 3	Moderate impairment	• can not live independently without regular support • needs prompting to shower daily and wear clean clothes • does not prepare own meals • frequently misses meals	11 to 30%

		• if living independently, a family member or community nurse visits, or needs to visit, 2 to 3 times a week to ensure a minimum level of hygiene and nutrition	
Class 4	Severe impairment	• needs supervised residential care • if unsupervised, may accidentally or deliberately hurt himself or herself	31 to 60%
Class 5	Totally impaired	• needs assistance with basic functions, for example, feeding or toileting	more than 60%

Area of functional impairment: social and recreational activities

Class	**Level of impairment**	**Examples of indicators of level of impairment** *Note—* These examples must be had regard to under schedule 15, section 4(3)(a)(i).	**Percentage impairment ranges** *Note—* These ranges may be had regard to under schedule 15, section 4(3)(b).
Class 1	Little or no impairment	• regularly goes to cinemas, restaurants or other recreational venues • belongs to clubs or associations and is actively involved in them	0 to 3%

Class 2	Mild impairment	• occasionally goes to social events without needing a support person, but does not become actively involved, for example, by dancing or cheering a team	4 to 10%
Class 3	Moderate impairment	• rarely goes to social events, and usually only when prompted by a family member or friend • does not become involved in social events • will not go out without a support person • remains quiet and withdrawn	11 to 30%
Class 4	Severe impairment	• never leaves own residence • tolerates the company of a family member or close friend • will go to a different room or garden when a person, other than a family member or close friend, comes to visit someone at own residence	31 to 60%
Class 5	Totally impaired	• can not tolerate living with anybody • extremely uncomfortable when visited by a close family member	more than 60%

Area of functional impairment: travel

Class	Level of impairment	Examples of indicators of level of impairment *Note—* These examples must be had regard to under schedule 15, section 4(3)(a)(i).	Percentage impairment ranges *Note—* These ranges may be had regard to under schedule 15, section 4(3)(b).
Class 1	Little or no impairment	• can travel to new environments without supervision	0 to 3%
Class 2	Mild impairment	• can travel without a support person, but only in a familiar area, for example, to go to the local shops or visit a neighbour	4 to 10%
Class 3	Moderate impairment	• can not travel away from own residence without a support person • there may be problems resulting from excessive anxiety or cognitive impairment	11 to 30%
Class 4	Severe impairment	• finds it extremely uncomfortable to leave his or her own residence even with a trusted person	31 to 60%
Class 5	Totally impaired	• can not be left unsupervised, even at own residence • may require 2 or more persons to supervise him or her when travelling	more than 60%

Area of functional impairment: social functioning

Class	**Level of impairment**	**Examples of indicators of level of impairment** *Note—* These examples must be had regard to under schedule 15, section 4(3)(a)(i).	**Percentage impairment ranges** *Note—* These ranges may be had regard to under schedule 15, section 4(3)(b).
Class 1	Little or no impairment	• has no difficulty in forming and sustaining relationships, for example, with a spouse or close friend lasting years	0 to 3%
Class 2	Mild impairment	• existing relationships are strained • tension and arguments between the injured worker and a spouse or close family member • some friendships are lost	4 to 10%
Class 3	Moderate impairment	• established relationships are severely strained, as is shown by periods of separation or domestic violence • if the injured worker has children, then a spouse, family members or community services are providing most of the care for the children	11 to 30%
Class 4	Severe impairment	• can not form or sustain long-term relationships	31 to 60%

		• pre-existing relationships, for example, with a spouse or close friend, have ended • can not care for dependants, for example, child dependants (if any) or an elderly parent	
Class 5	Totally impaired	• can not function within society • lives away from populated areas • actively avoids social contact	more than 60%

Area of functional impairment: concentration, persistence and pace

Class	**Level of impairment**	**Examples of indicators of level of impairment** *Note—* These examples must be had regard to under schedule 15, section 4(3)(a)(i).	**Percentage impairment ranges** *Note—* These ranges may be had regard to under schedule 15, section 4(3)(b).
Class 1	Little or no impairment	• can complete vocational education and training or a university course within a normal time frame	0 to 3%
Class 2	Mild impairment	• can undertake a basic or standard retraining course at a slower pace	4 to 10%

		• can focus on intellectually demanding tasks for up to 30 minutes, then may feel fatigued or develop headaches	
Class 3	Moderate impairment	• can not read more than newspaper articles • finds it difficult to follow complex instructions, for example, operating manuals or building plans • can not make significant repairs to motor vehicle or type long documents • can not follow a pattern for making clothes or tapestry or knitting	11 to 30%
Class 4	Severe impairment	• able only to read a few lines before losing concentration • has difficulty in following simple instructions • impaired concentration is obvious even during brief conversation • can not live alone or needs regular assistance from family members or community services	31 to 60%
Class 5	Totally impaired	• needs constant supervision and assistance within an institutional environment	more than 60%

Area of functional impairment: adaptation

Note—

This area of functional impairment deals with employability.

