Nominal Insurer 2020 Quarter 2 claims file review

State Insurance Regulatory Authority

22 February 2021

Building a better working world

Table of contents

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 (2019 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.

This report documents the second quarterly review for 2020.

1.2 Methodology

The second quarterly file review involved assessing a sample of 120 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 120 claims were drawn from a stratified random sample using the following criteria:

- Date claim reported between 1 April 2019 and 31 March 2020
- 80 claims managed by EML and 40 claims managed by Allianz
- 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 current COVID-19 pandemic, the majority of this review was conducted remotely. We would like to thank icare for facilitating this access and ensuring IT resources were available to support the review.

1.3 Results of review

1.3.1 Areas that have improved

Between the 2019 review and the first 2020 quarterly review, three areas of improvement were noted. The second 2020 quarterly review confirms that these areas continue to be areas of better claims management performance. These areas included:

- 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

- The time taken to move injured workers into the correct category of support from the initial triage decision continues to improve
- In most cases, the decision to appoint a workplace rehabilitation provider (WRP) was considered to be appropriate, and when that appointment was timely, it appeared to result in relatively better injury management and outcomes for the injured worker.

This review has also found a number of other areas are beginning to show improvement since the 2019 review. Appendix 1 compares the scores between the three reviews that have now been conducted. The scoring analysis indicates that between the EML claim cohorts reviewed, the following areas have shown improvement[1]:

- Liability determination
- Triage
- Medical management of injuries
- Payment of weekly benefits.

Discussions with icare have indicated that there are a number of initiatives that have been implemented during 2019 and 2020 with the aim of improving claims management. If these initiatives are effective then the reviews conducted across the 2020 calendar year should show continuous improvement.

1.3.2 Areas identified for improvement

The first 2020 quarterly review identified three main areas for improvement, and these areas were consistent with the findings of the initial 2019 review. This second 2020 quarterly review has shown some improvement in each of these areas but confirmed that they continue to require further improvement. Comparisons between the two 2020 reviews conducted to date are made throughout the remaining sections of this report and in Appendix 1.

Liability determination

In approximately two thirds of the files reviewed, the reviewers considered that there was an adequate understanding of the facts of the injury that enabled 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 67% of claims reviewed
- It was considered that all questions were answered at the time of making the final liability decision in 66% 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 65% of claims reviewed.

In approximately one third of claims reviewed, this understanding of the facts surrounding the injury was not well understood. This is not to conclude that the final liability decision was incorrect; however, it indicates that in around one third of claims reviewed, 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.

[1] Note that no Allianz claims were reviewed during the 2002 first quarter review

Injury management planning

It has previously been identified that the effectiveness of the injury management plans was one of the primary causes of poor outcomes for injured workers. This review collected more insight into the injury management plans.

The analysis showed that the main reasons that the injury management plans were not effective were:

- The employer was not kept informed of the significant requirements documented within the plan
- The plan did not include goals or actions to achieve the goals that were reasonably likely to lead to a return to work

Overall, it was found that the injury management planwas prepared in a timely manner in 73% of the claims reviewed, however, it was found that the injury management plan was effective in only 52% of the claims reviewed.

Payment of weekly benefits

For the claims reviewed, it appears that weekly benefits were paid at the correct rate in 78% of cases. Weekly benefits are more likely to be incorrect in cases where an interim PIAWE was used (approximately 45% of files reviewed used an interim PIAWE):

- Where an interim PIAWE amount was used, corrective payments only appear to have been made in approximately 75% of the claims reviewed
- There appeared to be sufficient evidence of a worker's incapacity to support the level of weekly benefits being paid in 85% of files reviewed (this is an improvement from the first 2020 quarterly review)
- Weekly benefits appear to have been paid at the correct rate in 78% of claims reviewed.

Other areas for improvement identified in this review include:

Timely appointment of workplace rehabilitation providers (WRPs)

This review found that overall, there was appropriate use of WRPs. Section 7.7 discusses the effectiveness of WRPs in more detail. It was found that timeliness of appointment of WRPs was a key indicator of success. For those claims where the appointment was not considered timely, the WRP was nearly always ineffective. If the timely appointment of IMPs could be improved then it is likely that the effectiveness of the WRPs could be improved.

Management of psychological injury claims

Each of the three reviews has identified concerns with management of psychological injury claims. This review examined 20 psychological injury claims and concluded that 10 of these were managed well and 10 were managed poorly. There was a correlation found between the initial investigation of liability and the subsequent management of the claim. That is, claims where the issues surrounding the circumstances of the claim were thoroughly investigated appeared to be claims that subsequently had effective injury management plans and better outcomes for the injured worker. The opposite was also observed, where claims with less than thorough investigation of liability often had poor injury management plans and poorer outcomes for injured workers. This finding is likely due to the capability of the individual case managers handling these complex claims.

