Nominal Insurer 2020 Quarter 1 claims file review

State Insurance Regulatory Authority

July 2020

Building a better working world

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1. Executive Summary

1.1 Background

During 2019, the State Insurance Regulatory Authority (SIRA) conducted a claims file review of Nominal Insurer (NI) claims from the 2018 accident year as part of the Compliance and Performance Review of the NI (initial review). SIRA's response to the compliance and performance review of the NI included a 21-point action plan. Action number 10 stated:

> *"During 2020, SIRA will conduct and publish a quarterly compliance and performance audit of claims management by the NI, under Division 4 of the Workers Compensation Act 1987, including file reviews utilising an enhanced methodology. Audit reports will be provided to the SIRA and icare boards."*

EY's scope is outlined in Section 2.2 of this report and is contained in a letter to Mr Darren Parker dated 21 January 2020. The letter sets out the terms of the engagement of Ernst & Young (EY, we, our) by SIRA to provide the services specified in the Scope section of that letter.

1.2 Methodology

The first quarterly file review, conducted in 2020 Quarter 1 (the 2020 Q1 review), involved assessing a sample of 85 claims based on a questionnaire of approximately 170 mostly binary questions covering the following aspects of the claim process:

- Claim acceptance and communication
- Liability determination
- Triage of claims
- Injury management and return to work
- Medical management and costs
- Weekly benefit assessment and payments
- Data quality

Comments were also collected to record observations of other items not covered by the questions.

The 85 claims were drawn from a stratified random sample using the following criteria:

- Date claim reported, or Date Entered Insurer System (DEIS), between 9 February 2019 and 31 December 2019
- Initial liability status of provisionally accepted, accepted or claim notification
- Injury type of fracture, sprains, psychological injury or other injury
- Weekly benefits duration of 1-4 weeks, 4-13 weeks, 13-26 weeks or 26+ weeks

Due to the development of the current COVID-19 pandemic, it was decided to halt the review early and only 85 files were able to be completed. The findings from the review are presented in this report.

1.3 Results of review

1.3.1 Areas that have improved

There were a number of areas of claims management that have improved since the initial review, including:

- For the majority of claims, the acceptance of notification and initial communication with the employer and injured worker were considered to be done well. The initial notification was compliant and the injured worker was accurately deemed a worker under the Act. Initial communication was timely and in the required form
- One of the key findings of the initial review was that claims were being incorrectly triaged and not remedied in a timely manner. This review found that many claims that were initially triaged

to Empower or Guide were subsequently moved to Support, as for the initial review. However, in most cases the movement to the higher level of support category was considered to occur in a timely manner. On average, Empower claims took 18 days to be moved to Support, and Guide claims took 31 days to be moved to Support. This compares to 90 and 32 days respectively found in the initial review

- In most cases, the decision to appoint a rehabilitation provider was considered to be appropriate and the appointment appeared to result in relatively better injury management
- In terms of medical management, there appeared to be appropriate scrutiny of requests for surgery and the associated costs. The controls that Guidewire has around the maximum gazette rates appeared to be helpful in this regard.

1.3.2 Areas identified for improvement.

There were three main areas that this review identified for improvement (and these areas are consistent with the findings of the initial review).

Liability determination

In many cases, the reviewers considered that there appeared to be an inadequate understanding of the facts of an injury that would enable an informed liability decision to be made. For example:

- It was considered that there was evidence of appropriate information gathering/investigation given the circumstances of the claim in 58% of claims reviewed
- It was considered that all questions were answered at the time of making the final liability decision in 48% of claims reviewed
- It was considered that all the information on the file been taken into account when the final liability decision was made in 60% of claims reviewed.

This is not to conclude that the final liability decision was incorrect; however, it indicates that in around 50% of claims, the reviewers considered that there was either information available that was not used or there were areas of uncertainty that were not investigated in making the final liability decision.

For 23 claims reviewed (27% of the sample), the employer expressed concerns regarding causation of the claim. In 19 of the 23 claims, the employer's concerns were not considered to be appropriately investigated or addressed. Ten of these were psychological injury claims (out of a total of 12 psychological injury claims reviewed).

Of the 12 psychological injury claims reviewed, the employer expressed concerns regarding the causation of the injury for 10 of these claims. The employer's concerns were considered to be fully investigated for only 1 of these 10 claims. In many of the other nine cases, the employer's actions, as recorded, appeared reasonable; however, the claimant's assertions appeared to be unchallenged.

Injury and medical management planning

Consistent with the findings from the initial review, it was identified in this review that injury management plans (IMPs) were often generic or basic, and in many instances, they were not appropriately updated to reflect the injured worker's changing circumstances:

- Of the 85 claims reviewed, 72 had an injury management plan prepared. The IMP was considered to be appropriate to the needs of the injured worker in 37 of these claims (52%). Furthermore, the reviewers considered that the plan was adhered to or reviewed on an ongoing basis in 47% of claims reviewed
- The IMP was considered to fulfill the requirements of Section 45 of the Act in 60% of cases.

It was found in many cases that there was inadequate engagement with relevant parties in the development of an IMP and return to work (RTW) plan. This indicates that the appropriateness of the IMP is likely limited by a lack of engagement with workers, employers and nominated treating doctors (NTDs). For example:

- It was considered there was adequate engagement with the worker in 65% of claims reviewed
- It was considered there was adequate engagement with the employer to discuss RTW options in 57% of claims reviewed
- It was considered there was adequate engagement with the treating doctor in 51% of claims reviewed.

Payment of weekly benefits

There were a number of areas of concern identified that indicated the potential for inaccuracies in the payment of weekly benefits:

- It was considered that sufficient information was collected to allow a determination of pre-injury average weekly earnings (PIAWE) for 72% of the claims reviewed
- An interim PIAWE amount was used in half of the files reviewed; however, corrective payments had been made as a result of using interim PIAWE in 30% of these cases
- There appeared to be sufficient evidence of a worker's incapacity to support the level of weekly benefits being paid in 54% of files reviewed.

1.4 Summary

Similar to the initial review conducted in 2019, this review has found a wide range of experience and capability amongst the case managers. This lack of experience appears to manifest itself in inconsistent decision making and insufficient investigation of matters such as liability causation.

The last question of the review asked if the case manager was pro-active in progressing the claim towards a satisfactory outcome. The file reviewers' responses to this question were negative for 48 files reviewed (56%). While the question is somewhat judgmental, the responses are supported by the factual findings presented throughout this report.

An overall conclusion of this review (consistent with the initial review) is that there is a lack of challenge within the claims management process. This is permeating all aspects of claims management, including:

- Acceptance of claims provisionally but then a failure to carry out the necessary investigations
- Leaving material questions surrounding the workplace accident and causation unanswered
- Commissioning investigations but then determining liability prior to their completion
- Receiving factual reports and not actioning them
- Relinquishing case management to either the surgeon or the rehabilitation provider
- A non-questioning attitude to the payment of diagnostic and other allied health service costs
- The use of interim PIAWE with no subsequent follow up to collect the complete wage data.

The case manager is key to ensuring optimal management of a claim's issues, including coordination of injury management, medical management and liaising with the employer to get the injured worker back to work as soon as they are fit. Each claim requires a clearly defined strategy and complimentary action plans backed up by rigid timeframes.

However, consistent with the initial review, injury management plans (IMPs) were considered to be inadequate in many cases. Often the IMPs were generic in nature without any detailed plan or goals outlined in them. Often the IMP simply documented past events or repeated what the treating doctor said in a certificate of capacity. Additionally, there was no adjustment of the plan as the

events of the claim unfolded. The documents reviewed did not appear to meet the relevant criteria for IMPs. Without a suitable plan, a claim is left to take its own course, which results in poor outcomes for the injured worker and greater expense for the scheme.

1.5 Reliances and Limitations

In our professional capacity and EY operating policy requirements, we are required to state the reliances and limitations of our report.

EY's scope is outlined in Section 2.2 of this report and is contained in a letter to Mr Darren Parker dated 21 January 2020. The letter sets out the terms of the engagement of Ernst & Young (EY, we, our) by SIRA to provide the services specified in the Scope section of that letter.

Our Report may be relied upon by SIRA for the purpose of the agreed scope only pursuant to the terms of our Contract Agreement SIRA//6358/2016 between EY and SIRA commencing on 20 April 2017. We disclaim all responsibility to any other party for all costs, loss, damage and liability that any third party may suffer or incur arising from or relating to or in any way connected with the contents of our Report, the provision of our Report to the other party or the reliance upon our Report by the other party. We are providing specific advice only for this engagement and for no other purpose and we disclaim any responsibility for the use of our advice for a different purpose or in a different context.

EY has acted in accordance with the instructions of SIRA in conducting its work and preparing the Report and, in doing so, has prepared the Report for the benefit of SIRA, and has considered only the interests of SIRA. The Report does not seek to address the specific circumstances of any other party, and EY makes no representations as to the appropriateness, accuracy or completeness of the Report for any other party's purposes. EY is under no obligation to provide any other party with any additional information or to update any of the information contained in the Report.

Judgements based on the data, methods and assumptions contained in the report should be made only after studying the report in its entirety, as conclusions reached by a review of a section or sections on an isolated basis may be incorrect.

2. Introduction

2.1 Background

During 2019, SIRA conducted a compliance and performance review of the NI. Part of that review, conducted by EY, was a claims file review of a sample of NI claims from the 2018 accident year (the initial review). The 2019 review was conducted by three senior claims specialists including one authorized officer from SIRA. 122 claims were reviewed that were selected based on a stratified random claims sample.

In order to conduct a claims file review that was as objective as possible, a questionnaire was developed that would lead to a consistent assessment of each claim file reviewed. The questionnaire consisted of approximately 170 mostly binary questions that had to be completed by the file reviewer. In addition, a number of dates and payment amounts were collected. The file reviewers also had free text fields they could use to record observations or other items not covered by the questions. The questions covered the following stages of the claims process:

- Claim acceptance and communication
- Liability determination
- Triage of claims
- Injury management and return to work
- Medical management and costs
- Weekly benefit assessment and payments
- Data quality

Once each questionnaire was completed, all results were collated and analysed. The outcomes of the 2019 review were documented in our report titled "Compliance and Performance Review of the Nominal Insurer – claims management" dated December 2019.