Class	**Level of impairment**	**Examples of indicators of level of impairment** *Note—* These examples must be had regard to under schedule 15, section 4(3)(a)(i).	**Percentage impairment ranges** *Note—* These ranges may be had regard to under schedule 15, section 4(3)(b).
Class 1	Little or no impairment	• can work full-time in the position (the ***pre-injury position***) in which the injured worker worked immediately before the injury • the injured worker's duties at work and performance of the duties are consistent with the worker's education and training • can cope with the normal demands of the job	0 to 3%
Class 2	Mild impairment	• can work in the pre-injury position, but for no more than 20 hours a week, for example, because the injured worker is no longer happy to work with particular persons • can work full-time in a different position where performance of the relevant duties requires the use of comparable skill and intellect to that required to perform the duties of the pre-injury position	4 to 10%

Class 3	Moderate impairment	• can not work at all in the pre-injury position • only able to work less than 20 hours a week in a different position where performance of the relevant duties requires less skill or is otherwise less demanding, for example, less stressful	11 to 30%
Class 4	Severe impairment	• can not work more than 1 or 2 days at a time • works less than 20 hours a fortnight • the pace at which work is done is reduced • attendance at work is erratic	31 to 60%
Class 5	Totally impaired	• needs constant supervision and assistance within an institutional environment	more than 60%

Schedule 17 General damages calculation provisions

section 189

Table 1—For an injury sustained from 1 July 2010 to 30 June 2011 (dates inclusive)			
Item	**Injury scale value**	**Base amount**	**Variable amount**
1	5 or less	—	Injury scale value x $1,180
2	10 or less but more than 5	$5,900	(Injury scale value - 5) x $1,410
3	15 or less but more than 10	$12,950	(Injury scale value - 10) x $1,650
4	20 or less but more than 15	$21,200	(Injury scale value - 15) x $1,880
5	25 or less but more than 20	$30,600	(Injury scale value - 20) x $2,120
6	30 or less but more than 25	$41,200	(Injury scale value - 25) x $2,360
7	35 or less but more than 30	$53,000	(Injury scale value - 30) x $2,590
8	40 or less but more than 35	$65,950	(Injury scale value - 35) x $2,830
9	50 or less but more than 40	$80,100	(Injury scale value - 40) x $3,040
10	60 or less but more than 50	$110,500	(Injury scale value - 50) x $3,250
11	70 or less but more than 60	$143,000	(Injury scale value - 60) x $3,460
12	80 or less but more than 70	$177,600	(Injury scale value - 70) x $3,680
13	90 or less but more than 80	$214,400	(Injury scale value - 80) x $3,890
14	100 or less but more than 90	$253,300	(Injury scale value - 90) x $4,120

Table 2—For an injury sustained from 1 July 2011 to 30 June 2012 (dates inclusive)			
Item	**Injury scale value**	**Base amount**	**Variable amount**
1	5 or less	—	Injury scale value x $1,210

Table 2—For an injury sustained from 1 July 2011 to 30 June 2012 (dates inclusive)			
Item	**Injury scale value**	**Base amount**	**Variable amount**
2	10 or less but more than 5	$6,050	(Injury scale value - 5) x $1,450
3	15 or less but more than 10	$13,300	(Injury scale value - 10) x $1,700
4	20 or less but more than 15	$21,800	(Injury scale value - 15) x $1,930
5	25 or less but more than 20	$31,450	(Injury scale value - 20) x $2,180
6	30 or less but more than 25	$42,350	(Injury scale value - 25) x $2,430
7	35 or less but more than 30	$54,500	(Injury scale value - 30) x $2,660
8	40 or less but more than 35	$67,800	(Injury scale value - 35) x $2,910
9	50 or less but more than 40	$82,350	(Injury scale value - 40) x $3,130
10	60 or less but more than 50	$113,650	(Injury scale value - 50) x $3,340
11	70 or less but more than 60	$147,050	(Injury scale value - 60) x $3,560
12	80 or less but more than 70	$182,650	(Injury scale value - 70) x $3,780
13	90 or less but more than 80	$220,450	(Injury scale value - 80) x $4,000
14	100 or less but more than 90	$260,450	(Injury scale value - 90) x $4,240

