REPORT OF REVIEW OF A SELECTION OF INSURER FILES RELATING TO THE INSURER INTERNAL REVIEW PROCESSES.

My qualifications and experience

Until mid-2017 I was a member of the NSW Bar when I retired from practice. I was a Claims Assessor under the provisions of the *Motor Accidents Compensation Act* 1999 between 2004 and 2017. Over the years at the Bar prior to my retirement I was briefed to appear in numerous motor accident cases and other types of personal injury claims.

Before being called to the Bar I practiced as a solicitor and was an accredited specialist in personal injury law.

For several years before my retirement I was a member of the Claims Assessors practice group.

During 2018 I was engaged by the State Insurance Regulatory Authority (SIRA) to be part of the panel interviewing applicants for the positions of Claims Assessor and Merit Reviewers under the provisions of the new motor accidents scheme.

I have been engaged by SIRA from time to time to examine and comment upon certain complaints relating to the conduct of insurers in relation to the handling of a number of motor accident claims.

I have been engaged by SIRA in the past to conduct reviews of a certain insurer's Motor Accident files.

Background and task

By letter received in November 2020 I was asked by SIRA to conduct an examination audit of a selection of insurer files relating to claims under the provisions of the *Motor Accident Injuries Act* 2017 (the Act). The relevant insurers were:

- Insurer A
- Insurer B
- Insurer C
- Insurer D

SIRA provided me with a list of files to be examined for each insurer as follows:

- Insurer A files
- Insurer B files
- Insurer C files
- Insurer D files

One of Insurer A's files on the SIRA list was not available and therefore I included another file which was on a reserve list. The unavailable file was 1 and apparently it had not been on the list provided by SIRA to Insurer A. The alternative file examined was 2.

Each of the files examined related to a claim where the claimant had sought an internal review of a particular decision pursuant to section 7.9 of the Act.

The letter of engagement dated November said as follows:

"The purpose of the review is to provide expert opinion on whether the insurers are meeting obligations under section 1.3 and 7.9 of the *Motor Accident Injuries Act* 2017 and associated Motor Accident Guidelines in their decision-making processes of internal reviews."

The file examinations were conducted on-line with the assistance of a representative of each insurer, and in each case, I received full co-operation. Each representative was also able to assist me with answers to questions relating to the insurer's procedures and policies. In relation to some of the files I asked for certain documents to be emailed to me, and whatever I asked for was provided.

I do not consider it necessary to report on each and every file examined but those details can be provided if required. However, I do specifically mention many of the files to highlight particular issues.

Insurer obligations under the Act and the Guidelines

Section 1.3 of the Act sets out the objectives of the Act. The parts of that section most relevant to this review are as follows:

(2) For that purpose, the objects of this Act are as follows—
(a) to encourage early and appropriate treatment and care to achieve optimum recovery of persons from injuries sustained in motor accidents and to maximise their return to work or other activities,
(b) to provide early and ongoing financial support for persons injured in motor accidents,
(d) to keep premiums for third-party policies affordable by ensuring that profits achieved by insurers do not exceed the amount that is sufficient to underwrite the relevant risk and by limiting benefits payable for minor injuries,
(f) to deter fraud in connection with compulsory third-party insurance,
(g) to encourage the early resolution of motor accident claims and the quick, cost effective and just resolution of disputes.

Section 7.9 of the Act sets up a procedure for certain decisions by insurers relating to claims to be reviewed internally before the need for them to be dealt with more formally by the Dispute Resolution Service (DRS). It provides as follows:

(1) A claimant may request an insurer to review any of the following decisions of the insurer made in connection with a claim made by the claimant (an ***internal review***)—
(a) a decision about a merit review matter,
(b) a decision about a medical assessment matter,
(c) a decision about a miscellaneous claims assessment matter.

(2) The claimant must provide the insurer with such information as the insurer may reasonably require and request for the purposes of an internal review.

(3) The Motor Accident Guidelines may make provision for or with respect to the following—
(a) the making of a request for an internal review,
(b) the time within which a request for an internal review is to be made,
(c) the individuals who may or may not conduct an internal review,
(d) the way in which an internal review is to be conducted (including requiring the giving of reasons for and supporting documentation in relation to an insurer's decision on an internal review).

Part 7[1] of the Guidelines sets out in some detail how an internal review may be requested and the procedure, requirements, and time limits to be observed by the insurer.