SIRA's response to the compliance and performance review of the NI included a 21 point action plan. Action number 10 stated:

> *"During 2020, SIRA will conduct and publish a quarterly compliance and performance audit of claims management by the NI, under Division 4 of the Workers Compensation Act 1987, including file reviews utilising an enhanced methodology. Audit reports will be provided to the SIRA and icare boards."*

This report covers the first 2020 quarterly file review conducted during February and March of 2020 (the 2020 Q1 review).

2.2 EY's scope

The scope of EY's services for this review are contained in a letter to Mr Darren Parker dated 21 January 2020. The letter sets out the terms of the engagement of Ernst & Young (EY, we, our) by the State Insurance Regulatory Authority (SIRA, you) to provide the services specified in the Scope section of that letter.

This report contains our conclusions from the claims file review conducted during the first quarter of 2020. EY's scope is summarised in the following table which details the claim stages examined and the areas of claims management assessed.

Claim stage	Areas assessed
1. Claim acceptance and communication	▸ If notification was compliant ▸ If the claimant was deemed to be a worker under the Act ▸ If the injury occurred during the course of employment ▸ Appropriate and timely communication with all parties
2. Liability determination	▸ Date of initial and subsequent liability decisions ▸ Appropriate investigations to determine liability carried out ▸ Views of the employer given due consideration ▸ Appropriate resolution of all issues raised ▸ Liability determination carried out in a timely manner
3. Triage	▸ Initial and subsequent triage categories ▸ Date of moving triage category ▸ Date of appointment of case manager ▸ Appropriateness of initial triage decision
4. Injury management	▸ Appropriateness of injury management plan ▸ Compliance with section 45 of the Act ▸ Evidence of employer involvement in getting injured worker back to work ▸ Appropriateness of any appointment of rehabilitation provider ▸ Effectiveness of rehabilitation provider ▸ Degree of engagement with injured worker, employer and treating doctor ▸ Appropriate communication with all parties during rehabilitation ▸ Appropriate review of injury management plan on an ongoing basis as treatment progresses
5. Medical management	▸ Appropriateness of information used to prepare the medical treatment plan ▸ Ongoing review of medical treatment plan ▸ Appropriate use of independent medical examination/examiner (IME) and/or medical support panel (MSP) ▸ Appropriate detail recorded on file to assess cost of medical treatment ▸ Required approvals for surgery ▸ Assessment of actual costs relative to expected ▸ Appropriate monitoring of treatment and its effectiveness ▸ Relevant challenge to treatment plan if proving ineffective
6. Weekly benefits	▸ Appropriate evidence recorded on file to enable calculation of PIAWE ▸ Appropriate use of interim PIAWE and any necessary subsequent corrections ▸ Weekly benefits paid in accordance with medical certificates (work capacity) recorded on file ▸ Appropriate reimbursement schedules on file to justify payments made ▸ Timeliness of payments made
7. Data quality	Check quality of certain data fields (if relevant) including: ▸ Liability status date ▸ Payment classification number ▸ Payee ID ▸ Work status code ▸ Date ceased work ▸ Actual date resumed work ▸ Number of days off

This review involved:

- Using a consistent set of evaluation criteria to assess the files (predominantly the same criteria as used for the initial review)
- Reviewing the sample of files based on this evaluation criteria and recording the findings
- Consulting with an assigned icare contact person as needed to clarify relevant matters in each claim
- Consolidating the individual review findings and discussing the main issues emerging with icare
- Documenting the detailed review of each file.

In assessing the claim files, the following guiding principles were used:

- Questions are structured such that Yes is a positive response
- Either Yes or No is a preferred response rather than N/A, which should only be used when it is a patently correct response (e.g. where the question may not be relevant for the claim being reviewed)
- Many questions relate to timeliness. If evidence was necessary but not obtained, it is therefore not timely
- Where a question assesses evidence on file, the evidence must be clear and not open to interpretation, otherwise the answer is No
- Some areas of assessment are by their nature subjective; the reviewer shall apply judgement and have consideration of all aspects of the claim.

It was intended to cover 120 files during the review. However, as the COVID-19 situation was developing, it was decided to halt the review early and 85 files were completed.

3. Methodology and data

3.1 Data

A random sample of claims was extracted from the CDR data as at 31 December 2019 based on certain criteria. The claims header file and the payment transaction file were predominantly used as the data sources on which to assess the criteria.

3.2 Review methodology

In order to conduct a claims file review that was as objective as possible, a questionnaire was developed that would lead to a consistent assessment of each claim reviewed. In addition, a number of dates and payment amounts were collected. The file reviewers also had free text fields they could use to record observations or other items not covered by the questions. The questions covered the following stages of the claims process:

- Claim notification and communication
- Liability determination
- Triage
- Injury management and return to work
- Medical management and costs
- Weekly benefit assessment and payments
- Assessment of data quality of certain fields

Once each questionnaire was completed, all results were collated and analysed. These results are summarised and presented in this report.

3.3 Claims sample

A stratified random sample of 120 claims was initially selected for this claims file review, though as noted earlier, only 85 files were actually reviewed. The strata used for the sampling were:

- All claims managed by Employers Mutual Limited (EML)
- Date claim reported between 9 February 2019 and 31 December 2019[1] and hence administered on the Guidewire IT platform
- Initial liability status of provisionally accepted, accepted or notification
- Injury type of fracture, sprains, psychological injury or other injury
- Weekly benefits duration of 1-4 weeks, 4-13 weeks, 13-26 weeks or 26+ weeks[2]

The mix of claims reviewed by injury type, initial liability status and duration is summarised in the following table and compared with the mix of all 2019 EML claims. The mix of sample claims is broadly consistent with the mix of all claims.

[1] Date Entered Insurer System (DEIS) is chosen to be after claims were moved onto the NISP

[2] Time lost claim > 1 week off work

	Population #	Population %	Sample #	Sample %
Injury Type				
Fractures	5,803	32.0%	**37**	30.8%
Other	6,951	38.3%	**44**	36.7%
Psychological	1,965	10.8%	**18**	15.0%
Sprains	3,432	18.9%	**21**	17.5%
	18,151		120	
Initial Liability Status				
Provisionally Accepted Claims	12,747	70.2%	**77**	64.2%
Liability Accepted	2,223	12.2%	**20**	16.7%
Notification of work related injury	3,181	17.5%	**23**	19.2%
	18,151		120	
Duration Band				
1-4 weeks	7,812	43.0%	**48**	40.0%
4-13 weeks	6,146	33.9%	**38**	31.7%
13-26 weeks	2,634	14.5%	**20**	16.7%
26+ weeks	1,559	8.6%	**14**	11.7%
Total	**18,151**		**120**	**100.0%**

4. Claim acceptance and communication

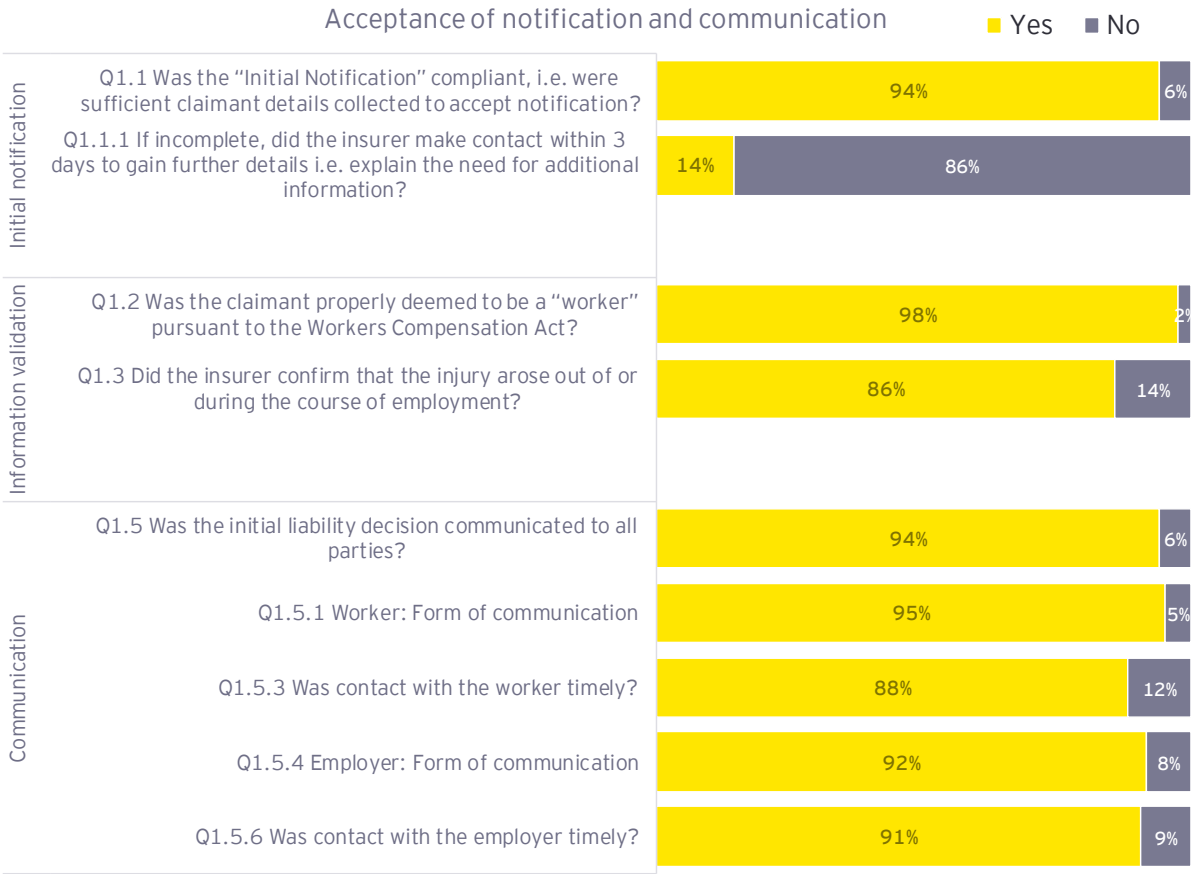
4.1 Key findings

The key findings regarding the initial acceptance of claim notifications and initial communication with employers and injured workers are:

- Sufficient detail regarding the claimant was collected to accept notification in 94% of files reviewed
- The claimant was correctly deemed to be a worker under the Act in 98% of files reviewed
- The initial liability decision was communicated to all parties, written communication to both the employer and claimant was evident on the file, and that communication was considered to be timely in more than 90% of the files reviewed
- The claims manager had not confirmed that the injury arose of or during the course of employment in 14% of files reviewed (12 claims of 85). This is elaborated upon in the next section regarding liability acceptance.