Table 3—For an injury sustained from 1 July 2012 to 30 June 2013 (dates inclusive)			
Item	**Injury scale value**	**Base amount**	**Variable amount**
1	5 or less	—	Injury scale value x $1270
2	10 or less but more than 5	$6,350	(Injury scale value - 5) x $1,530
3	15 or less but more than 10	$14,000	(Injury scale value - 10) x $1,790
4	20 or less but more than 15	$22,950	(Injury scale value - 15) x $2,030
5	25 or less but more than 20	$33,100	(Injury scale value - 20) x $2,300
6	30 or less but more than 25	$44,600	(Injury scale value - 25) x $2,560
7	35 or less but more than 30	$57,400	(Injury scale value - 30) x $2,800

Table 3—For an injury sustained from 1 July 2012 to 30 June 2013 (dates inclusive)			
Item	**Injury scale value**	**Base amount**	**Variable amount**
8	40 or less but more than 35	$71,400	(Injury scale value - 35) x $3,070
9	50 or less but more than 40	$86,750	(Injury scale value - 40) x $3,300
10	60 or less but more than 50	$119,750	(Injury scale value - 50) x $3,520
11	70 or less but more than 60	$154,950	(Injury scale value - 60) x $3,750
12	80 or less but more than 70	$192,450	(Injury scale value - 70) x $3,980
13	90 or less but more than 80	$232,250	(Injury scale value - 80) x $4,210
14	100 or less but more than 90	$274,350	(Injury scale value - 90) x $4,470

Table 4—For an injury sustained from 1 July 2013 to 30 June 2014 (dates inclusive)			
Item	**Injury scale value**	**Base amount**	**Variable amount**
1	5 or less	—	Injury scale value x $1,310
2	10 or less but more than 5	$6,550	(Injury scale value - 5) x $1,580
3	15 or less but more than 10	$14,450	(Injury scale value - 10) x $1,840
4	20 or less but more than 15	$23,650	(Injury scale value - 15) x $2,090
5	25 or less but more than 20	$34,100	(Injury scale value - 20) x $2,370
6	30 or less but more than 25	$45,950	(Injury scale value - 25) x $2,640
7	35 or less but more than 30	$59,150	(Injury scale value - 30) x $2,880
8	40 or less but more than 35	$73,550	(Injury scale value - 35) x $3,160
9	50 or less but more than 40	$89,350	(Injury scale value - 40) x $3,400
10	60 or less but more than 50	$123,350	(Injury scale value - 50) x $3,620
11	70 or less but more than 60	$159,550	(Injury scale value - 60) x $3,860
12	80 or less but more than 70	$198,150	(Injury scale value - 70) x $4,100
13	90 or less but more than 80	$239,150	(Injury scale value - 80) x $4,340

Table 4—For an injury sustained from 1 July 2013 to 30 June 2014 (dates inclusive)			
Item	**Injury scale value**	**Base amount**	**Variable amount**
14	100 or less but more than 90	$282,550	(Injury scale value - 90) x $4,600

Table 5—For an injury sustained from 1 July 2014 to 30 June 2015 (dates inclusive)			
Item	**Injury scale value**	**Base amount**	**Variable amount**
1	5 or less	—	Injury scale value x $1,360
2	10 or less but more than 5	$6,800	(Injury scale value - 5) x $1,640
3	15 or less but more than 10	$15,000	(Injury scale value - 10) x $1,910
4	20 or less but more than 15	$24,550	(Injury scale value - 15) x $2,170
5	25 or less but more than 20	$35,400	(Injury scale value - 20) x $2,460
6	30 or less but more than 25	$47,700	(Injury scale value - 25) x $2,740
7	35 or less but more than 30	$61,400	(Injury scale value - 30) x $2,990
8	40 or less but more than 35	$76,350	(Injury scale value - 35) x $3,280
9	50 or less but more than 40	$92,750	(Injury scale value - 40) x $3,530
10	60 or less but more than 50	$128,050	(Injury scale value - 50) x $3,760
11	70 or less but more than 60	$165,650	(Injury scale value - 60) x $4,010
12	80 or less but more than 70	$205,750	(Injury scale value - 70) x $4,260
13	90 or less but more than 80	$248,350	(Injury scale value - 80) x $4,500
14	100 or less but more than 90	$293,350	(Injury scale value - 90) x $4,770