Guideline 7.17 sets out details of the insurer's obligations and duties to:

- act in good faith
- endeavour to resolve a claim as justly and expeditiously as possible
- act honestly and fairly while participating in any dispute resolution process
- not mislead the parties

In my view the observance by the insurers of the more detailed obligations imposed by the Guidelines are a particular part of the observance of the more general obligations set out in Section 1.3 and Guideline7.17. The internal review process is clearly designed to provide a quick and cost-effective mechanism to help ensure that claims are resolved as justly and expeditiously as possible, and that the Section 1.3 objectives are complied with. Therefore, compliance with the Guidelines is important, and when reviewing the files, I had regard to all the provisions of Part 7 and whether there had been compliance with the various Guidelines in each case. In particular I had regard to the following:

- 7.41 and 7,42 relating to the acceptance or rejection of a late application for an internal review
- 7.44 relating to the ways in which a claimant can request an internal review
- 7.45 relating to what an application must include
- 7.47 to 7.49 which requires and insurer to acknowledge an internal review application within 2 business days and whether it considers it has the power to conduct the review

[1] In this report the Guideline references are to version 5. I note that Guideline version 6 was recently introduced. There seem to be no relevant changes covering the issues of this report.

- 7.50, which provides as follows:
  If the insurer accepts that it has the power to conduct an internal review of the decision, the insurer must advise the claimant as soon as practicable, and preferably within seven days of receiving the application, of:

  > 1/ issues under review – the elements of the original decision that the insurer understands are under review
  > 2/ internal reviewer – the person allocated as the internal reviewer to conduct the internal review
  > 3/ additional information – any additional relevant documents or information required from the claimant for the internal review, and any additional information or documentation that the insurer has that is relevant to the internal review and has not previously been provided to the claimant
  > 4/ how to make contact – how the claimant can contact the insurer about the internal review, and how the claimant can contact the advisory service about the internal review.

- 7.54 which provides as follows:

  > The individual appointed by the insurer as the internal reviewer to conduct the internal review:
  > 7.54.1 must be someone who has the required skills, experience, knowledge, training, capacity and capability to conduct the internal review in accordance with the objects of the Act, the obligations and duties established in this Part of the Motor Accident Guidelines, and the claims handling principles established in these Guidelines,
  > 7.54.2 must not be someone who has been involved in making or advising on the insurer's initial decision, who has previously managed any aspect of the claim or who the initial decision-maker reports to or manages directly, and
  > 7.54.3 may be someone who has previously conducted an internal review in relation to the same claim.

- 7.55 which provides as follows:
  > The internal review must be conducted in the way that best supports the objects of the Act, given the facts and circumstances of the particular claim and the particular internal review, which may include undertaking the review on the papers, using teleconferences, video conferences or face-to-face meetings as appropriate.
- 7.56 which deals with how a review is to be conducted
- 7.57 to 7.60 which deals with new information
- 7.61 which deals with how the reviewer is to determine the application.
- 7.62 which deals with what decision a reviewer can make
- 7.63 which sets out the time limit for notifying a claimant of the outcome of the review.

- Table 7.1 which sets out the time limits for completing a review. Depending upon the nature of the review it is 14 or 21 days but can be extended up to a maximum of 28 days where further information is provided
- 7.67 which sets what details the insurer must provide when advising the claimant of the internal review decision.

I will deal with each insurer separately.

Insurer A

I reviewed the Insurers' files in November 2020 with the assistance of a Claims Consultant and I held a further phone conference with the Claims Consultant in December 2020 where I sought clarification of certain issues. I also communicated with the Claims Consultant by email where I requested copies of certain documents.

The Claims Consultant advised me that:

- The internal review personnel are completely separate to those making the decisions to be reviewed. The personnel in the Internal Review section do not handle claims. They are not part of the same division.
- Reviewers are only appointed if they have the requisite skills, experience, knowledge, and capabilities to undertake the task. Recruitment is merit based and competitive. Recruits are then trained extensively and that there is ongoing training and mentoring.
- All decisions are peer reviewed before completion and there are regular meetings of the internal review team.
- All DRS decisions relating to Insurer A's matters are particularly discussed by the review team.
- Generally late review applications are accepted although sometimes an explanation is asked for. None of the files reviewed by me where the review application was late were rejected.
- I was provided with copies of internal documentation provided to reviewers relating to the obligations imposed by the Guidelines.

Simply reviewing the files did not enable me to verify the above information but I observed nothing to indicate that it was incorrect in any way.

I now refer below to a number of files where there was some apparent breach of the Act or Guidelines or some other pertinent issue.

Claim number 1

The claimant in this matter requested several internal reviews. The review that I examined related to the question of whether the claimant had suffered a minor injury. That determination has a significant impact upon the level of benefits receivable by the claimant. The initial decision was that the claimant's injuries were minor.

