Australian Government

Safety, Rehabilitation and Compensation Commission

Determining Authority KPI Specifications

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1 Introduction

1.1 Background

The Safety, Rehabilitation and Compensation Commission (the Commission) oversees the regulatory operations of the *Safety, Rehabilitation and Compensation Act 1988* (the SRC Act) and the *Occupational Health and Safety Act 1991* (the OHS Act).

The Commission's objective is to foster improvement in occupational health and safety and workers' compensation in the Australian Government jurisdiction by:

- setting targets to improve health and safety standards in workplaces
- monitoring performance in relation to occupational health and safety, rehabilitation and compensation
- providing advice to the Minister on issues relating to improving occupational health and safety, rehabilitation and workers' compensation.

This document establishes a reporting framework (the Determining Authority KPIs) to provide the Commission with an overview of the performance of the jurisdiction. The Determining Authority KPIs (DAKPIs) address prevention, injury management and return to work (RTW), and claims management.

This document replaces the *Commission Indicator Specifications, October 2009*.

1.2 Performance reporting and target setting

The performance of licensed self-insurers against the DAKPIs is an important component of the Licensee Improvement Program (LIP). The performance of Comcare (in relation to claims management KPIs) and premium payers (in relation to prevention and injury management and RTW KPIs) is also reported to the Commission in order to:

- address the Commission's function under s89B of the SRC Act to ensure, as far as practicable, there is equity of outcomes resulting from administrative practices and procedures used by Comcare and a licensed self-insurer in the performance of their respective functions
- provide a benchmark for the performance of licensed self-insurers
- enable overall scheme performance to be determined.

Each year, at its June meeting, the Commission reviews performance to 31 March and sets financial year targets against the DAKPIs.

1.3 Frequency and timing of reporting

The Commission considers quarterly scheme performance reports, which address scheme trends and the performance of determining authorities and premium payers against the DAKPIs and targets. These reports are compiled by Comcare from claims based data submitted to the Commission Data Warehouse (CDW) and information collected directly from determining authorities (non-claims based data, e.g. workforce data). The requirements for reporting to the CDW are set out in the latest version of the *Commission Data Warehouse Specifications*.

Each licensed self-insurer's performance against the DAKPI targets for the 12 months ending 31 March is considered along with the results of other regulatory assessments in preparing an overall LIP report to the Commission's June meeting.

1.4 Enquiries

Further information on DAKPI reporting requirements may be obtained from the Director, Performance Analysis Team, Chief Actuary Group, Comcare on 1300 366 979.

2 Glossary

Accepted Claim A claim for compensation where liability has been accepted under the SRC Act.

CDW The Commission Data Warehouse (CDW) is a data repository for unit claims data provided by determining authorities (i.e. Comcare and licensed self-insurers). The *Commission Data Warehouse Specifications* describe the requirements for determining authorities under the SRC Act to submit data to the CDW.

Claim Any compliant claim for compensation, for example, the initial liability claim, claim for payment of medical expenses, claim for impairment payments, claim for cost of services rendered or claim for incapacity benefits.

Commuting Travel to or from work as defined in section 6 of the SRC Act. This does not include travel associated with employment. That is where travel is part of an employee's duties or where the cost of travel is met by the employer.

Commuting claim A claim for an injury sustained when travelling to or from work, as defined in section 6 of the SRC Act (see commuting). Commuting claims are identified by a *Duty status code* of '04' (Travelling to or from work) (refer Item B10 in the CDW Specifications).

Compliance date In relation to a new claim, the date on which the claim, being compliant with legislative requirements, was received by the determining authority. This is identified by the earliest *Date/time of determination status change* in relation to a claim where the corresponding *Determination status code* is 'U' (Undetermined), 'A' (Accepted) or 'R' (Rejected) (refer Items C2 and C3 in the CDW Specifications). Also see note on page 7.

Continuance Refers to an injured worker continuing on incapacity benefits. The continuance rate measures the proportion of injured workers who, having reached 4 weeks of incapacity, continue to 13 weeks or more of incapacity.

Current determination status The current decision regarding liability for compensation in relation to a claim. This is identified by the *Determination status code* that corresponds to the latest *Date/time of determination status change* in relation to a claim (refer Items C2 and C3 in the CDW Specifications). Also see note on page 7.