Table 6—For an injury sustained from 1 July 2015 to 30 June 2017 (dates inclusive)			
Item	**Injury scale value**	**Base amount**	**Variable amount**
1	5 or less	—	Injury scale value x $1,390

Table 6—For an injury sustained from 1 July 2015 to 30 June 2017 (dates inclusive)			
Item	**Injury scale value**	**Base amount**	**Variable amount**
2	10 or less but more than 5	$6,950	(Injury scale value - 5) x $1,680
3	15 or less but more than 10	$15,350	(Injury scale value - 10) x $1,960
4	20 or less but more than 15	$25,150	(Injury scale value - 15) x $2,220
5	25 or less but more than 20	$36,250	(Injury scale value - 20) x $2,520
6	30 or less but more than 25	$48,850	(Injury scale value - 25) x $2,810
7	35 or less but more than 30	$62,900	(Injury scale value - 30) x $3,060
8	40 or less but more than 35	$78,200	(Injury scale value - 35) x $3,360
9	50 or less but more than 40	$95,000	(Injury scale value - 40) x $3,620
10	60 or less but more than 50	$131,200	(Injury scale value - 50) x $3,850
11	70 or less but more than 60	$169,700	(Injury scale value - 60) x $4,110
12	80 or less but more than 70	$210,800	(Injury scale value - 70) x $4,360
13	90 or less but more than 80	$254,400	(Injury scale value - 80) x $4,610
14	100 or less but more than 90	$300,500	(Injury scale value - 90) x $4,890

Table 7—For an injury sustained from 1 July 2017 to 30 June 2018 (dates inclusive)			
Item	**Injury scale value**	**Base amount**	**Variable amount**
1	5 or less	—	Injury scale value x $1,410
2	10 or less but more than 5	$7,050	(Injury scale value - 5) x $1,710
3	15 or less but more than 10	$15,600	(Injury scale value - 10) x $1,990
4	20 or less but more than 15	$25,550	(Injury scale value - 15) x $2,260
5	25 or less but more than 20	$36,850	(Injury scale value - 20) x $2,560
6	30 or less but more than 25	$49,650	(Injury scale value - 25) x $2,860
7	35 or less but more than 30	$63,950	(Injury scale value - 30) x $3,110

Table 7—For an injury sustained from 1 July 2017 to 30 June 2018 (dates inclusive)			
Item	**Injury scale value**	**Base amount**	**Variable amount**
8	40 or less but more than 35	$79,500	(Injury scale value - 35) x $3,420
9	50 or less but more than 40	$96,600	(Injury scale value - 40) x $3,680
10	60 or less but more than 50	$133,400	(Injury scale value - 50) x $3,920
11	70 or less but more than 60	$172,600	(Injury scale value - 60) x $4,180
12	80 or less but more than 70	$214,400	(Injury scale value - 70) x $4,440
13	90 or less but more than 80	$258,800	(Injury scale value - 80) x $4,690
14	100 or less but more than 90	$305,700	(Injury scale value - 90) x $4,970

Table 8—For an injury sustained from 1 July 2018 to 30 June 2019 (dates inclusive)			
Item	**Injury scale value**	**Base amount**	**Variable amount**
1	5 or less	—	Injury scale value x $1,450
2	10 or less but more than 5	$7,250	(Injury scale value - 5) x $1,760
3	15 or less but more than 10	$16,050	(Injury scale value - 10) x $2,050
4	20 or less but more than 15	$26,300	(Injury scale value - 15) x $2,330
5	25 or less but more than 20	$37,950	(Injury scale value - 20) x $2,640
6	30 or less but more than 25	$51,150	(Injury scale value - 25) x $2,950
7	35 or less but more than 30	$65,900	(Injury scale value - 30) x $3,210
8	40 or less but more than 35	$81,950	(Injury scale value - 35) x $3,530
9	50 or less but more than 40	$99,600	(Injury scale value - 40) x $3,790
10	60 or less but more than 50	$137,500	(Injury scale value - 50) x $4,040
11	70 or less but more than 60	$177,900	(Injury scale value - 60) x $4,310
12	80 or less but more than 70	$221,000	(Injury scale value - 70) x $4,580
13	90 or less but more than 80	$266,800	(Injury scale value - 80) x $4,830