The claimant sought a review out of time, but the insurer accepted the application. However, the insurer did not provide the claimant with the advice required by Guideline 7.50. Also, the Review was not carried out within the required 21 days. It was 11 day's late.

The Review Officer overturned the original decision, and the decision appears to me to have been reasonable. The reviewer sought to explain legal and factual basis for the review decision, but in my view the reasons were overly detailed and contained too much information. The Guidelines only require "brief reasons". I will comment later in this report on the issue of the writing of reasons.

Claim number 2

In this matter the claimant sought an internal review relating to the assessment of the quantification of weekly benefits. The review application was made in January 2020. Guidelines 7.47 and 7.50 were complied with, however the review was not completed within the required 14 days. It was due in January 2020 but was not completed until March 2020.

The review officer provided well written reasons and increased the amount of weekly benefits. There was no DRS application.

Claim number 3

In this matter the claimant sought five internal reviews relating to refusals to fund treatment. Four of the decisions were overturned on review. The fifth decision was not overturned on review but was overturned at DRS. One of the review decisions did not comply with the relevant time limit. The request for review was made in May 2019 but the review decision was not made until July 2019.

There also appears to have been non-compliance with Guideline 7.50 in relation to two of the review applications.

All of the review decisions, except for the decision that was ultimately overturned at DRS, appear to have been appropriate on the material available. However, it was difficult to understand the basis for original claims decisions. In my view this file illustrates the importance of an internal review system.

Claim number 4

The claimant sought an internal review relating to the assessment of his pre-accident earning capacity. The application was made in May 2020 and acknowledged on that date as per Guideline 7.47. However, there was no compliance with Guideline 7.50.
The review was due in May 2020 but was not completed until 22 calendar days after acknowledgement in breach of Guideline 7.63.

In the same matter the claimant also sought an internal review of a decision that the claimant was mostly or wholly at fault. The application for a review was made in November 2019 and acknowledged on that date. However, the notice required by Guideline 7.50 was not sent until 20 calendar days after acknowledgement. Also, the review decision was due in November 2019 but was not completed until 13 calendar days after the due date.

The review found that the claimant was not wholly or mostly at fault.

Claim number 5

The claims officer determined that the claimant was wholly at fault for the accident and the claimant lodged a review application in March 2020. That application was acknowledged as per Guideline 7.47 on 4 March but no notification as required by Guideline 7.50 was provided.

The review decision was due in March 2020 but was not completed until 35 calendar days after the due date. The original decision was overturned.

I asked the Claims Consultant for an explanation as to why the review decision was delayed. The email response is below:

> Can you say why the Review was delayed until April 2020?
>
> - In the second half of 2019 Insurer A experienced significant increases in the volume of new applications for Internal Review which exceeded anticipated workloads and which exceeded the capacity of the appropriate staff members to undertake Internal Reviews, and unfortunately, a significant backlog of overdue Internal Reviews developed.
> - Throughout this period of significant growth Insurer A sought to recruit additional appropriate staff members to undertake Internal Reviews and to complete their recruitment, onboarding and training to better meet the increasing demand and to reduce the backlog of overdue Internal Reviews. Additional supporting actions and improvements were implemented including new team structures, and clear and open communications with affected claimants.
> - Insurer A worked closely in consultation with SIRA as the backlog was reduced during the first half of 2020, and the backlog was eradicated completely by June 2020. During the period while Insurer A were reducing the backlog, the majority of Internal Reviews finalised were outside their Internal Review timeframes as a result of the large queue of open Internal Reviews on hand ahead of new applications being received.
> - In the 6-months since the eradication of the backlog in June 2020, Insurer A have finalised Internal Reviews within their timeframes.

Claim number 6

This was a review application relating to the assessment of the claimant's weekly benefits. The notification as required by Guideline 7.50 was not sent until 18 days after receipt of the review application. The review decision was required in May 2020 but was not provided until 14 calendar days after the required date.

The amount of weekly benefits was increased on review.

Claim number 7

In this matter the claims officer had determined that the claimant was wholly or mostly at fault for the accident. That decision was overturned on review.

The claimant's solicitors sought a review of the decision in December 2019. The application included well-written submissions relating to the issue of fault. The notification pursuant to Guideline 7.50 was not sent until January 2020.

The review officer overturned the original decision and found that the claimant was not mostly at fault. The reasons were very comprehensive, although in my view, they contained too much, and some unnecessary detail. I do note that Guideline 7.67 only requires "brief reasons" for the decision. I will make some comment later in this report relating to the issue of reasons.