Date of injury For an injury, the date on which the injury as defined by s. 6 of the SRC Act occurred; or for a disease, the date when medical treatment was first sought, or first resulted in incapacity or impairment (disease) as defined by s. 7(4) of the SRC Act.

Death due to claim flag A flag that identifies whether the worker died as a result of the claimed injury/disease (refer Item B22 in the CDW Specifications).

Determination A decision regarding liability for compensation or rehabilitation under the SRC Act. For a new claim, determination means the initial decision regarding liability.

Determination status code A code that identifies the determination status of a claim (refer Item C3 in the CDW Specifications).

Disease From 13 April 2007, any ailment suffered by an employee, or the aggravation of such an ailment, that is contributed to, to a significant degree, by the employee's employment.

Disease claim As specified by the *Nature of injury/disease code* (e.g. for claims coded in accordance with TOOCS3.1, claims with a *Nature of injury/disease code* between 401 and 949 inclusive) (refer Item B4 in the CDW Specifications).

FTE Employee	Full Time Equivalent Employee The total number of FTE employees who worked in the reporting period is defined as the total hours worked by all employees in the reporting period divided by the average/standard hours worked in full-time jobs.
Incapacity	A diminished ability to earn. For the purpose of the DAKPIs, only periods in which a worker is actually absent from work (lost time) due to a compensable condition are counted. The amount of lost time in relation to a claim is identified by the total *Incapacity weeks* (refer Item G7 in the CDW specifications). A period over which an employee works his or her normal pre-injury weekly hours, but is in receipt of incapacity payments due to "make-up pay", is not considered as lost time. Accordingly, determining authorities should ensure that, where an incapacity determination is reported to the CDW in relation to an employee who is working his or her normal weekly hours, while all data fields are still required, the *Incapacity weeks* should be reported as zero.
Incapacity benefit	A payment made by a determining authority, directly or indirectly, by way of income maintenance.
Incident notification	A written or verbal report made to Comcare of an injury, illness or disease that meets the notification criteria provided by the OHS Act and OHS (Safety Arrangements) Regulations.
Initial determination date	In relation to a new claim, the date upon which the first decision was taken to accept or deny liability for compensation. This is identified by the earliest *Date/time of determination status change* in relation to a claim where the corresponding *Determination status code* is 'A' (Accepted) or 'R' (Rejected) (refer Items C2 and C3 in the CDW Specifications). Also see note on page 7.
Initial determination status	In relation to a new claim, the first decision taken to accept or deny liability for compensation. This is identified by the 'A' (accepted) or 'R' (Rejected) *Determination status code* in relation to a claim with the earliest corresponding *Date/time of determination status change* (refer Items C2 and C3 in the CDW Specifications). Also see note on page 7.
Injury	Refers to either an injury or disease (unless otherwise specified). An injury can be a physical or mental injury and includes aggravation of a pre-existing ailment.
Injury claim	As specified by the *Nature of injury/disease code* (e.g. for claims coded in accordance with TOOCS3.1, claims with a *Nature of injury/disease code* between 101 and 399 or 951 and 999 inclusive) (refer Item B4 in the CDW Specifications).
New claim	A claim that complies with the requirements of section 54 of the SRC Act.
Original determination	Any decision made by a delegate in respect of compensation or rehabilitation that is capable of being the subject of a reconsideration. An initial determination is also an original determination.
Reconsideration	An employee or employer, who is dissatisfied with a decision made by a determining authority, may ask for that decision to be reviewed by an officer not involved in the making of the decision in question. The result of such a review is called a reviewable decision.
Reconsideration decision code	A code that identifies the outcome of a reconsideration (refer Item H7 in the CDW Specifications).
Reconsideration decision date	The date a decision in writing (i.e. reviewable decision) was made in relation to a reconsideration. This is identified by the *Reconsideration decision date* (refer Item H6 in the CDW Specifications).
Reconsideration initiator code	A code that identifies the party that initiated a reconsideration (refer Item H4 in the CDW Specifications).

Reconsideration received date

The date a request for a reconsideration is received by the determining authority. This is identified by the *Reconsideration request received date* (refer Item H3 in the CDW Specifications).

Where the claimant or employer requests a reconsideration and seeks an extension of time to supply additional information, or indicates that further information will be forthcoming, the date of receipt may be taken to be the date when all additional information is received from the claimant or employer. In these cases, the *Reconsideration request received date* should reflect the date the additional information was received. There is no scope to adjust the date of receipt if information is sought by the determining authority from either the employer or the employee.