Table 8—For an injury sustained from 1 July 2018 to 30 June 2019 (dates inclusive)			
Item	**Injury scale value**	**Base amount**	**Variable amount**
14	100 or less but more than 90	$315,100	(Injury scale value - 90) x $5,120

Table 9—For an injury sustained from 1 July 2019 to 30 June 2020 (dates inclusive)			
Item	**Injury scale value**	**Base amount**	**Variable amount**
1	5 or less	—	Injury scale value x $1,490
2	10 or less but more than 5	$7,450	(Injury scale value - 5) x $1,810
3	15 or less but more than 10	$16,500	(Injury scale value - 10) x $2,110
4	20 or less but more than 15	$27,050	(Injury scale value - 15) x $2,400
5	25 or less but more than 20	$39,050	(Injury scale value - 20) x $2,720
6	30 or less but more than 25	$52,650	(Injury scale value - 25) x $3,040
7	35 or less but more than 30	$67,850	(Injury scale value - 30) x $3,310
8	40 or less but more than 35	$84,400	(Injury scale value - 35) x $3,640
9	50 or less but more than 40	$102,600	(Injury scale value - 40) x $3,900
10	60 or less but more than 50	$141,600	(Injury scale value - 50) x $4,160
11	70 or less but more than 60	$183,200	(Injury scale value - 60) x $4,440
12	80 or less but more than 70	$227,600	(Injury scale value - 70) x $4,720
13	90 or less but more than 80	$274,800	(Injury scale value - 80) x $4,980
14	100 or less but more than 90	$324,600	(Injury scale value - 90) x $5,270

Table 10—For an injury sustained on or after 1 July 2020		
Item	**Injury scale value**	**General damages**
1	0	0
2	1	0.95 times QOTE

Table 10—For an injury sustained on or after 1 July 2020		
Item	**Injury scale value**	**General damages**
3	2	1.90 times QOTE
4	3	2.84 times QOTE
5	4	3.79 times QOTE
6	5	4.74 times QOTE
7	6	5.89 times QOTE
8	7	7.04 times QOTE
9	8	8.19 times QOTE
10	9	9.34 times QOTE
11	10	10.49 times QOTE
12	11	11.83 times QOTE
13	12	13.17 times QOTE
14	13	14.51 times QOTE
15	14	15.85 times QOTE
16	15	17.19 times QOTE
17	16	18.72 times QOTE
18	17	20.24 times QOTE
19	18	21.76 times QOTE
20	19	23.29 times QOTE
21	20	24.81 times QOTE
22	21	26.54 times QOTE
23	22	28.27 times QOTE
24	23	30.00 times QOTE
25	24	31.73 times QOTE
26	25	33.45 times QOTE
27	26	35.39 times QOTE
28	27	37.32 times QOTE

Table 10—For an injury sustained on or after 1 July 2020		
Item	**Injury scale value**	**General damages**
29	28	39.25 times QOTE
30	29	41.18 times QOTE
31	30	43.11 times QOTE
32	31	45.21 times QOTE
33	32	47.32 times QOTE
34	33	49.42 times QOTE
35	34	51.52 times QOTE
36	35	53.63 times QOTE
37	36	55.94 times QOTE
38	37	58.25 times QOTE
39	38	60.56 times QOTE
40	39	62.88 times QOTE
41	40	65.19 times QOTE
42	41	67.67 times QOTE
43	42	70.14 times QOTE
44	43	72.62 times QOTE
45	44	75.10 times QOTE
46	45	77.58 times QOTE
47	46	80.06 times QOTE
48	47	82.53 times QOTE
49	48	85.01 times QOTE
50	49	87.49 times QOTE
51	50	89.97 times QOTE
52	51	92.61 times QOTE
53	52	95.25 times QOTE
54	53	97.90 times QOTE