4.2 Detailed results

The key questions asked, and the responses recorded, for the 85 claims reviewed are summarised in the following graphic



Regarding the results above, we make the following observations:

- 6% of claims reviewed were not a compliant notification. From the sample size, this is only 5 claims and therefore question 1.1.1. is only representative of a very small sample size
- For 12 claims (14%), the case manager had not confirmed that the injury was caused by the claimant's employment. Of these claims:
  - 4 were psychiatric injury claims (discussed in section 5.5 below)
  - 3 were sprains
  - 5 were "other" injury types

  Some of the issue noted by the reviewers included:
  - Past medical history not being taken into account
  - A technical specialist recommending additional information be obtained but the investigations were not followed through
  - Further investigation being warranted as the injuries sustained were not consistent with the duties carried out by the injured worker
- Regarding communication with the worker and employer, this was considered timely in above 90% of cases for the Support and Specialised segments. For the Empower/Guide segments, the timeliness of communication was lower, at around 85%. This lower proportion may be correlated with the lack of a dedicated claims manager in the Empower/Guide segments.

5. Liability determination

5.1 Key findings

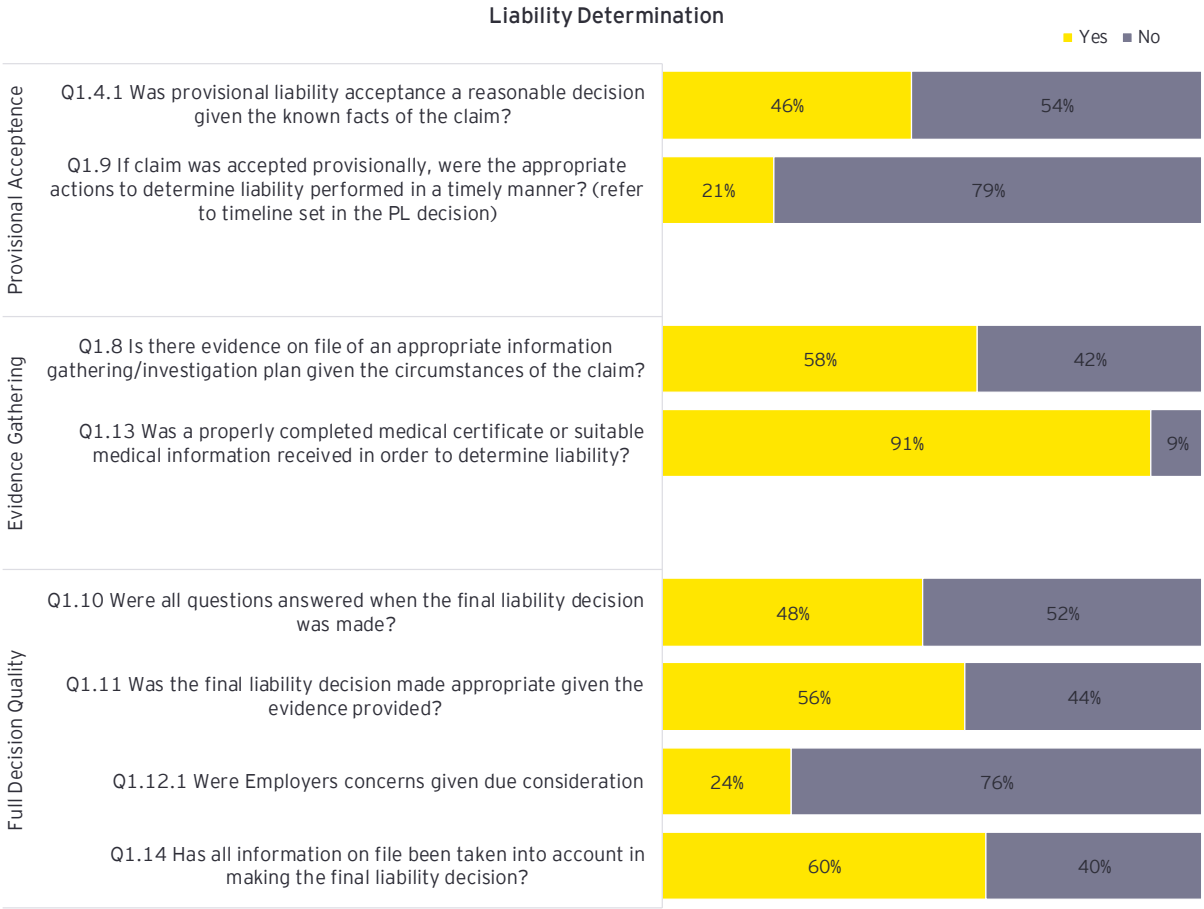
Liability determination was one of three main areas of concern identified during the review. The key findings regarding the determination of liability are:

- Consistent with the findings from the initial review, it was considered that there is an over-reliance on the use of provisional liability when claims could be accepted at initial notification
    - Of the 85 claims reviewed, 66 were accepted provisionally. For 35 of these claims (54%), it was considered there was sufficient information available at notification to accept liability. There appeared to be no need to accept the claims provisionally. Of the 31 claims that the reviewers concluded were appropriately accepted provisionally, 18 (58%) were considered to have unanswered questions when liability was accepted. See below for additional comments on provisional liability
- A properly completed medical certificate was received in 91% of cases
- There appeared to be an inadequate understanding of the facts of an injury that would enable an informed liability decision to be made. For example, the reviewers found:
    - That there was evidence of appropriate information gathering/investigation given the circumstances of the claim in 58% of claims reviewed
    - That all questions were answered at the time of making the final liability decision in 48% of claims reviewed
    - That all the information on the file had been taken into account when the final liability decision was made in 60% of claims reviewed

  This is not to conclude that the final liability decision was incorrect; however, it indicated to the file reviewers that there was either information available that was not used or there were areas of uncertainty that were not investigated in making the final liability decision in almost 50% of claims.
- For 23 claims reviewed (27% of the sample), the employer expressed concern regarding causation of the claim. 10 of these were psychological injury claims (refer to the next bullet). In 19 of the 23 claims, the reviewers considered that the employer's concerns were not appropriately investigated or addressed
- 12 psychological injury claims were reviewed. For 10 of these claims, there was evidence on the file that the employer had expressed concerns regarding the causation of the injury. It was considered that the employer's concerns were fully investigated for only 1 of these 10 claims. See further below for more comments on the management of psychological injury claims.

5.2 Detailed results

The key questions asked, and the responses recorded, for the 85 claims reviewed are summarised in the following graphic:



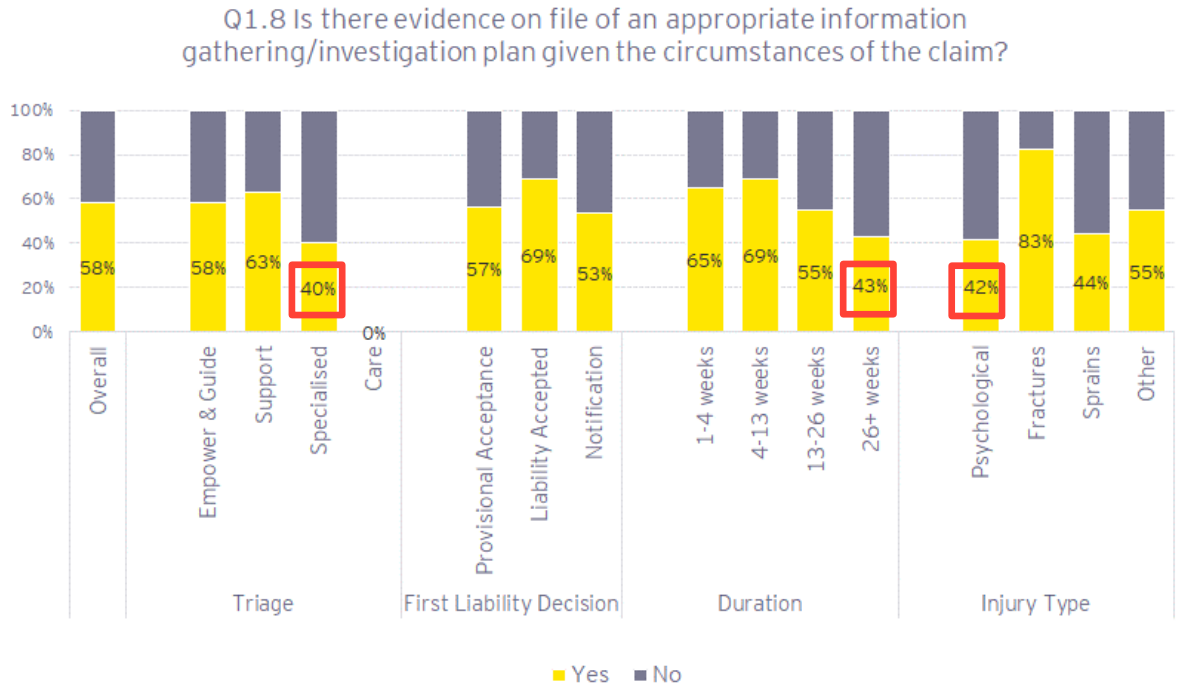
5.3 Provisional liability

Regarding the use of provisional liability:

- Of the 85 claims reviewed, 66 were accepted provisionally. For 35 of these claims (54%), the reviewers considered that there was sufficient information available at notification to accept liability, and that there was no need to accept the claims provisionally
- Of the remaining 31 claims (with provisional liability acceptance considered to be appropriate), 18 (58%) claims appeared to have unanswered questions when liability was subsequently accepted. Although the provisional acceptance of the claim was considered to be the correct decision, the additional time afforded by this decision did not appear to be used to thoroughly investigate the circumstances surrounding the claim
- Of the 35 claims that should have had liability accepted immediately, 14 remain with a liability status of provisional although a number remain open and have a first liability status date dating back to March 2019. Of the remaining 21 claims, the average number of days for a full liability decision was 113 days, with the longest duration being 275 days.

5.4 Lack of evidence gathering and investigation

The following graph looks more closely at the question of evidence collection and investigation across the various segments of the sample that were analysed.