Reviewable decision

A decision reconsidered by a determining authority under s. 38 or s. 62 of the SRC Act. Only when there is a reviewable decision can there be an application to the Administrative Appeals Tribunal (see reconsideration and AAT).

Takeover claim flag

A flag that identifies claims for which the determining authority has taken over liability from another body (refer Item B33 in the CDW Specifications).

TOOCS

The Type of Occurrence Classification System (TOOCS) provides a system for coding the circumstances surrounding an injury/disease occurrence. The current classification system in use is the 3rd edition, revision 1 (TOOCS3.1).

Note: The following table illustrates how the compliance date, initial determination date, initial determination status and current determination status are identified from monthly CDW data.

When a compliant claim is received in the first instance by a determining authority, the first *Determination status code* recorded in relation to the claim would be 'U' (undetermined) and the corresponding *Date/time of determination status change* would indicate the compliance date (see Claim A below).

When a non-compliant claim received, the first *Determination status code* recorded in relation to the claim would be 'N' (non-compliant) (note that a determining authority may elect not to report a non-compliant claim to the CDW). If the non-compliance is addressed and a compliant claim subsequently received, a new *Determination status code* of 'U' (undetermined) would be recorded and the corresponding *Date/time of determination status change* would indicate the compliance date (Claim B).

When an initial decision to accept or deny liability has been made in relation to a claim, a new *Determination status code* of either 'A' (Accepted) or 'R' (Rejected) would be recorded, indicating the initial determination status. The corresponding *Date/time of determination status change* would indicate the initial determination date (Claims A and B).

In all cases, even where a decision to accept or deny liability has not yet been made, the current determination status is identified by the latest recorded *Determination status code* in relation to a claim. For example, for a claim that was withdrawn prior to determination, and upon which no further action has occurred, the current determination status would be 'W' (withdrawn) (Claim C).

Claim identifier[1]	Date/time of determination status change[2]	Determination status code[3]
A	1 Feb 2010 (Compliance date)	'U'
A	4 Feb 2010 (Initial determination date)	'A' (Initial and current determination status)
B	2 Mar 2011	'N'
B	10 Mar 2011 (Compliance date)	'U'
B	28 Mar 2011 (Initial determination date)	'R' (Initial determination status)
B	2 May 2011	'A' (Current determination status)
C	14 Mar 2011	'U'
C	5 Apr 2011	'W' (Current determination status)

1 Refer item C1 in CDW Specifications
2 Refer item C2 in CDW Specifications (date component only)
3 Refer item C3 in CDW Specifications

3 Overview

The following table provides an overview of the DAKPIs.

DAKPI number	DAKPI title	Unit	Brief KPI description
DAKPI 1	Number of fatalities	Number	Number of worker fatalities notified to Comcare and claims accepted for death due to work related injury in the reporting period.
DAKPI 2	Incidence of serious claims	Incidence rate	Number of claims (excluding commuting claims) in which the first week of incapacity was determined, in the reporting period, per 1000 FTE employees.
DAKPI 3	Incidence of claims	Incidence rate	Number of claims (excluding commuting claims) initially accepted, in the reporting period, per 1000 FTE employees.
DAKPI 4	Audit results – WHS management systems	Percentage	The percentage of all audit criteria assessed as 'conformant', based on the Commission approved *National Self Insurer OHS Audit Tool* (NAT Commonwealth).
DAKPI 5	Claims continuance rate – 13 weeks	Percentage	The percentage of claims that reached 4 weeks or more of incapacity that subsequently reached 13 weeks or more of incapacity in the reporting period.
DAKPI 6	Audit results – rehabilitation management systems	Percentage	The percentage of all audit criteria assessed as 'conformant', based on the Commission's *Rehabilitation Management Systems Audit Tool.*
DAKPI 7	Timeliness – determination of new claims	Percentage	The overall percentage of new claims determined in the reporting period within 20 calendar days (injury) and 60 calendar days (disease) from the date of receipt by the determining authority.
DAKPI 8	Timeliness – decisions on requests for reconsideration	Percentage	The percentage of reconsideration requests decided, in the reporting period, within 30 calendar days from date of receipt by the determining authority.
DAKPI 9	Audit results – claims management systems	Percentage	The percentage of all audit criteria assessed as 'conformant', based on the Commission's *Claims Management Systems Audit Tool.*