Comments

I was provided with copies of the standard letters used by Insurer A for compliance with Guidelines 7.47 and 7.50. They are separate documents and appear to me to comply with all the requirements of those Guidelines.

I am satisfied that the review system which has been put in place by the insurers demonstrate a general intent to comply with the objectives of the Act, although as can be seen from the above, I found several instances where the Guidelines were not complied with. To that extent, the insurers were not resolving the claims as expeditiously as possible, and in relation to those files it cannot be said that the insurers had met all of their obligations under the Act and Guidelines.

The files which I reviewed did not demonstrate any reluctance to overturn or to change a claims officer's decision. The review team appears to operate as an entity separate to, and independent of, the claims handling section.

Insurer B

I reviewed the Insurer's files in November 2020 with the assistance of a Claims Consultant and I subsequently communicated with the Claims Consultant by email where I sought clarification of certain issues and requested copies of certain documents.

The Claims Consultant advised me that:

- the internal review personnel are completely separate to those making the decisions to be reviewed. The personnel in the Internal Review section do not handle claims and the section is located in a separate place.
- Reviewers are only appointed if they have the requisite skills, experience, knowledge and capabilities to undertake the task and that they are trained extensively and that there is ongoing training, including a "buddy" system for new recruits.
- All decisions are pooled and can be viewed by others in the section. Not every decision is peer reviewed but the review team have weekly meetings.
- Generally late review applications are accepted although sometimes an explanation is asked for. None of the files reviewed by me where the review application was late were rejected and the Claims Consultant was not aware of any late application ever being rejected.

Simply reviewing the files did not enable me to verify the above information but I observed nothing to indicate that it was incorrect in any way.

I now refer below to a number of files where there was some apparent breach of the Act or Guidelines or some other pertinent issue.

Claim number 1

In this matter the claims officer had determined that the claimant was wholly at fault and had non-minor injuries. The claimant sought a review of the fault decision, and also of a refusal to pay for treatment after the first 26 weeks.

The review application, covering both issues, was made in writing, and received by Insurer B in July 2019. A letter of acknowledgement was sent 2 calendar days after receiving the application in purported compliance with Guidelines 7.47 to 7.50. This was the only communication with the claimant between the receipt of the review application and the review decisions which were both made in the one determination 9 calendar days after the acknowledgement.

In my view the decision letter did not fully comply with the Guidelines in that it:

- Made no mention of whether the insurer accepted that it had the power to conduct the internal review as required by Guideline 7.49,
- Did not mention the issues under review as required by Guideline 7.50.1 and
- Did not give the identity of the internal reviewer as required by Guideline 7.50.2

The review decisions were in time and upheld the original decision. There was no DRS application.

Claim number 2

The claims officer had determined that the claimant was wholly at fault for the accident. The claimant sought a review in June 2020 which was acknowledged on the same day of receiving the review. This letter did indicate that Insurer B accepted that it had the power to conduct the review and did mention the issues under review. However, it did not specifically mention the identity of the person conducting the review.

The review decision was within time and upheld the original decision. In my view the reasons were not as well-written as they could have been and did not appear to me to be a correct decision on basis of the material available. The claimant made a DRS application.

Claim number 3

In this matter the claims officer had determined that the claimant had suffered a minor injury and that there was a level of contributory negligence. The claimant sought a review of both decisions in an application received in September 2019 and an acknowledgement letter was sent the day after the application was received. That letter was in purported compliance with Guidelines 7.47 to 7.49, and also Guideline 7.50.

However, the letter did not comply with Guideline 7.49 in that it made no specific mention of whether the insurer accepted that it had the power to conduct the review. Nor did the letter comply with Guideline 7.50 in that it made no mention of:

- The issues under review or
- The identity of the internal reviewer

The review decisions were made within time and overturned the contributory negligence decision, but upheld the minor injury decision. In my view both decisions were reasonable on the available material. There was no DRS application.

Claim number 4

The claims officer had determined that there was a level of contributory negligence. The claimant sought a review of the decision in an application received in June 2019 and an acknowledgement letter was sent 5 calendar days after receiving the application. That letter was in purported compliance with Guidelines 7.47 to 7.49 and Guideline 7.50.

However, the letter did not comply with Guideline 7.49 in that it made no specific mention of whether the insurer accepted that it had the power to conduct the review and it was not sent within 2 business days. Nor did the letter comply with Guideline 7.50 in that it made no mention of:

- The issues under review or
- The identity of the internal reviewer

The review decision was within time and overturned the original contributory negligence decision. In my view the decision reasonable on the available material. There was no DRS application.