Table 10—For an injury sustained on or after 1 July 2020		
Item	**Injury scale value**	**General damages**
55	54	100.54 times QOTE
56	55	103.18 times QOTE
57	56	105.82 times QOTE
58	57	108.47 times QOTE
59	58	111.11 times QOTE
60	59	113.75 times QOTE
61	60	116.40 times QOTE
62	61	119.22 times QOTE
63	62	122.04 times QOTE
64	63	124.86 times QOTE
65	64	127.68 times QOTE
66	65	130.50 times QOTE
67	66	133.32 times QOTE
68	67	136.14 times QOTE
69	68	138.96 times QOTE
70	69	141.78 times QOTE
71	70	144.60 times QOTE
72	71	147.60 times QOTE
73	72	150.60 times QOTE
74	73	153.60 times QOTE
75	74	156.60 times QOTE
76	75	159.60 times QOTE
77	76	162.60 times QOTE
78	77	165.60 times QOTE
79	78	168.59 times QOTE
80	79	171.59 times QOTE

Table 10—For an injury sustained on or after 1 July 2020		
Item	**Injury scale value**	**General damages**
81	80	174.59 times QOTE
82	81	177.76 times QOTE
83	82	180.92 times QOTE
84	83	184.08 times QOTE
85	84	187.25 times QOTE
86	85	190.41 times QOTE
87	86	193.58 times QOTE
88	87	196.74 times QOTE
89	88	199.90 times QOTE
90	89	203.07 times QOTE
91	90	206.23 times QOTE
92	91	209.58 times QOTE
93	92	212.93 times QOTE
94	93	216.28 times QOTE
95	94	219.62 times QOTE
96	95	222.97 times QOTE
97	96	226.32 times QOTE
98	97	229.67 times QOTE
99	98	233.02 times QOTE
100	99	236.36 times QOTE
101	100	239.71 times QOTE

Schedule 18 Dictionary

section 3

actuarial standard means the document called 'Professional Standard 302—Valuations of general insurance claims' issued by the Actuaries Institute.

actuary means an actuary approved by the Regulator.

adverse psychological reaction does not include a mental disorder.

AMA 5 means the 5th edition of the Guides to the evaluation of permanent impairment published by the American Medical Association.

ankylosis means fixation of a joint in a specific position.

annual levy, for part 2, division 3, see section 16.

application day, in relation to a self-insurer, for part 3, division 1, see section 26.

appointed actuary—

(a) for part 3, division 1, see section 28; or

(b) for part 3, division 2, see section 39; or

(c) for part 3, division 3, see section 50; or

(d) for part 3, division 4, see section 60; or

(e) for part 3, division 5, subdivision 2, see section 72; or

(f) for part 3, division 5, subdivision 3, see section 81(1); or

(g) for part 3, division 6, see section 91(1).

arbiter means the actuarial arbiter appointed under section 100.

assessed premium, for an employer, means premium calculated using the employer's wages for a period of insurance.

assessment day—

(a) in relation to a self-insurer, for part 3, division 1, see section 26; or

(b) in relation to a member, for part 3, division 2, see section 37; or

(c) in relation to a former self-insurer, for part 3, division 3, see section 48; or

(d) in relation to a non-scheme member, for part 3, division 6, see section 89.

cancellation day—

(a) in relation to a former self-insurer, for part 3, division 3, see section 48; or

(b) in relation to a non-scheme employer, for part 3, division 5, see section 69.

category, for schedule 6, see schedule 6, section 2(1)(b).

children's functional independence measure, for part 6, division 1, see section 151.

claim means—

(a) an application for compensation; or

(b) a claim for damages.

consecutive categories, for schedule 6, see schedule 6, section 3.

consent day, in relation to a member, for part 3, division 2, see section 37.

corresponding score, for a category, for schedule 6, see schedule 6, section 1.

decision, of an insurer, for part 4, division 4, subdivision 4, see section 134.

digestive system—

(a) means the organs and other parts of the body forming the alimentary tract, and includes the tongue, throat and abdominal wall; but

(b) does not include an organ or other part of the body mentioned in the injury column of schedule 14.

dominant injury, of multiple injuries, means—

(a) the injury of the multiple injuries having the highest range; or

(b) if 2 or more of the injuries have the highest range—the injury (of those 2 or more injuries) that is selected as the dominant injury by a court assessing an ISV.

DPI amount, for schedule 5, see schedule 5, section 1(a).