We note the following on the graphic above:

- Relative to other segments, psychological injury claims (also correlated with the Specialised triage segment) demonstrate poorer evidence gathering / investigation, with 42% of the files reviewed considered to demonstrate appropriate evidence gathering/investigation
- 35 claims were identified where it was assessed that there was a lack of evidence on file of appropriate information gathering. 7 of these were psychological injury claims. Of the remainder, in 13 cases the worker was not interviewed to establish the full facts of the incident. In 14 cases the employer was not interviewed, with 10 of these cases overlapping. That is, in 10 cases neither the worker nor the employer was interviewed to establish the full facts of the incident
- The concerns noted by the file reviewers included:
  - Indications of pre-existing conditions which were not investigated
  - Investigations were begun but not completed or reports were received after liability decisions had been made
  - An apparent lack of enquiry into the circumstances surrounding the injury and how it occurred
- Of the 26+ week claim cohort, 12 claims (57% of the cohort) showed a lack of evidence gathering. It is not clear if this was related to these claims being incurred in the first half of 2019 (during the Guidewire transition) or if the lack of evidence gathering had contributed to these becoming long-term claims. Four of this cohort were psychological injury claims.

5.5 Psychological injury claims

We make the following comments on the 12 psychological injury claims reviewed:

- For 10 of the 12 claims, the employer expressed concerns regarding the causation of the injury. For only 1 of these 10 claims did it appear that the employer's concerns were fully investigated
- This review identified instances in which an incorrect interpretation of Section 11A of the Workers Compensation Act appeared to be applied (in the view of the reviewers, 8 of the 12 claims had cause for section 11A to be considered). By way of explanation, a psychological claim only becomes valid if the condition is work related and arose from the unreasonable actions of the employer. The reviewers considered that too often, it was assumed that the employer's actions were unreasonable when the evidence recorded on the file indicated that potentially, they were not
- The issues raised by the reviewers included:
    - Employer raising valid concerns; however, no evidence of a factual investigation being carried out
    - Investigations carried out that supported the employer's concerns, however, the report appeared to be ignored
    - Investigations were carried out but not considered to have been acted on in a timely manner (see example below)
    - The existence of psychological factors unrelated to employment which were apparently not given adequate weight when considering liability
- Other concerns that the reviewers found with the management of psychological injury claims included:
    - 9 of the 12 claims were considered to have unanswered questions regarding causation when the final liability decision was made. Given the evidence available on the file at the time of the decision, the final liability decision did not appear appropriate
    - 7 of the 12 claims were considered to have only a generic injury management plan that did not meet the requirements of the Act, and for 3 of the remaining claims, the IMP was not developed until 4 months after the date of notification. This means that for 58% of this cohort, the reviewers found that there was no clearly articulated plan regarding returning the injured worker to health or employment.

Following is an example of a poorly managed psychological injury claim. This claim was notified on 10 April 2019 and liability was fully accepted on 5 November 2019. The reviewer considered that the claims manager organised for the appropriate investigations to be carried out, however, the results of the investigation did not appear to have been acted on in a timely manner. This appears to have resulted in expense being incurred for a claim that should have been denied or at least disputed:

> *"The claimant was counselled because of comments she made towards her fellow workmates. For example, one employee complained that the claimant called her a "space cadet" because she missed some shifts. The employer was duty bound to counsel the claimant and this was done in a reasonable manner. A factual investigation was completed and received on 10/6/2019. This report confirmed the reasonableness of the employer's actions. Despite this, the claim was not disputed pursuant to Section 11A and a full acceptance was granted on 5/11/2019. The claim was then sent to outside appointed lawyers to comment on whether the worker had a legitimate claim. The solicitors advised that the employer would most likely be found to have acted reasonably and the claim should be formally disputed pursuant to Section 11A. This was done on 8/1/2020 and nothing has been heard from the claimant since."*

5.6 Other concerns raised by the reviewers

Apart from concerns regarding the psychological injury claims that are documented above, the main concerns expressed by the reviewers related to what were considered as inadequate factual investigations to enable a clear understanding of the workplace accident and associated injury. To illustrate these concerns, a number of comments made by the reviewers are included below. While relating to specific claims, these comments are representative of the issues identified:

- It was considered that the worker had clear degenerative conditions and other pathology, but there did not appear to be an attempt to understand the injured worker's pre-accident medical history and whether the fall was the reason for his incapacity

- Documentation on the file was considered to be poor, such that the mechanism of the claimant's injury remains unclear. The first certificate referred to an aggravation, but it was unclear what happened when he sustained this aggravation. Further, the file suggested to the reviewer that it is unclear whether any incident happened at work, and there was an additional complication of another claim in relation to an earlier alleged incident

- The reviewer noted that the worker's version of the event was markedly different from the employer's version, and there were external, non-work related factors, that may have contributed to the condition. None of these potential red flags appeared to have been investigated and there was no expert opinion linking the worker's condition to the incident

- The claimant had an extensive history of shoulder problems, including previous operative treatment, and a recent (and potentially significant) incident/fall at work. The reviewer considered that additional medical investigations and an assessment of the previous injury were warranted, which did not occur

- The employer was advised by two employees that the worker had received his injury at home. The claims manager did initiate requests for clinical notes from the nominated treating doctor (NTD) but did not appear to request them from the worker's chiropractor. The reviewer found limited information in the case notes to indicate discussions were held with the employer to provide an outcome to the investigations. The employer did confront the worker with the allegations and provided minutes of the meeting to EML, but the reviewer found little indication that the employer's concerns were satisfactorily resolved.

6. Triage of claims

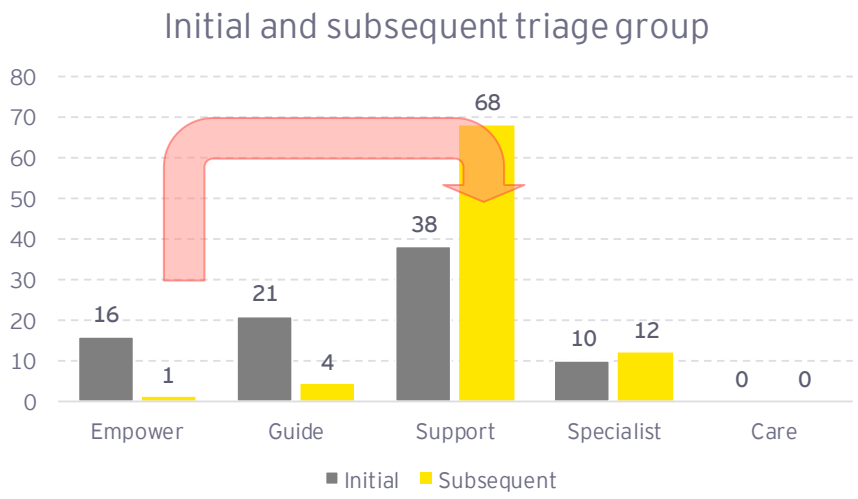
6.1 Key findings

The key findings regarding the triage of claims are:

- One of the key findings of the initial review was that claims were being wrongly triaged and not remedied in a timely manner. This review also found that many claims that were initially triaged to Empower or Guide were subsequently moved to Support; however, this movement occurred in a more timely manner than identified at the initial review. There appear to remain a number of claims taking longer to transition than the triage "model" should allow
- Of 42 claims reviewed that were initially triaged into Empower/Guide, 5 remain in that category. The remainder were moved to the Support segment
- Empower claims took on average 18 days to be moved to Support (this includes two outliers that took 42 days and 50 days respectively)
- Guide claims took on average 31 days to be moved to Support (this includes two outliers that took 114 and 115 days respectively)
- Of the 38 claims that were initially triaged to Support, 36 have remained in that segment.

6.2 Detailed results

The following graphic shows that the majority of claims reviewed ended up in the "Support" category. The 10 claims that started in the "Specialist" category were all psychological injury claims.

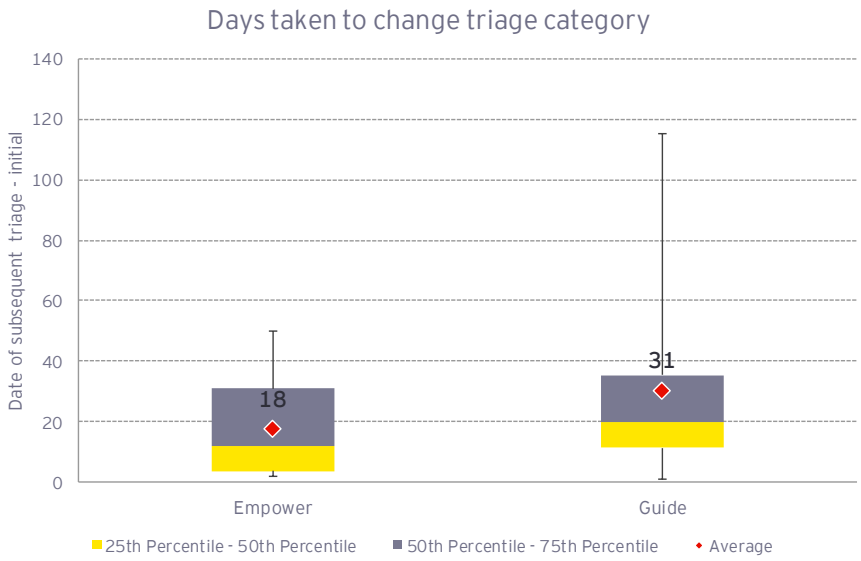


The following table shows the same data in a slightly different manner, highlighting that very few of the claims reviewed that commenced in Empower/Guide remained in Empower/Guide.