Claim number 5

This was a Nominal Defendant claim relating to an unidentified vehicle. The claims officer had determined that there was no proper due inquiry and search and that a treatment application should be declined. The claimant sought a review of both decisions. The application relating to the issue of treatment was received in March 2020 and an acknowledgement letter was sent 5 calendar days after receiving the application. The application relating to the issue of due inquiry and search was received in June 2020 and an acknowledgement sent 5 calendar days after receipt. The letters were in purported compliance with Guidelines 7.47 to 7.49 and Guideline 7.50.

However, the letters did not comply with Guideline 7.49 in that they made no specific mention of whether the insurer accepted that it had the power to conduct the review. Nor did the letters comply with Guideline 7.50 in that they made no mention of:

- The issues under review or
- The identity of the internal reviewer

Both decisions were within time and maintained the original decisions. In my view the due inquiry and search decision was not well-written, and it was taken to DRS. The Claims Assessor held that due inquiry and search had been made.

The Claims Assessor's decision was made in November 2020, but as at 15 calendar days after the decision, which was the date of my file inspection, no steps had been taken by Insurer B to correct the position and there had been no communication with the claimant.

Claim number 6

This matter involved a review application as to whether the claimant was wholly at fault for the accident. The review application was made in June 2020 and acknowledged within time. On this occasion the acknowledgement letter did mention the issues for review and that Insurer B accepted that it had power to conduct the review.

The review was conducted within time and maintained the original decision. In my view the reasons could have been better expressed, although the decision seems to correct on the available material. There were long quotes from a number of documents which were unnecessary. I will make comment about the general standard of decision writing later in this report.

The claimant made a DRS application which upheld the review decision.

Claim number 7

This matter involved a review application as to whether certain treatment would be paid for. The review application was made in June 2020 and acknowledged within time. On this occasion the acknowledgement letter dated 4 calendar days after receiving the application, did mention the issues for review and that Insurer B accepted that it had power to conduct the review.

The review was conducted within time and allowed the treatment. In my view the reasons were short, succinct, and well-written, and the decision seems to correct on the available material. The original claims decision seemed to me to be unfortunate.

Claim number 8

This matter involved a review application as to the amount of weekly benefits. The Guidelines were followed except that the letter to the claimant did not specifically say who the review officer was to be. The original decision was upheld with well-written reasons.

Claim number 9

This matter involved a review application as to whether a full and satisfactory explanation had been given for a late claim. The claim had been rejected. The Guidelines were followed except that the letter to the claimant did not specifically say who the review officer was to be. The original decision was upheld with well-written reasons.

Comments

I am satisfied that the review system which has been put in place by the insurer demonstrates general intent to comply with the objectives of the Act, although as can be seen from the above, I found several instances where the Guidelines were not complied with. To that extent, the insurer was not resolving the claim as expeditiously as possible, and in relation to those files, it cannot be said that the insurer has met all of its obligations under the Act and Guidelines.

The files which I reviewed did not demonstrate any reluctance to overturn or to change a claims officer's decision. The review team appears to operate as an entity separate to, and independent of, the claims handling section.

I was informed by the Claims Consultant that the Insurer's practice was, and still is, to send only one communication in purported compliance with Guidelines 7.47 to 7.50. There seems to be no reason why this cannot be done provided the communication is sent out within 2 business days as required by Guideline 7.47.

Insurer C

I reviewed the Insurer's files in November 2020 with the assistance of the Claim Consultants and I subsequently communicated with the Claim Consultant's by email where I sought clarification of certain issues and requested copies of certain documents.

I was advised me that:

- the internal review personnel are completely separate to those making the decisions to be reviewed. The personnel in the Internal Review section do not handle claims. Internal Review team is part of customer relations and they do not report to the claims section. Claims and the Review teams have different locations.
- Reviewers are only appointed if they have the requisite skills, experience, knowledge and capabilities to undertake the task and that they are trained extensively and that there is ongoing training, including a mentor system for new recruits. I was advised that Insurer C is conscious of the need for ongoing training and have an intention to make such training more formalised.
- The review team have regular meetings and discussions about decisions. There is both formal and informal exchanges of information.
- Generally late review applications are accepted although sometimes an explanation is asked for. None of the files reviewed by me where the review application was late were rejected.

Simply reviewing the files did not enable me to verify the above information but I observed nothing to indicate that it was incorrect in any way.

I now refer below to a number of files where there was some apparent breach of the Act or Guidelines or some other pertinent issue.

Claim number 1

In this matter the claimant lodged a review application relating to treatment in May 2019 by telephone. It was acknowledged by letter the following calendar day which complied with Guidelines 7.47 to 7.50. The review was completed, and a certificate of determination sent within time, but unfortunately no reasons were provided.