4 Determining Authority KPIs (DAKPIs)

DAKPI 1 Number of fatalities	
Description	Number of work-related fatalities reported, either through an incident notification or an accepted claim.
Reporting basis	• Incident notifications for death received by Comcare in the reporting period, irrespective of the date of incident or date of death. • Accepted death claims determined in the reporting period, for which a related OHS incident notification has not already been received, irrespective of the date of death or the date of receipt of the claim.
Scope	Licensed self-insurers, Australian Government premium payers and the ADF.
Data source	OHS incident notifications received from employers and monthly CDW data.
Data elements	***Notified fatalities:*** number of deaths for which an OHS incident notification was received by Comcare in the reporting period. ***Compensated fatalities:*** number of claims, for which a related OHS incident notification has not already been received, with: • an initial determination date in the reporting period; and • a *Death due to claim flag* of *Y* (yes).
Data exclusions	Notified fatalities: • Incidents assessed by Comcare to be not notifiable • Contractors • Third parties Compensated fatalities: • Disease claims • Commuting claims • Claims with a current *Determination status code* other than *A* (Accepted) Note: While OHS incident notifications in relation to contractor and third party fatalities, along with disease and commuting claims, are excluded from this KPI for the purpose of measuring performance against targets, they are reported to the Commission for information.
Calculation	DAKPI 1 = *Notified fatalities* + *Compensated fatalities*
Data update frequency	Monthly.

The above DAKPI may need to be revised once the new Commonwealth's *Work Health and Safety (WHS) Bill* is enacted.

DAKPI 2 Incidence of serious claims	
Description	The number of claims with one week or more of incapacity per 1000 FTE employees.
Reporting basis	Claims in which the first week of incapacity was determined in the reporting period, irrespective of the date of injury, the date of receipt of the claim, initial determination date, dates of incapacity, subsequent void record/s or redetermination/s.
Scope	Licensed self-insurers and Australian Government premium payers.
Data source	Monthly CDW data and FTE employee data provided separately by licensed self-insurers.
Data elements	***Serious claims:*** number of claims in which the first week of incapacity was determined in the reporting period. ***FTE employees:*** number of FTE employees for the reporting period. Note: The incidence of serious claims for the 12 month periods ending 30 September, 31 December, 31 March and 30 June will be reported based on actual FTE employee data provided by licensed self-insurers for the corresponding periods. For the intervening periods, the incidence of serious claims will be reported based on the most recent FTE employee data available. For example, the incidence of serious claims for the 12 months ending 31 October and 30 November will be reported based on the actual FTE employee data provided by licensed self-insurers for the 12 months ending 30 September.
Data exclusions	• Commuting claims.
Calculation	$\text{DAKPI 2} = \frac{\textit{Serious claims}}{\textit{FTE employees}} \times 1000$
Data update frequency	Monthly.

The above DAKPI requires accurate details of the number of full-time equivalent (FTE) employees to be provided by licensed self-insurers. Inaccurate FTE data will obviously result in an over or under reporting of actual claims incidence rate both for the individual licensed self-insurer and the scheme as a whole.

DAKPI 3 Incidence of claims	
Description	Number of accepted claims per 1000 FTE employees.
Reporting basis	Claims initially accepted in the reporting period.
Scope	Licensed self-insurers and Australian Government premium payers.
Data source	Monthly CDW data.
Data elements	***Accepted claims:*** number of claims with: • an initial determination date in the reporting period; and • an initial *Determination status code* of *A* (Accepted). ***FTE employees:*** number of FTE employees for the reporting period Note: The incidence of claims for the 12 month periods ending 30 September, 31 December, 31 March and 30 June will be reported based on actual FTE employee data provided by licensed self-insurers for the corresponding periods. For the intervening periods, the incidence of claims will be reported based on the most recent FTE employee data available. For example, the incidence of claims for the 12 months ending 31 October and 30 November will be reported based on the actual FTE employee data provided by licensed self-insurers for the 12 months ending 30 September.
Data exclusions	• Commuting claims.
Calculation	$\text{DAKPI 3} = \frac{\textit{Accepted claims}}{\textit{FTE employees}} \times 1000$
Data update frequency	Monthly.