		Subsequent Triage				
		Empower	Guide	Support	Specialist	Care
Initial Triage	Empower	1	1	14	0	0
	Guide	0	3	18	0	0
	Support	0	0	36	2	0
	Specialist	0	0	0	10	0
	Care	0	0	0	0	0

The following graphic shows the number of days taken for the claims to be moved to the necessary segment:

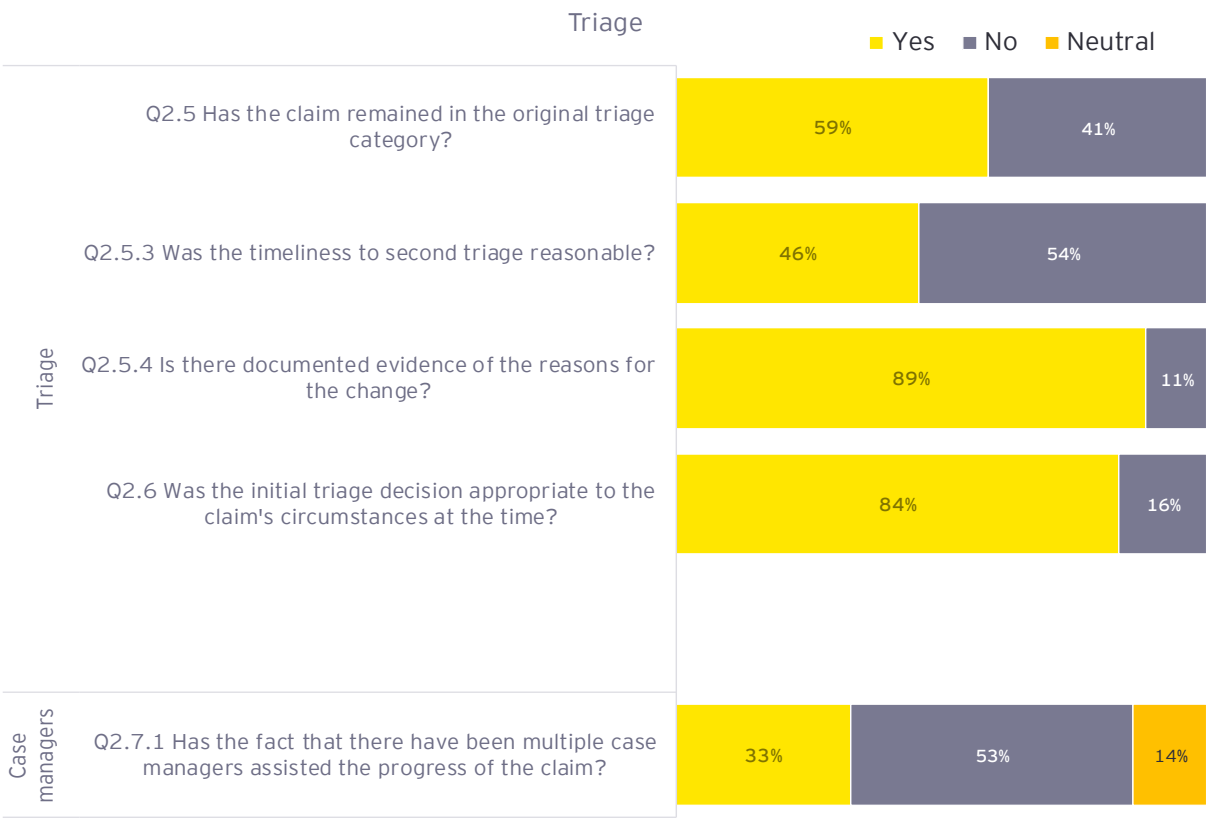
- Empower claims took on average 18 days to be moved
- Guide claims took on average 31 days



For comparison, at the initial review, the time taken to move claims to the required level of support was:

- For Empower claims, it took on average 90 calendar days to move claims
- For Guide claims, it took on average 32 calendar days to move claims

The key questions asked, and the responses recorded, for the 85 claims reviewed are summarised in the following graphic:


Triage
Yes
No
Neutral
Triage
Q2.5 Has the claim remained in the original triage category?
59%
41%
Q2.5.3 Was the timeliness to second triage reasonable?
46%
54%
Q2.5.4 Is there documented evidence of the reasons for the change?
89%
11%
Q2.6 Was the initial triage decision appropriate to the claim's circumstances at the time?
84%
16%
Case managers
Q2.7.1 Has the fact that there have been multiple case managers assisted the progress of the claim?
33%
53%
14%

7. Injury management

7.1 Key findings

Injury management was one of three main areas of concern identified during the review. The key findings regarding injury management (IMP) are:

- Consistent with the findings from the initial review, it was identified that injury management plans (IMPs) were often generic or basic and in many instances, they were not appropriately updated to reflect injured worker's changing circumstances
- Of the 85 claims reviewed, 72 had an IMP prepared. The IMP was considered appropriate to the needs of the injured worker in 37 of these claims (52%). Furthermore, the plan appeared to be adhered to or reviewed on an ongoing basis in 47% of claims reviewed
- Consistent with findings from the initial review, claims management was considered to be reactive rather than pro-active. The reviewers found that the case manager was pro-actively involved in claims management in 42% of claims reviewed, and the case manager was pro-active once a rehabilitation provider had been appointed to a claim in 56% of claims reviewed
- The preparation of an IMP was considered to be timely in 69% of cases
- The IMP fulfilled the requirements of Section 45 of the Act in 60% of cases.

It was found in many cases that there was inadequate engagement with relevant parties in the development of an IMP and return to work (RTW) plan. This indicated that the appropriateness of the IMP is likely limited by a lack of engagement with workers, employers and treating doctors. For example, the reviewers assessed that:

- There was adequate engagement with the worker in 65% of claims reviewed
- There was adequate engagement with the employer in 57% of claims reviewed
- There was adequate engagement with the treating doctor in 51% of claims reviewed
- The employer was involved in RTW conversations in 63% of claims reviewed.

The review found a number of inadequacies with the IMPs. For example:

- The injured worker's work capacity was considered within the IMP in 52% of claims reviewed
- The decisions and rationale behind injury management decisions were clearly documented in the case records in 55% of claims reviewed.

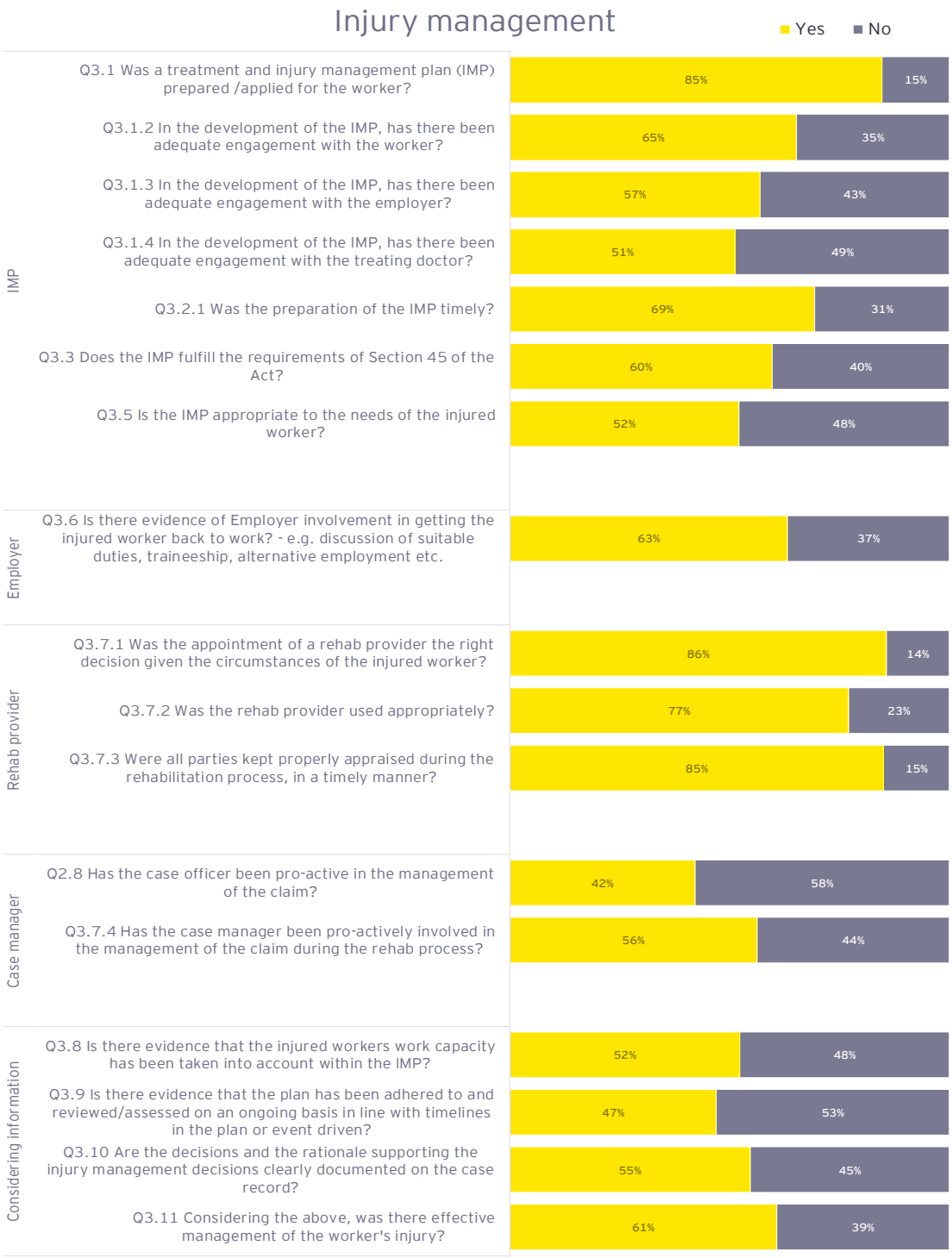
Regarding the use of rehabilitation providers, the review found that overall, there was appropriate use and relatively good outcomes from the involvement of rehabilitation providers. Out of the 85 claims reviewed, 48 claims were appointed to a rehabilitation provider, 30 claims were not appointed to a rehabilitation provider and in 7 cases, rehabilitation appointment was not applicable. The following responses expand upon the involvement of rehabilitation providers:

- Out of the 78 claims where use of a rehabilitation provider was considered applicable, the decision made was appropriate to the circumstances in 86% of instances
- Out of the 48 claims with an appointed rehabilitation provider, it was used appropriately in 77% of instances
- Out of the 48 claims with an appointed rehabilitation provider, all parties were kept properly appraised throughout the rehab process in 85% of instances.

Overall, the reviewers considered that there was effective management of the worker's injury in 60% of claims reviewed.