I was informed that Insurer C sent only the one letter in purported compliance with Guidelines 7.47 and 7.50. This was the case with each file that I examined.

Claim number 2

An application was made for an internal review in June 2019 as to whether some treatment was reasonable and necessary, but was not sent by the claims section to the internal review section until 14 calendar days after which meant that Guideline 7.47 and 7.50 were not complied with and that the review could not be completed within the 14 day requirement.

The insurer contacted the claimant's solicitor and offered to complete the review but for some reason the solicitor declined the offer and made a DRS application[2].

DRS upheld the original decision to refuse treatment.

Claim number 3

The claimant sought an internal review in September 2020 relating to the question of earning capacity. It was not acknowledged until 6 calendar days after receipt which breached Guideline 7.47.

The review was completed within time and upheld the original claims decision.

Claim number 4

This matter involved the question of whether the claimant was mostly or wholly at fault for the accident. Claims had determined by notice issued in February 2020 that he was wholly or mainly at fault and a review application was made in April 2020 which was outside the 28 days. The insurer accepted the application and acknowledged in April which was within 2 business days.

The review decision was within time and affirmed the original decision. The claimant made a DRS application where it was held that it was a blameless accident.

Claim number 4

This was an internal review relating to the claimant's earning capacity. It was a complicated matter involving a family trust. The application for internal review was made in April 2020 and acknowledged next calendar day in compliance with the Guidelines.

Further information was sought from the claimant and discussions were held with the claimant and his accountant. There were also internal insurer meetings to discuss the matter. The review was completed within time and there was no DRS application. The reasons were concise and clear and brief and well written.

I mention this matter because it was a good example of a well-handled internal review.

Comments

I am satisfied that the review system which has been put in place by the insurer demonstrates a general intent to comply with the objectives of the Act and compliance was quite good. However, as can be seen from the above, I found a few instances where the Guidelines were not complied with. To that extent, the insurer was not resolving the claim

[2] It is difficult to understand why the solicitor would have refused to allow the internal review to be carried out. It seems that it would have been in the claimant's interest to have the review.

as expeditiously as possible, and in relation to those files, it cannot be said that the insurer has met all of its obligations under the Act and Guidelines.

The files which I reviewed did not demonstrate any reluctance to overturn or to change a claims officer's decision. The review team appears to operate as an entity separate to, and independent of, the claims handling section.

Insurer D

I reviewed the Insurer's files in December 2020 with the assistance of the Claim Consultants and I subsequently communicated with the Claim Consultants by email where I sought clarification of certain issues and requested copies of certain documents.

I was advised that:

- the internal review personnel are completely separate to those making the decisions to be reviewed. The personnel in the Internal Review section do not handle claims. Internal Review team is part of customer relations and they do
- not report to the claims section. Claims and the Review team have different locations.
- Reviewers are only appointed if they have the requisite skills, experience, knowledge and capabilities to undertake the task and that they are trained extensively and that there is ongoing training, including a "buddy" system for new recruits.
- The review team have regular meetings and discussions about decisions. There is both formal and informal exchanges of information.
- Generally late review applications are accepted although sometimes an explanation is asked for. None of the files reviewed by me where the review application was late were rejected.

Simply reviewing the files did not enable me to verify the above information but I observed nothing to indicate that it was incorrect in any way.

I now refer below to a number of files where there was some apparent breach of the Act or Guidelines or some other pertinent issue.

Claim number 1

This matter involved a review application relating to a claims decision that the claimant had a minor injury. The application was made out of time in July 2019 but accepted by the insurer. The application was acknowledged in ~~A~~august 2019 which was late and in breach of the Guidelines. The review decision was made in September 2019 which was also late and in breach of the Guidelines. The review affirmed the original decision.

In this matter only one communication was sent out in purported compliance with Guidelines 7.47 and 7.50. This is the case in relation to all files examined and was, and still

is, the Insurer's practice. As mentioned earlier in this report, there seems to be no reason why this cannot be done, provided it is sent out within 2 business days in order to comply with Guideline 7.47.

The wording of the standard letter contains the information required by Guidelines 7.47 to 7.50 although it does not specifically say that the Insurer accepts that it has the power to conduct the internal review as required by Guideline 7.49.

The above comments about the acknowledgement letter apply to all of the Insurer files mentioned below.

Claim number 2

This matter involved two applications for internal review. One related to a claims decision that the claimant had a minor injury and the other concerned the question of the amount of weekly benefits. Both requests for internal review were made within time. The request for review of the minor injury decision was made in May 2019 and the request for review of the weekly benefits decision was made in June 2019.