1.4 Summary

The 2019 review and the first 2020 quarterly review found a wide range of experience and capability amongst case managers. This lack of experience appeared to manifest itself in inconsistent decision making, insufficient investigation of matters such as liability causation and a general lack of pro-activity on the part of the case manager to progress the claim forward within reasonable timeframes.

This review has confirmed these observations, although areas of improvement across a range of case management activities have been observed. Appendix 1 compares the results of the three reviews completed to date across the range of case management activities assessed.

The last question of the reviews 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 49 files reviewed (41%). This is an improvement relative to the first 2020 quarterly review (48 files or 56% rated as negative). While the question is somewhat judgmental, the responses are supported by the factual findings presented throughout this report.

Albeit that this review has shown some improvement, an overall conclusion of the reviews to date is that there is a lack of pro-activity and in some cases challenge within the claims management process. This appears to permeate all aspects of claims management, including:

- Acceptance of claims provisionally but then failure to carry out the necessary investigations
- Leaving material questions surrounding the workplace accident and causation unanswered
- Receiving factual reports with no evidence on file that they were given appropriate review or consideration
- Relinquishing case management to either the surgeon or the workplace rehabilitation provider (WRP)
- Inadequate injury management plans that do not document goals and timeframes
- A non-questioning approach to the payment of diagnostic and other allied health service costs
- Mistakes being made with the payment of weekly benefits
- Actions and strategies not being carried out in a timely manner.

The case manager is key to ensuring optimal claims management, including coordination of injury management, medical management and liaising with the employer to get the injured worker back to work as soon as they have capacity. Each claim requires careful consideration of its individual facts and circumstances, with a tailored strategy that is carried out in a timely manner. Some timeframes are prescribed in legislation, however where they are not, the focus must be on efficient and effective claims handling, aligned to SIRA and community expectations (noting that often, SIRAs expectations in relation to timeframes are outlined in the standards of practice).

However, injury management plans were considered to be inadequate in many cases. Often the injury management plans were generic in nature without any detailed plan or goals outlined in them, and 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 often did not appear to meet the required criteria for injury management plans. 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 accordance with normal professional practice, neither EY, nor any member or employee thereof undertakes responsibility in any way whatsoever to any person other than SIRA in respect of this report. Neither the whole of this report, or any part thereof, or any reference thereto may be published in any document, statement or circular nor in any communication with other third parties without prior EY written approval of the form and context in which it will appear.

Further reliances and limitations are outlined in Section 11 of this report

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 2019 review). The 2019 review was conducted by three senior claims specialists including one authorised 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 second 2020 quarterly file review conducted during July and August of 2020 (the 2020 Q2 review). A previous report was prepared for the first 2020 quarterly review (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 second 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 2020 Q2 review involved:

- Using a consistent set of evaluation criteria to assess the files (predominantly the same criteria as used for the 2019 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
- Discussion of individual claim findings with icare during twice weekly status meetings held throughout the review
- 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.

3. Methodology and data

3.1 Data

A random sample of claims was extracted from the CDR data as at 31 March 2020 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.

In assessing decisions and action taken on individual claims regard has been had for:

- Workers Compensation Act 1987 (the 1987 Act)
- Workplace Injury Management and Workers Compensation Act 1998 (the 1998 Act)
- SIRA's Standards of Practice, expectations for insurer claims administration and conduct (SIRA's Standards of Practice)
- SIRA's workers compensation guidelines (SIRA's guidelines)

3.3 Claims sample

A stratified random sample of 120 claims was selected for this 2020 Q2 review. The strata used for the sampling were:

- 80 claims managed by Employers Mutual Limited (EML) and 40 claims managed by Allianz
- Date claim reported between 1 April 2019 and 31 March 2020 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].

[2] Time lost claim > 1 week off work

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 accident year claims. The mix of sample claims is broadly consistent with the mix of all claims.

Strata	Population %	Q2 sample #	Q2 sample %	Q1 sample #	Q1 sample %
Injury Type					
Fractures	32.2%	35	29.1%	37	30.8%
Other	39.7%	44	36.7%	44	36.7%
Psychological	9.6%	20	16.7%	18	15.0%
Sprains	18.5%	21	17.5%	21	17.5%
Initial liability status					
Provisional acceptance	69.6%	73	60.8%	77	64.2%
Liability accepted	15.4%	20	16.7%	20	16.7%
Notification	15.0%	27	22.5%	23	19.2%
Duration					
1-4 weeks	42.7%	37	30.8%	48	40.0%
4-13 weeks	33.3%	41	34.2%	38	31.7%
13-26 weeks	15.2%	26	21.7%	20	16.7%
26+weeks	8.7%	16	13.3%	14	11.7%