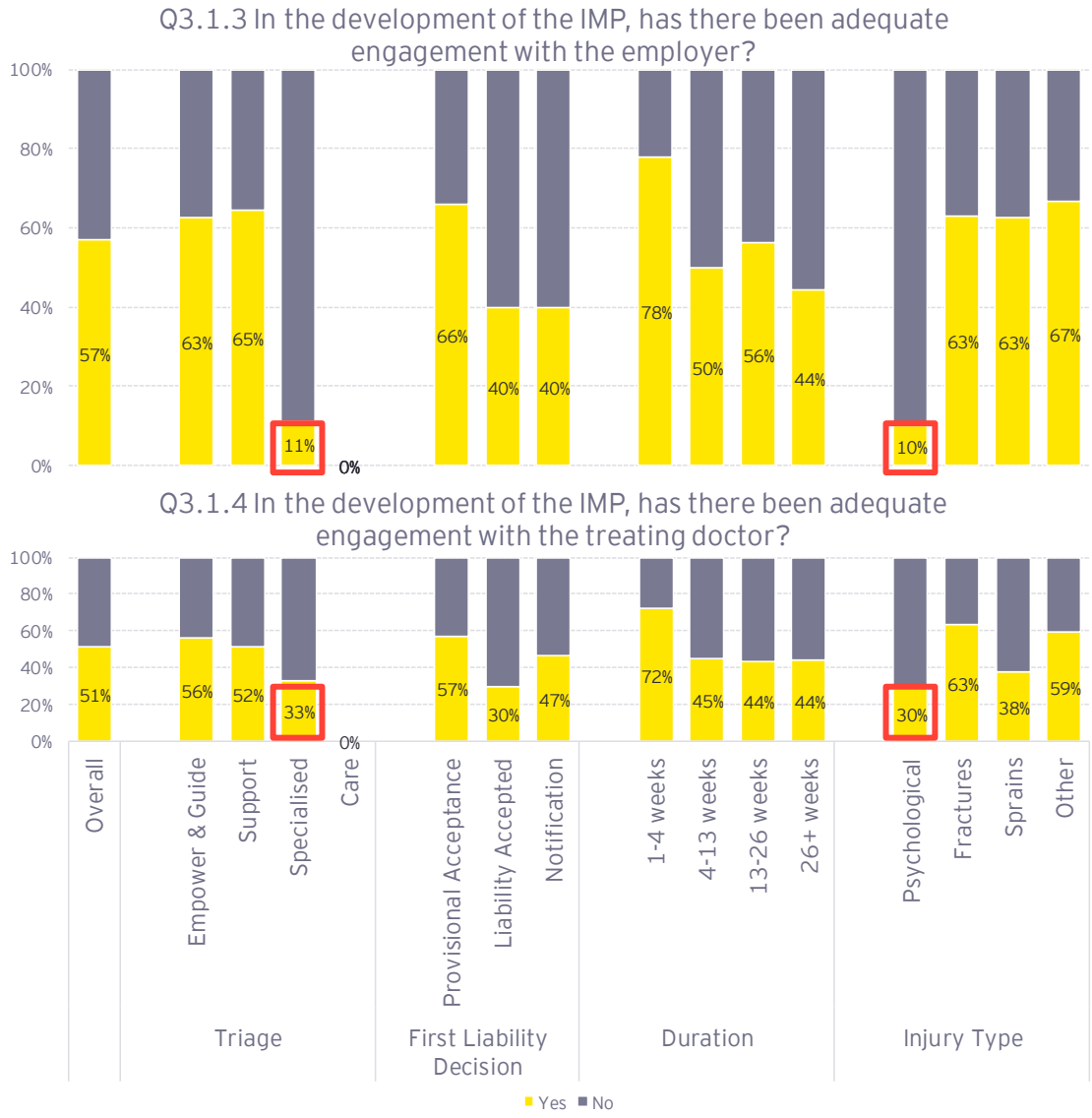
7.2 Detailed results

The key questions asked, and the responses recorded, for the 85 claims reviewed are summarised in the following graphic:



7.3 Engagement with employer and treating doctor

The following graph looks more closely at engagement with employers and treating doctors in the development of an IMP:



We note the following on the graphic above:

- A lack of engagement with the employer is evident with psychological injury claims (and correlated with the Specialised triage segment)
- Engagement with the treating doctor is lowest for psychological injury claims (and correlated with the Specialised triage segment)

7.4 Appropriateness and effectiveness of IMP

The following graphic looks more closely at the appropriateness of the IMP:

We note the following on the graphic above:

- The IMP was considered to be the least appropriate and effective for Specialised and psychological claims (which are generally in the Specialised triage category). The reviewers found that there was a consistent lack of evidence for these claims around employer involvement, setting RTW plans and goals and ongoing maintenance of the IMP. Reviewer comments on one poorly handled psychological claim included:

  > *"A rehab provider should be appointed as the claimant exhibits little interest in going back to work. This is also important as there are issues with to relations between fellow employees. The claimant is extremely aggressive and will have difficulty returning to the workplace. Close liaison between all parties is essential. The plan appears to wait for the worker to return on her own volition. This is extremely unlikely to occur."*

- The reviewers also found that the IMP template is not well constructed. Often the goals and actions were administrative goals and actions. Also, the responsibility for the goals and actions was mostly placed on the worker and was not representative of the stakeholders involved in the injury management of the claim. Examples of goal-related actions were the verbatim quoting of section 119 of the 1998 Act as the action for the worker, and quoting of the AMA surgery code as the goal and the description of the AMA code from the AMA handbook as the action

- Often there was no prospective element to the plan. The IMP is supposed to be prospective and aspirational:

"a plan for coordinating and managing those aspects of injury management that concern the treatment, rehabilitation and retraining of an injured worker, for the purpose of achieving a timely, safe and durable return to work for the worker.

An injury management plan can provide for the treatment, rehabilitation and retraining to be given or provided to the injured worker" (S42 1998 Act).

The templates seen during the review do not support this concept.

7.5 Case management

The reviewers considered that there was an overall lack of proactive case management by the case managers. This is consistent with the findings from the initial review.

Some common themes identified among the claims reviewed include:

- Injury management appeared to be less effective for claims of greater than 13 weeks duration. This may be due to deteriorating proactivity over time, with the file reviewers often noting that the case manager was most active when they were just appointed
- Often investigations were set in train but then either not followed up or the results, when available, appeared to be ignored
- Actions were taken at the instigation of other stakeholders such as the employer, the broker or the rehabilitation provider
- Generic IMPs issued that were not updated as the claim progressed
- Provisional liability being used but then no follow up investigations conducted (at times because there was nothing to follow up, indicating that there was no need to apply provisional liability)
- Interim PIAWE used with no follow-up to determine final PIAWE (refer to section 9)
- A comment that was often made by the reviewers was "the claim was left to take its course", the implication being that the case management was reactive. This is reflective of the summary points above.

7.6 Concerns raised by the reviewers

The main concerns raised by the reviewers related to inadequate IMPs. To illustrate these concerns, a number of comments made by the reviewers are included below. While relating to specific claims, these comments are representative of the issues identified:

- There was no evidence of consultation with the worker, employer or NTD; the plan included no injury management goals, with no actions were tailored to the worker's return to work
- Most action appeared to happen around the time that the case manager was appointed, however the plan was issued two months after approval for surgery and contained no goals
- No active injury management was apparent from the case notes and the plan; physiotherapy was prescribed but there was no evidence it was discussed with the worker or approved to proceed
- There is no documented plan; the certificates of capacity were difficult to read; it appeared that the physio is directing the claim. There is no RTW strategy apparent on the file apart from the initial views expressed by the physio
- There was limited evidence of active injury management, with the claimant showing little interest in returning to work. This is despite some evidence the claimant has some capacity. The level of correspondence and other communication from the rehab provider was considered to be inadequate.

8. Medical management

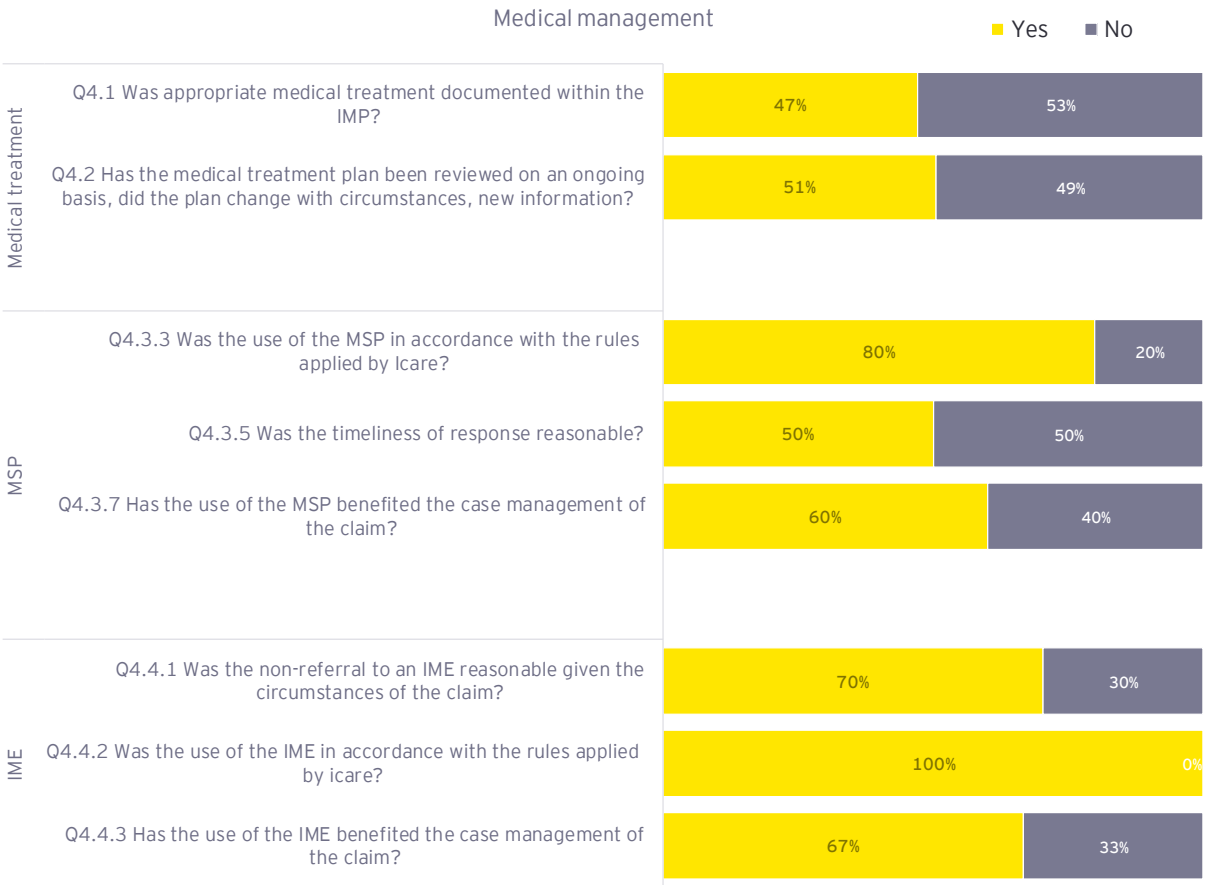
8.1 Key findings

The key findings regarding medical management are:

- Appropriate medical treatment was documented within the IMP in 47% of claims reviewed, and the medical treatment plan was updated on an ongoing basis and changed with new information in 51% of claims reviewed
- Consistent with findings from the initial review, there is very limited use of the Medical Services Panel (MSP). Out of the 85 claims reviewed, 5 claims (6%) involved the MSP in the approval of treatment:
  - 3 out of the 5 had timely responses from the MSP which benefited the case management of the claim
  - There were a limited number of cases where the claim may have benefited from the engagement of the MSP
- Out of the 85 claims reviewed, 9 claims (11%) were referred to an Independent Medical Examiner (IME):
  - All 9 referrals were in accordance with the rules applied by icare
  - In the remaining 74 claims that an IME was not engaged:
    - It was found that the non-referral to an IME was reasonable give the circumstances of the claim for 52 claims (70%)
    - For the other 22 claims (30%), it was thought that the circumstances of the claim would have benefited from the appointment of an IME
- Surgery was not required in 60 claims (71%), a surgery request was approved in 24 claims, and the surgery request was rejected for 1 claim
  - In all cases, surgery approval followed the processes set out by icare
  - Costs associated with surgery were properly scrutinised in 88% of cases
  - In the majority of these cases, the Nominated Treating Surgeon (NTS) effectively took over the management of the claim, producing an effective injury management plan. Overall, it was considered that relatively better outcomes were achieved in these circumstances.