The above DAKPI requires accurate details of the number of full-time equivalent (FTE) employees to be provided by licensed self-insurers. Inaccurate FTE data will obviously result in an over or under reporting of actual claims incidence rate both for the individual licensed self-insurer and the scheme as a whole.

DAKPI 4 Audit results—WHS management systems	
Description	The results of WHS management systems audits of employers, as assessed using the *National OHS Audit Tool* (NAT Commonwealth). The NAT (Commonwealth) comprises 112 criteria across five modules as follows: 1. HSMAs (1 criteria) 2. Planning (12 criteria) 3. Implementation (83 criteria) 4. Measurement and evaluation (14 criteria) 5. Management review (2 criteria). Audit results will be expressed as a percentage of audit criteria assessed as conformant. Criteria not assessed or not able to be verified by the audit are not included in this indicator. Where a licensed self-insurer conducts an internal audit using an audit tool other than the NAT, results of the audit will be mapped by the licensed self-insurer to the five NAT modules.
Reporting basis	WHS management systems audits conducted in the reporting period. This indicator will incorporate the results of WHS management system audits undertaken by Comcare for licensed self-insurers on tier 1 and those due for licence extension, as well as the results of internal audits undertaken by licensed self-insurers on tiers 2 and 3. In those circumstances where Comcare undertakes an audit prior to licence extension and the licensed self-insurer also undertakes a self audit in the same year, the Comcare audit result will be used for the purpose of reporting against this KPI. WHS management systems audit results for Australian Government premium paying agencies and the ADF will be included as they become available.
Scope	Licensed self-insurers, Australian Government premium payers and the ADF.
Data source	WHS management systems audit reports.
Data elements	***Conformant***$_1$: The number of module 1 criteria assessed by the audit as conformant. ***Non-conformant***$_1$: The number of module 1 criteria assessed by the audit as non-conformant. ***Conformant***$_2$: The number of module 2 criteria assessed by the audit as conformant. ***Non-conformant***$_2$: The number of module 2 criteria assessed by the audit as non-conformant. ***Conformant***$_3$: The number of module 3 criteria assessed by the audit as conformant. ***Non-conformant***$_3$: The number of module 3 criteria assessed by the audit as non-conformant. ***Conformant***$_4$: The number of module 4 criteria assessed by the audit as conformant. ***Non-conformant***$_4$: The number of module 4 criteria assessed by the audit as non-conformant. ***Conformant***$_5$: The number of module 5 criteria assessed by the audit as conformant. ***Non-conformant***$_5$: The number of module 5 criteria assessed by the audit as non-conformant.

Data exclusions	Nil.
Calculation	$\text{DAKPI 4} = \dfrac{\sum_{n=1}^{5} Conformant_n}{\sum_{n=1}^{5} (Conformant_n + Non\text{-}conformant_n)} \times 100$
Data update frequency	Annually.

The NAT (Commonwealth) may need to be revised once the new Commonwealth's *Work Health and Safety (WHS) Bill* is enacted to ensure the audit tool aligns with the new legislative requirements.

DAKPI 5 Claims continuance rate—13 weeks	
Description	The percentage of claims with 4 weeks or more of incapacity that continued to 13 weeks or more of incapacity.
Reporting basis	Claims reaching four weeks or more of incapacity that were initially determined between 6 and 18 months prior to the calculation date. For example, when reporting data for the 12 months ending 30 April 2013, this refers to claims: • initially determined between 1 November 2011 and 31 October 2012 (both end dates inclusive); and • that reached 4 weeks of incapacity on or before 30 April 2013. To enable comparisons over time, this KPI is not updated to reflect ongoing claim development.
Scope	Licensed self-insurers and Australian and ACT Government premium payers.
Data source	Monthly CDW data.
Data elements	***Number of claims with 13 weeks incapacity:*** number of claims: • with an initial determination date: – after the day 18 months prior to the calculation date – on or before the day 6 months prior to the calculation date; and • that reached 13 weeks of incapacity on or before the calculation date. ***Number of claims with 4 weeks incapacity:*** number of claims: • with an initial claim determination date: – after the day 18 months prior to the calculation date – on or before the day 6 months prior to the calculation date; and • that reached 4 weeks of incapacity on or before the calculation date. For both data elements, the calculation date is the last day of the 12 month period for which data is to be reported. For example: • when reporting data for 2010–11, the calculation date is 30 June 2011; • when reporting data for the 12 months ending 30 April 2013, the calculation date is 30 April 2013.
Data exclusions	• Claims with a *Death due to claim flag* of *Y* (yes).
Calculation	$\text{DAKPI 5} = \dfrac{\textit{Number of claims with 13 weeks incapacity}}{\textit{Number of claims 4 weeks incapacity}} \times 100$
Data update frequency	Monthly.