DSM 4 means the 4th edition of the Diagnostic and statistical manual of mental disorders, text revision (DSM-IV-TR) published by the American Psychiatric Association in 2000.

estimated claims liability has the same meaning as in section 84(8) of the Act.

final day, in relation to a non-scheme member, for part 3, division 6, see section 89.

financial quarter means a period of 3 months beginning on 1 January, 1 April, 1 July or 1 October.

former self-insurer, for part 3, division 3, see section 48.

functional independence measure, for part 6, division 1, see section 151.

further premium, for an employer, means an amount, other than assessed premium or provisional premium, payable by an employer to WorkCover under the Act, and includes the following—

(a) arrears of premium;

(b) additional premium under section 8(3);

(c) interest on premium under section 10(2);

(d) an amount of unpaid premium or a payment or penalty payable under section 57(2) of the Act;

(e) additional premium for late payment under section 61 or 62 of the Act;

(f) additional premium under section 63 of the Act.

highest range means the range of ISVs having the highest maximum ISV.

household worker means a person employed solely in and about, or in connection with, a private dwelling house or the grounds of a private dwelling house.

injured worker means a worker who has sustained an injury.

injury, for part 4, division 4 and schedule 5, see section 123.

ISV means injury scale value.

Le Fort I fracture means a horizontal segmented fracture of the alveolar process of the maxilla.

Le Fort II fracture means a unilateral or bilateral fracture of the maxilla—

(a) in which the body of the maxilla is separated from the facial skeleton and pyramidal in shape; and

(b) that may extend through the body of the maxilla down the midline of the hard palate, through the floor of the orbit and into the nasal cavity.

Le Fort III fracture means a fracture in which the entire maxilla and 1 or more facial bones are completely separated from the brain case.

legal cost amount, for schedule 5, see schedule 5, section 1(b).

licence, in relation to a self-insurer, means a licence to be a self-insurer mentioned in section 71 or 72 of the Act.

medical certificate means—

(a) in relation to an application under section 132 of the Act—

  (i) a certificate given by a doctor or nurse practitioner as required under section 132(3)(a) of the Act; or

  (ii) a certificate given by a registered dentist as permitted under section 132(4) of the Act; or

(b) in relation to an application under section 132A of the Act—

(i) a certificate given by a doctor as required under section 132A(3)(c)(i) of the Act; or

(ii) a certificate given by a registered dentist as permitted under section 132A(4) of the Act; or

(c) in relation to an application under section 132B of the Act—a certificate given by a doctor as required under section 132B(3)(c)(i) of the Act.

medical expert, for an assessment of a PIRS rating, means a person—

(a) who is appropriately qualified to perform the assessment, including, for example, a psychologist, neuropsychologist or psychiatrist; and

(b) who has had appropriate training in the use of the PIRS.

medical specialty means a branch of medicine that is a recognised specialty under the Health Practitioner Regulation National Law.

member, for part 3, division 2, see section 37.

mental disorder means a mental disorder recognised under DSM 4.

modified barthel index means 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.

new insurer, for part 3, division 2, see section 38.

nurse means a person registered under the Health Practitioner Regulation National Law to practise in the nursing profession, other than as a student.

old insurer, for part 3, division 2, see section 38.

old self-insurer, for part 3, division 6, see section 89.

outstanding liability, for part 3, division 1, see section 26.

panel, for part 4, division 4, see section 123.

PIRS means the psychiatric impairment rating scale stated in schedule 16.

PIRS rating, for a mental disorder, means a rating on the PIRS for the permanent impairment caused by the mental disorder.

pre-existing, in relation to an injury, means existing at the time immediately before the injury.

premium includes assessed premium, provisional premium and further premium.

provisional annual levy, for part 2, division 3, see section 19(2)(a).

provisional premium, for an employer, means premium calculated using a reasonable estimate of wages for a period of insurance.

qualifying condition, for part 4, division 4, see section 123.

range, in relation to an ISV for an injury, means the range of ISVs for the injury stated in schedule 14.

reading, of a chest x-ray, for schedule 6, see schedule 6, section 2.

second appointed actuary, for part 3, division 4, see section 66(1).

section 193A compensation, for an injury, for part 4, division 4, see section 123.

section 193A notice, for part 4, division 4, see section 129(1).

self-insurer's data, for part 3, division 4, see section 58.

specialty medical assessment tribunal see section 197(b).

specified date, for part 2, division 3, see section 18(2).

summary report—

(a) for part 3, division 1, see section 32(1); or

(b) for part 3, division 2, see section 43(1); or

(c) for part 3, division 3, see section 54(1); or

(d) for part 3, division 5, subdivision 2, see section 76(1); or

(e) for part 3, division 5, subdivision 3, see section 85(1); or

(f) for part 3, division 6, see section 95(1).