8.2 Detailed results

The following graphic summarises the key outcomes of the medical management review:



8.3 Medical treatment plan

The reviewers' findings with regard to medical treatment planning are consistent with those described in the previous section regarding injury management planning:

- There has been an overall lack of documentation of medical treatment within the IMP as well as ongoing maintenance of the plan
- Claims with a duration between 1-4 weeks were considered to have the most appropriately documented medical treatment within their IMPs, reflecting a need for less or simpler medical treatment
- The reviewers expressed concerns that no medical treatment plan was set for 21 claims (25%)'.

Following is an example of the views expressed for this cohort of 21 claims:

> *"The first IMP after the Provisional Liability letter contains no information about RTW goal and only has responsibilities for the worker. The second IMP is exactly the same as the first except for changing dates. No medical treatment included. No reference to workplace rehabilitation. There was no medical management plan for the claim initiated by EML."*

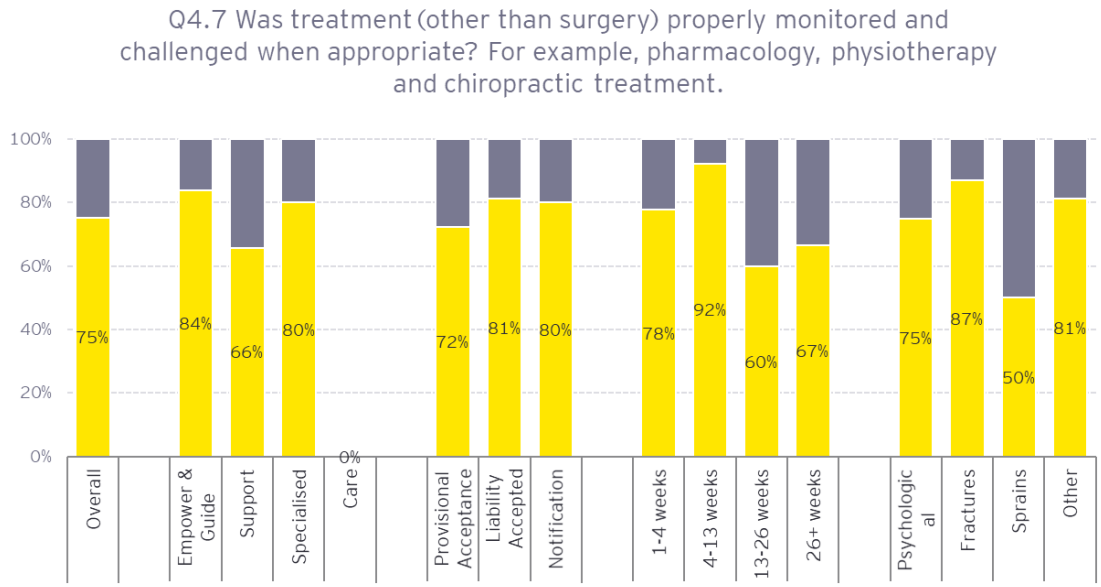
8.4 Use of an IME

There were 22 claims or 26% of the sample where the reviewers thought that referral to an IME would have benefited the management of the claim. The main reasons for this view were primarily:

- An IME would have determined that the nature of the injury and the nature of the workplace accident were inconsistent
- Past medical history, appropriately reviewed by an IME, needed to be considered in determining liability
- An IME would have assisted in assessing ongoing work capacity.

8.5 Monitoring of treatment costs (other than surgery)

The following graphic looks more closely at the monitoring of treatment costs other than surgery;



In 75% of cases, it was considered there was appropriate monitoring of medical costs (excluding surgery). It can be seen that for claims of longer duration, the reviewers concluded that the necessary scrutiny of medical costs decreased. This is likely related to the finding that case managers become less active for the longer duration claims.

"Sprain" injuries had a low level of treatment scrutiny, and this was primarily related to the number of chiropractic or physiotherapy visits. One claim in particular had 32 chiropractic treatments paid for in a 5 week period without an allied health recovery request evident on file.

In the 22 claims (25% of the sample) that the reviewers considered did not have sufficient scrutiny of medical costs, there is a high correlation with the view that they did not have a sufficient medical treatment plan documented in the IMP (15 of the 22 claims). This 25% cohort involved a range of possible over-servicing issues including diagnostic services, pharmaceuticals and allied health services.

8.6 Concerns raised by the reviewers

The main concerns raised by the reviewers can be summarised into two main categories: potentially inadequate medical management plans and limited use of IME's when further clarity around liability and incapacity would have benefited the management of the claim. A number of comments made by the reviewers are included below. While relating to specific claims, these comments are representative of the issues identified.

Medical management plans

- Results from radiology reports not appearing to initiate discussions between the case manager and the NTD, or get included in the IMP in any meaningful way
- The plan appearing to be largely retrospective
- Appropriate medical treatment not being documented in the IMP, despite indications that the appropriate medical management processes were followed: i.e. a copy of the certificate of capacity was sent to EML and the employer within 48 hours of issuance; the NTD, psychologist, psychiatrist and rehab consultant were authorized to communicate and share information and to attend treatment requested by treating providers and approved by EML; a certificate of capacity was obtained every 28 days; however, there was no mention of treatment or services that are required or have been approved.

Independent Medical Examinations

- Indications that a referral to an IME was considered by the claims officer but did not appear to have been followed up
- No involvement of an IME despite the apparent need to clarify whether the injury could have occurred as described, whether it was consistent with a delayed report of injury, and whether he was fit for work
- No involvement of an IME, despite the nature of the injury appearing to be suspicious and the claimant having a clear and reported past history of similar back problems; this suggested that referral to an IME would have been beneficial.

9. Payment of weekly benefits

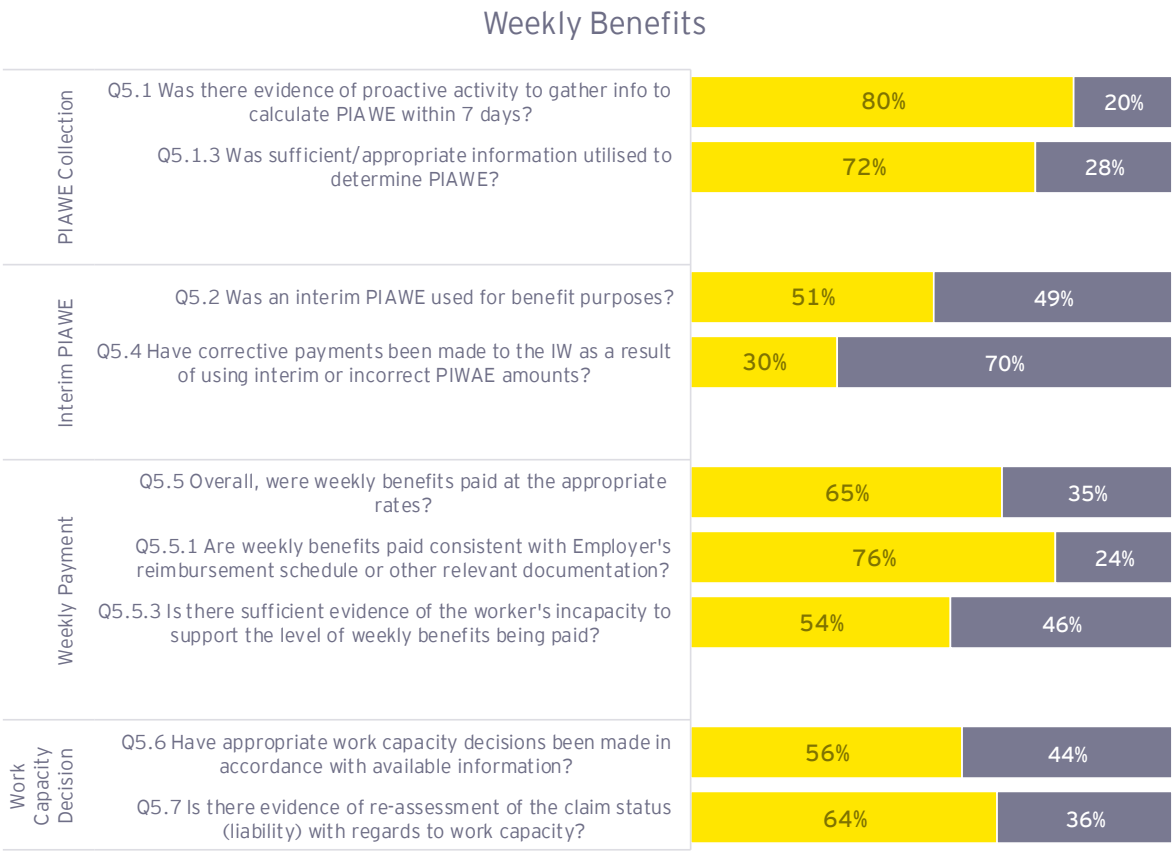
9.1 Key findings

The key findings regarding weekly payments are:

- It was considered that sufficient information was collected to allow a determination of PIAWE for 72% of the claims reviewed
- An interim PIAWE amount was used in around 50% of the files reviewed. Corrective payments had been made as a result of using interim PIAWE in 30% of these cases
- There was sufficient evidence of a worker's incapacity to support the level of weekly benefits being paid in 54% of files reviewed.