DAKPI 6 Audit results—rehabilitation management systems	
Description	The results of rehabilitation management systems audits of employers, as assessed using the *Rehabilitation management systems audit tool.* The *Rehabilitation management systems audit tool* comprises 35 criteria across five modules as follows: 1. Commitment and corporate governance (6 criteria) 2. Planning (5 criteria) 3. Implementation (13 criteria) 4. Measurement and evaluation (9 criteria); and 5. Review and improvement (2 criteria). Audit results will be expressed as a percentage of all audit criteria assessed as conformant. Criteria not assessed or not able to be verified by the audit are not included in this indicator.
Reporting basis	Rehabilitation management systems audits conducted in the reporting period. This indicator will incorporate the results of rehabilitation management systems audits undertaken by Comcare for licensed self-insurers on tier 1 and those due for licence extension, as well as the results of internal audits undertaken by licensed self-insurers on tiers 2 and 3. In those circumstances where Comcare undertakes an audit prior to licence extension and the licensed self-insurer also undertakes a self audit in the same year, the Comcare audit result will be used for the purpose of reporting against this KPI. Rehabilitation management systems audit results for premium paying agencies will be included as they become available.
Scope	Licensed self-insurers and Australian and ACT Government premium payers.
Data source	Rehabilitation management systems audit reports.
Data elements	***Conformant***$_1$: The number of module 1 criteria assessed by the audit as conformant. ***Non-conformant***$_1$: The number of module 1 criteria assessed by the audit as non-conformant. ***Conformant***$_2$: The number of module 2 criteria assessed by the audit as conformant. ***Non-conformant***$_2$: The number of module 2 criteria assessed by the audit as non-conformant. ***Conformant***$_3$: The number of module 3 criteria assessed by the audit as conformant. ***Non-conformant***$_3$: The number of module 3 criteria assessed by the audit as non-conformant. ***Conformant***$_4$: The number of module 4 criteria assessed by the audit as conformant. ***Non-conformant***$_4$: The number of module 4 criteria assessed by the audit as non-conformant. ***Conformant***$_5$: The number of module 5 criteria assessed by the audit as conformant. ***Non-conformant***$_5$: The number of module 5 criteria assessed by the audit as non-conformant.
Data exclusions	Nil.
Calculation	$\text{DAKPI 6} = \dfrac{\sum_{n=1}^{5} Conformant_n}{\sum_{n=1}^{5} (Conformant_n + Non\text{-}conformant_n)} \times 100$
Data update frequency	Annually.

DAKPI 7 Timeliness—determination of new claims	
Description	The percentage of new claims determined within: • 20 calendar days for injury claims • 60 calendar days for disease claims from date of receipt by the determining authority of a compliant claim. For example, if 40 of 50 injury claims are determined within the standard 20 calendar days and 45 of 50 disease claims are determined within the standard 60 calendar days, the overall percentage of new claims determined within the standard timeframes would be 85%.
Reporting basis	Claims with an initial determination date in the reporting period.
Scope	Licensed self-insurers and Comcare.
Data source	Monthly CDW data.
Data elements	***Claims determined:*** number of claims with an initial determination date in the reporting period ***Within timeframe (injury):*** for all injury claims with an initial determination date in the reporting period, the number of claims determined within 20 calendar days of the compliance date (i.e. initial determination date minus compliance date ≤ 20 days) ***Within timeframe (disease):*** for all disease claims with an initial determination date in the reporting period, the number of claims determined within 60 calendar days of the compliance date (i.e. initial determination date minus compliance date ≤ 60 days).
Data exclusions	• Claims with a *Takeover claim flag* of *Y* (yes); and • Claims with a current *Determination status code* of *D* (deleted) or *W* (withdrawn).
Calculation	$\text{DAKPI 7} = \dfrac{\textit{Within timeframe (injury)} + \textit{Within timeframe (disease)}}{\textit{Claims determined}} \times 100$
Data update frequency	Monthly.