The minor injury request was not acknowledged until July 2019 and the review decision was made three days after acknowledgement. Both were late and in breach of the Guidelines.

The weekly payments request was not acknowledged until July 2019 and the review decision was made the same day. Both were in breach of the Guidelines.

The acknowledgment in the minor injury matter of July 2019 was only a short email which did not comply in any way with the requirements of Guidelines 7.47 to 7.50.

Claim number 3

This matter involved three applications for internal review, but I report on just two of them. One related to a claims decision that the claimant had a minor injury and the other concerned the question of the amount of weekly benefits. Both requests for internal review were made within time. The request for review of the minor injury decision was made in May 2019 and the request for review of the weekly benefits decision was made in June 2019.

The minor injury request was not acknowledged until July 2019 and the review decision was 10 calendar days after. Both were in breach of the Guidelines.

The weekly benefits request was not acknowledged until July 2019 and the review decision was made in August 2019. Both were in breach of the Guidelines.

The delays in this matter were particularly unfortunate because there had already been an email exchange with the claimant which indicated that the claimant was unhappy with the way the claim was being handled.

The minor injury review affirmed the original decision and the claimant has made a DRS application. DRS has not yet dealt with the matter.

The weekly benefits review resulted in the amount being increased.

Claim number 4

This matter involved a review application relating to a claims decision that the claimant had a minor injury. The application was made within time in August 2019 and acknowledged 8 calendar days after receipt, which was late. The review decision was made in September 2019 which was within time. The review overturned the original decision.

Claim number 5

This matter involved a review application relating to a claims decision that the claimant was mostly or wholly at fault. The application was made in September 2019 and acknowledged 13 calendar days after receipt, which was in breach of the Guidelines. The review decision was made in September which was within time. The review overturned the original decision and decided that the claimant was not mostly or wholly at fault.

Claim number 6

This matter involved a review application relating to a claims decision that the claimant had a minor injury. The application was made within time in November 2019 and acknowledged the day after receipt. Further information was received from the claimant's solicitors which extended the date for the review decision to December 2019. The review decision was made in accordance with the Guidelines in December 2019. The review overturned the original decision.

Claim number 7

This matter involved a review application relating to a claim's decision declining a request for treatment. A request for review was made in October 2019 but not acknowledged until 14 calendar days after the request was received, which was in breach of the Guidelines. The review decision was due in October 2019 but was provided late. The review varied the original decision and allowed some treatment.

Claim number 8

This matter involved a review application relating to a claim's decision concerning the amount of weekly benefits. A request for review was made in April 2020 and acknowledged on the same day. The review dated 3 calendar days after varied the original decision with a better outcome for the claimant.

Claim number 9

This matter involved a review application relating to a claims decision that the claimant was guilty of 30% contributory negligence. The application, which contained detailed submissions from the claimant's solicitors, was made in May 2020 and acknowledged 7 calendar days after receipt, which was late and in breach of the Guidelines. The review decision was 12 calendar days after the date of acknowledgement which was within time. The review overturned the original decision and decided that the claimant was not mostly or wholly at fault.

In my view the review decision was appropriate.

Claim number 10

This matter involved a review application relating to a claim's decision declining a request for treatment. A request for review was made in May 2020 but was not acknowledged, which was in breach of the Guidelines. The review decision was due in May 2020 but was not provided until 17 calendar days after the due date, in breach of the Guidelines. The review maintained the original decision.

Claim number 11

This matter involved two applications for internal review. One relating to the amount of weekly benefits and one relating to a claims decision that the claimant had a minor injury. Both acknowledgements were a few days late but both review decisions were within time.

Claim number 12

This matter involved a review application relating to a claim's decision concerning the amount of weekly benefits. A request for review was made in September 2020 and acknowledged next calendar day.

The review decision was due in September 2020 but was not made until 14 calendar days after the due date in breach of the Guidelines. The review decision varied the original decision with a better outcome for the claimant.

Comments

I am satisfied that the review system which has been put in place by the insurer demonstrates general intent to comply with the objectives of the Act, although as can be seen from the above, I found several instances where the Guidelines were not complied with. To that extent, the insurer was not resolving the claim as expeditiously as possible, and in relation to those files, it cannot be said that the insurer has met all of its obligations under the Act and Guidelines.

The files which I reviewed did not demonstrate any reluctance to overturn or to change a claims officer's decision. The review team appears to operate as an entity separate to, and independent of, the claims handling section.

I was informed that the Insurer's practice was, and still is, to send only one communication in purported compliance with Guidelines 7.47 to 7.50. There seems to be no reason why this cannot be done provided the communication is sent out within 2 day as required by Guideline 7.47. As mentioned above, the Insurer's standard acknowledgement letter does not mention that the Insurer accepts that it has the power to conduct an internal review.