9.2 Detailed results

The detailed questions regarding weekly payments and the results of these questions are shown in the following graphic:



9.3 Concerns raised by the reviewers

The main concerns raised by the reviewers can be summarised into 3 main categories (as per the key findings in section 9.1). For` each of the 3 main categories, a number of comments made by the reviewers are included below. While relating to specific claims, these comments are representative of the issues identified.

Evidence to support PIAWE collection

Claim example 1: Interim PIAWE paid at $755.60 per week:

- EML did not appear to have collected wage information from employer, and made an interim PIAWE decision based on the Award
- However, the worker reported wages at a higher level than the interim PIAWE (close to $1,200 per week)
- There appeared to be no active follow up of PIAWE details, however the employer provided details 3 weeks post claim notification. This led to a secondary PIAWE decision, which did not appear to have been communicated to the worker or employer.

Claim example 2: PIAWE paid at $963.15 per week

- The initial PIAWE calculation was undertaken after discussions with the worker based on his assessment of ordinary earnings (this was $1,013.84 and multiplied by 95% in Guidewire to be used as the PIAWE)
- A subsequent PIAWE calculation was performed using the EML PIAWE calculator using wage information provided by the employer, resulting in a different PIAWE of $907.23
- There is also a case note by the claims manager to the employer that the PIAWE is a different figure of $983.31, with the reviewer unable to ascertain the source of this figure
- The latter figure of $983.31 was used for all PIAWE payments except for the first week which was paid using the figure based on the worker's reported wages ($963.15).

Interim PIAWE and corrective payments

Claim example 3: Interim PIAWE paid at $999.60 per week

- The initial PIAWE work capacity decision at was a reduction on the interim PIAWE that was included in the provisional liability acceptance letter (from $999.60 to $897.54)
- It did not appear that EML advised the employer of the reduction in PIAWE for over 3 months, as the employer continued to pay weekly compensation to the worker at the higher PIAWE rate for that period
- The employer subsequently commenced paying the worker at 80% of the corrected PIAWE rate, however there was no evidence on file that the change in PIAWE was advised to the worker
- The employer paid the worker 95% of PIAWE for 18 weeks, resulting in an overpayment to the worker for 5 weeks (the worker has no current work capacity so should have dropped to 80% of PIAWE after 13 weeks as a legislated stepdown).

Claim example 4: Interim PIAWE paid at $1,010.52 per week

- The employer provided wage records to confirm AWE, which accorded with what the employer advised the case manager over the telephone on the day provisional liability was accepted
- The PIAWE was based on the worker's ordinary hours of 36 hours per week, however the worker regularly worked overtime each week at increased hourly rates, which nearly doubled his base pay
- It did not appear that the employer or the injured worker raised this discrepancy as an issue to the insurer, however the injured worker did complain of being under financial stress (he was effectively receiving 60% of his entitlements).

Weekly benefits inconsistent with worker's incapacity

Claims example 5: PIAWE paid at $429.72 per week

- Payments did not appear to have been made in accordance with certificates of incapacity
- Some compensation appeared to have been paid for periods where there was not corresponding certificate of incapacity
- There was also another period in which the claimant was not paid even though there were certificates of incapacity and he was in hospital.

Claims example 6: Interim PIAWE paid at $950.00 per week

- The file indicated three certificates covering a total of six weeks incapacity, however three other certificates were difficult to read, and it was unclear if they were medical certificates other than they were stored in the medical certificate documents box
- The claimant was paid for 26 weeks incapacity, despite what the reviewer concluded was an apparent lack of medical support.

10. Data quality

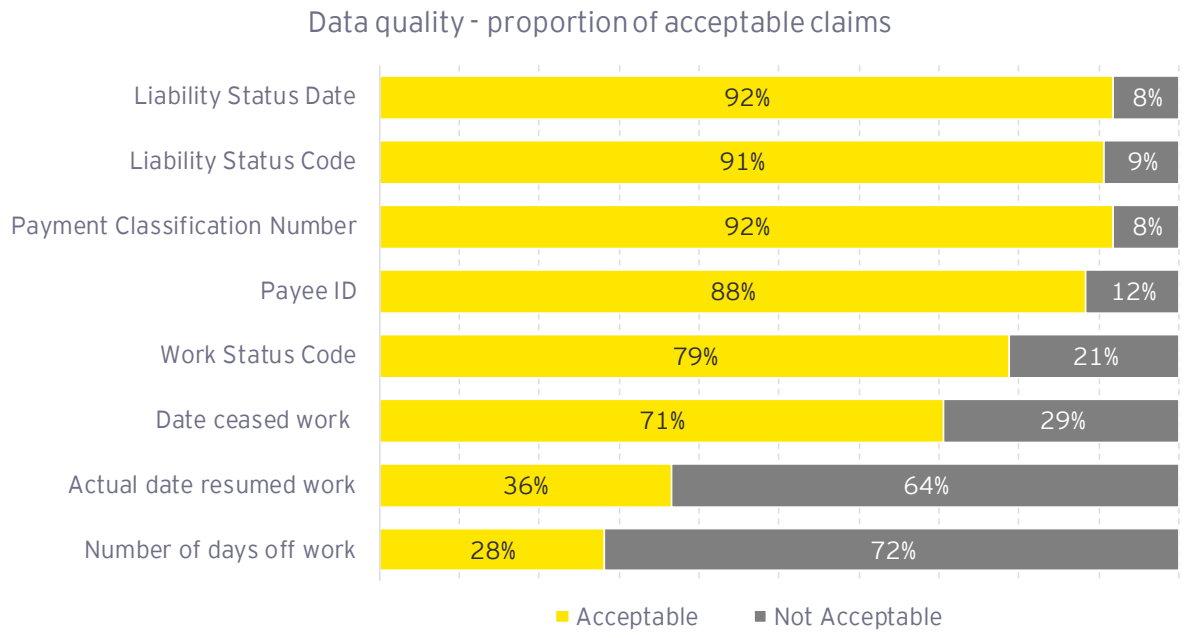
10.1 Key findings

During the review a number of data fields were assessed for accuracy:

- The data fields assessed as showing greater than 90% accuracy included:
  - Liability Status Date
  - Liability Status Code
  - Payment classification Number
- Payee ID had 88% accuracy
- The work status code was 79% accurate and the date ceased work was 71% accurate
- The actual date resumed work and number of days off work were shown to be highly inaccurate (36% and 28% respectively).

10.2 Detailed results

The detailed data fields and results from this claims file review are shown in the following graphic:



Appendix 1: Scoring

The claims file review questionnaire had a simple scoring mechanism built into it. Questions were structured such that a "yes" answer was a positive score and a "no" answer was a negative score. The scoring worked off these answers such that a "yes" scored a 1 and a "no" scored a 0.

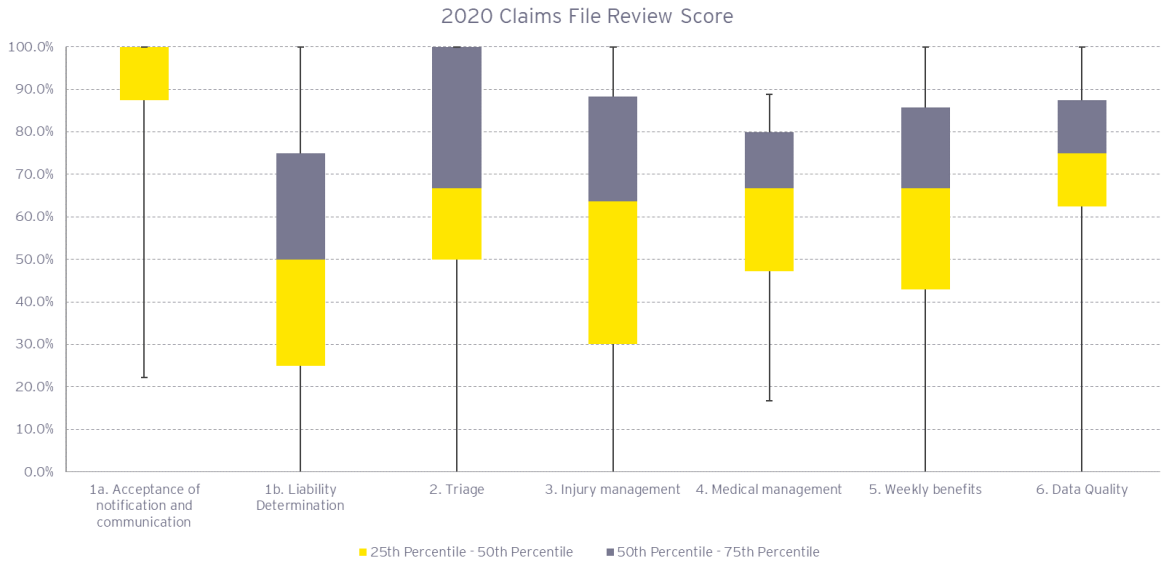
Not all questions were given a score. For example, the question "Did this claim involve surgery?" was not scored, however the subsequent question "Were the costs associated with surgery properly scrutinised?" was scored.

The scores were then added for each question within each section discussed in this report and divided by the total number of scored questions for that section.

For example, a score of 60% for injury management means that of the available injury management questions, 60% were answered in the positive "yes" and 40% in the negative "no".

The scores in an absolute sense have limited value; however, as further claims file reviews are carried out over time, it would be expected that the scores will increase as claims management improves.

The scores for this review are shown in the following graphic.



The plots for each section can be interpreted as:

- The median score is where the yellow and grey boxes meet
- The grey box shows the scores between the 50th and 75th percentile
- The yellow box shows the scores between the 25th and 50th percentile
- 99% of observations fall between the top and bottom "whiskers" of the graph.

The following table compares the scores in this review with those in the initial review.

We make the following observations on the score comparison:

- The scores for acceptance of notification and communication are high. The reduction in scores observed relates to a limited number of claims
- The scores for triage have improved, and this is primarily related to improved timeliness of moving claims to the correct level of support
- The scores for injury management, medical management and weekly benefits are effectively the same after taking into account the variability in the scores
- The scores for liability determination have decreased, and this is one of the main findings of the current review
- The fields assessed for data quality were not included in the first review.

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