The above DAKPI may need to be revised once the new *Safety, Rehabilitation and Compensation and Other Legislation Amendment Bill 2011* is enacted to ensure alignment with the new legislative requirements, which would allow for the setting of time limits for the determination of a claim.

DAKPI 8 Timeliness—decisions on requests for reconsideration	
Description	The percentage of reconsideration requests decided within 30 calendar days from date of receipt by the determining authority. The date of receipt is the date the reconsideration request is received by the determining authority. In those cases where the claimant or employer requests a reconsideration and seeks an extension of time to supply additional information, or indicates that further information will be forthcoming, the date of receipt will be taken to be the date when all additional information is received from the claimant or employer. There is no scope to alter the date of receipt if information is sought by the determining authority from either the employer or the employee.
Reporting basis	Reconsiderations with a reconsideration decision (i.e. reviewable decision) date in the reporting period.
Scope	Licensed self-insurers and Comcare.
Data source	Monthly CDW data.
Data elements	***Reconsiderations decided:*** number of reconsideration requests with a *Reconsideration decision date* in the reporting period ***Within timeframe:*** for all reconsideration requests with a *Reconsideration decision date* in the reporting period, the number of requests decided within 30 calendar days of date of receipt by the determining authority (i.e. *Reconsideration decision date* minus *Reconsideration received date* ≤ 30 days)
Data exclusions	• Reconsiderations with a *Reconsideration initiator code* of *S* [self (determining authority)]; and • Reconsiderations with a *Reconsideration decision code* of *W* (withdrawn).
Calculation	$\text{DAKPI 8} = \frac{\textit{Within timeframe}}{\textit{Reconsiderations decided}} \times 100$
Data update frequency	Monthly.

The above DAKPI may need to be revised once the new *Safety, Rehabilitation and Compensation and Other Legislation Amendment Bill 2011* is enacted to ensure alignment with the new legislative requirements, which would allow for the setting of time limits for the making of a reconsideration of a determination.

DAKPI 9 Audit results—claims management systems	
Description	The results of claims management systems audits of determining authorities, as assessed using the *Claims management systems audit tool.* The *Claims management systems audit tool* comprises 46 criteria across five modules as follows: 1. Commitment and corporate governance (6 criteria) 2. Planning (6 criteria) 3. Implementation (24 criteria) 4. Measurement and evaluation (8 criteria); and 5. Review and improvement (2 criteria). Audit results will be expressed as a percentage of all audit criteria assessed as conformant. Criteria not assessed or not able to be verified by the audit are not included in this indicator.
Reporting basis	Claims management systems audits conducted in the reporting period. This indicator will incorporate the results of claims management systems audits undertaken by Comcare for licensed self-insurers on tier 1 and those due for licence extension, as well as the results of internal audits undertaken by licensed self-insurers on tiers 2 and 3. In those circumstances where Comcare undertakes an audit prior to licence extension and the licensed self-insurer also undertakes a self audit in the same year, the Comcare audit result will be used for the purpose of reporting against this KPI. Comcare will also be subject to periodic claims management system audits for the purpose of benchmarking.
Scope	Licensed self-insurers and Comcare.
Data source	Claims management systems audit reports.
Data elements	***Conformant***$_1$: The number of module 1 criteria assessed by the audit as conformant. ***Non-conformant***$_1$: The number of module 1 criteria assessed by the audit as non-conformant. ***Conformant***$_2$: The number of module 2 criteria assessed by the audit as conformant. ***Non-conformant***$_2$: The number of module 2 criteria assessed by the audit as non-conformant. ***Conformant***$_3$: The number of module 3 criteria assessed by the audit as conformant. ***Non-conformant***$_3$: The number of module 3 criteria assessed by the audit as non-conformant. ***Conformant***$_4$: The number of module 4 criteria assessed by the audit as conformant. ***Non-conformant***$_4$: The number of module 4 criteria assessed by the audit as non-conformant. ***Conformant***$_5$: The number of module 5 criteria assessed by the audit as conformant. ***Non-conformant***$_5$: The number of module 5 criteria assessed by the audit as non-conformant.
Data exclusions	Nil.
Calculation	$\text{DAKPI 9} = \dfrac{\sum_{n=1}^{5} Conformant_n}{\sum_{n=1}^{5} (Conformant_n + Non\text{-}conformant_n)} \times 100$
Data update frequency	Annually.