SOME GENERAL COMMENTS

Compliance with the Act and Guidelines

My impression is that each of the insurers is taking seriously their obligations to conduct internal reviews in an independent and professional way. However, it is also clear that there have been significant breaches of the Guidelines, particularly of Guidelines 7.47, 7.50 and 7.63. These are all important Guidelines designed to ensure that claims are resolved justly, expeditiously, fairly, and in a cost-effective manner and that claimants are kept informed of developments.

I observed nothing to suggest that any of the insurers had not acted in good faith or honestly or had misled the parties.

From the claims decisions documents that I observed it appears that all of the insurers are appropriately advising the claimants of their rights to seek an internal review.

I saw no example of a review application being rejected because it was late or because it might not have complied strictly with Guideline 7.45.

In relation to Guideline 7.49, one of the insurers indicated that it was sometimes difficult to make a decision about accepting or rejecting an application within the 2 business day time limit. My view is that the Guideline should remain as it is. However, there does seem to be an issue about whether an internal review application can be made where no decision has been made[3]. Perhaps the Guidelines could clarify this matter. The issue did not arise in any of the files that I examined but it was mentioned to me in discussions.

In relation to Guideline 7.50, I am unsure why the guidelines impose a rather uncertain time limit. Perhaps the time limit should simply be within 7 days.

Some insurers send separate communications in compliance with Guidelines 7.47 and 7.50 whilst others just send the one communication to cover both, and each insurer adopts its own wording for such communications. My view is that it would be preferable

[3] The particular example mentioned to me was that of due inquiry and search in an unidentified vehicle case.

if the format of such communications was standardised so that every claimant received the same communications[4] irrespective of which insurer they were dealing with.
I did not observe any example of an insurer not accepting that it had the power to conduct an internal review.

In relation to Guideline 7.54 please see my comments above.

In relation to Guideline 7.55, nearly all of the reviews in the inspected files were conducted on the papers. There was really only one example of the use of the other methods mentioned in the Guidelines.

In relation to Guideline 7.57 I did observe examples of decisions being altered by the provision of new information, but most were dealt with without further information. My impression from discussions with insurer representatives is that there may be some reluctance to seek further information because of the very short time frames provided by Guideline 7.63. I note that under Guideline 7.64 the time extension of up to 14 extra days (with a 28 day limit) only applies where additional information is actually provided, and not just where such information is requested. I do not consider the time limits to be too short, having regard to the objectives of the internal review system.

Review Officer decision writing

In the body of the report, I made several comments about the good or otherwise standard of decision writing. The standard of decision writing in the files that I reviewed was quite variable. The Guidelines only require brief reasons, but in some instances the reasons contained long quotes from various documents which in my view were completely unnecessary.

It might be helpful if all Internal Reviewers were provided with some training about good decision writing. When I was a Claims Assessor we were provided with such training and it was extremely helpful.

Minor Injury

The Act adopts the term “minor injury”, and a claimant with a minor injury is generally not able to claim benefits after 26 weeks. In some circumstances, treatment expenses can be paid beyond the 26 weeks.

When reviewing the files, I noticed that a number of claimants who clearly had a minor injury as defined by the Act and Guidelines, but who were experiencing significant pain and discomfort, took strong exception to their injury being characterized as “minor”. They then lodged applications for review when they clearly had no prospect of success.

[4] Naturally, the communication would need to be adapted for the particular circumstances of the case.

The representative of one insurer described the fact that claimants with a minor injury are being told that treatment expenses are not likely to be paid after a few more months as a "friction point." This was consistent with my observation.

It was clearly a Government decision to adopt the term "minor injury". `

Because the term is in the Act and is likely to remain, I would suggest that perhaps the factsheet titled "Understanding Minor Injury" could do more to acknowledge that claimants who have a minor injury may well be suffering from significant pain and disruption of daily living. Also, perhaps the nature of the availability of treatment expenses beyond 26 weeks could be highlighted.

I gather that there is no provision in the Guidelines relating to the forwarding of the factsheet, but that the insurers have agreed informally to send it to claimants where there is a minor injury decision. I did not check whether this is being done, but in my view, it is important that claimants are properly informed about the meaning of the term as it used in the Act and Guidelines. I would suggest that consideration be given to including an appropriate provision in the Guidelines.

Please advise whether there are any aspects of this report that require further comment or clarification.

I enclose a copy of my invoice for your kind attention.

Yours faithfully,

JOHN WATTS