4. Notification acceptance and communication

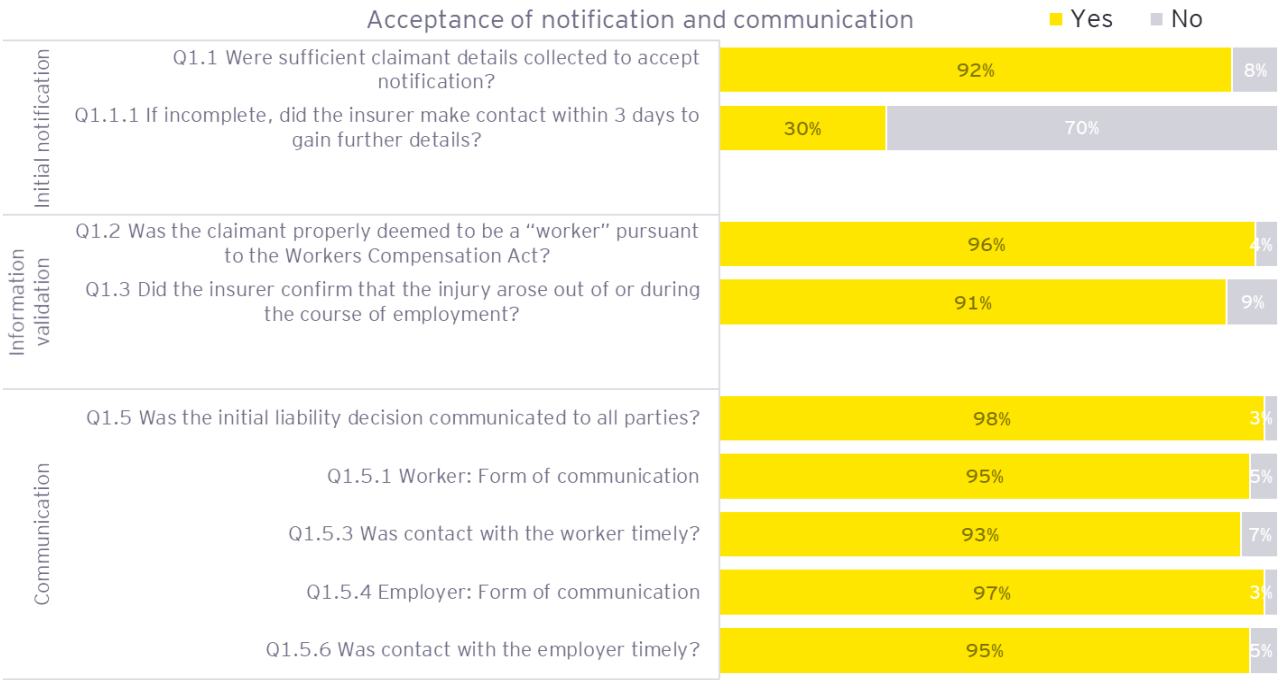
4.1 Key findings

The key findings regarding 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 92% of files reviewed (2020 Q1 review was 94%)
- The claimant was correctly deemed to be a worker under the Act in 98% of files reviewed (2020 Q1 review was 96%)
- 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 timely in 93% of the files reviewed (2020 Q1 review was 90%)
- The claims manager had not confirmed that the injury arose from or during the course of employment in 9% of files reviewed (2020 Q1 review was 14% of files reviewed). This aspect is elaborated upon in the next section regarding liability acceptance.

4.2 Detailed results

The key questions asked, and the responses recorded, for the 120 claims reviewed are summarised in the following graphic



Regarding the results above, we make the following observations:

- 8% of claims reviewed were not a compliant notification. From the sample size, this is only 9 claims and therefore question 1.1.1 is only representative of a very small sample size
- For 11 claims (9%), the case manager had not confirmed that the injury was caused by the claimant's employment. Of these claims:
  - 3 were psychiatric injury claims (discussed in section 5.5 below)
  - 3 were fractures
  - 5 were "other" injury types

  Some of the issues noted by the reviewers included:
  - Further factual or medical investigation being warranted, as the injuries sustained were not consistent with the duties carried out by the injured worker
  - Past medical history not being taken into account
  - Investigations begun but the final liability decision being made prior to these investigations being completed
- Regarding communication with the worker and employer, this was considered appropriate and timely in most cases (above 93%)
- The quality of notification acceptance and communication was similar between EML and Allianz
- Overall, for notification acceptance and communication, the results for the 2020 Q2 review are similar to the 2020 Q1 review (the two reviews are compared in Appendix 1).

5. Liability determination

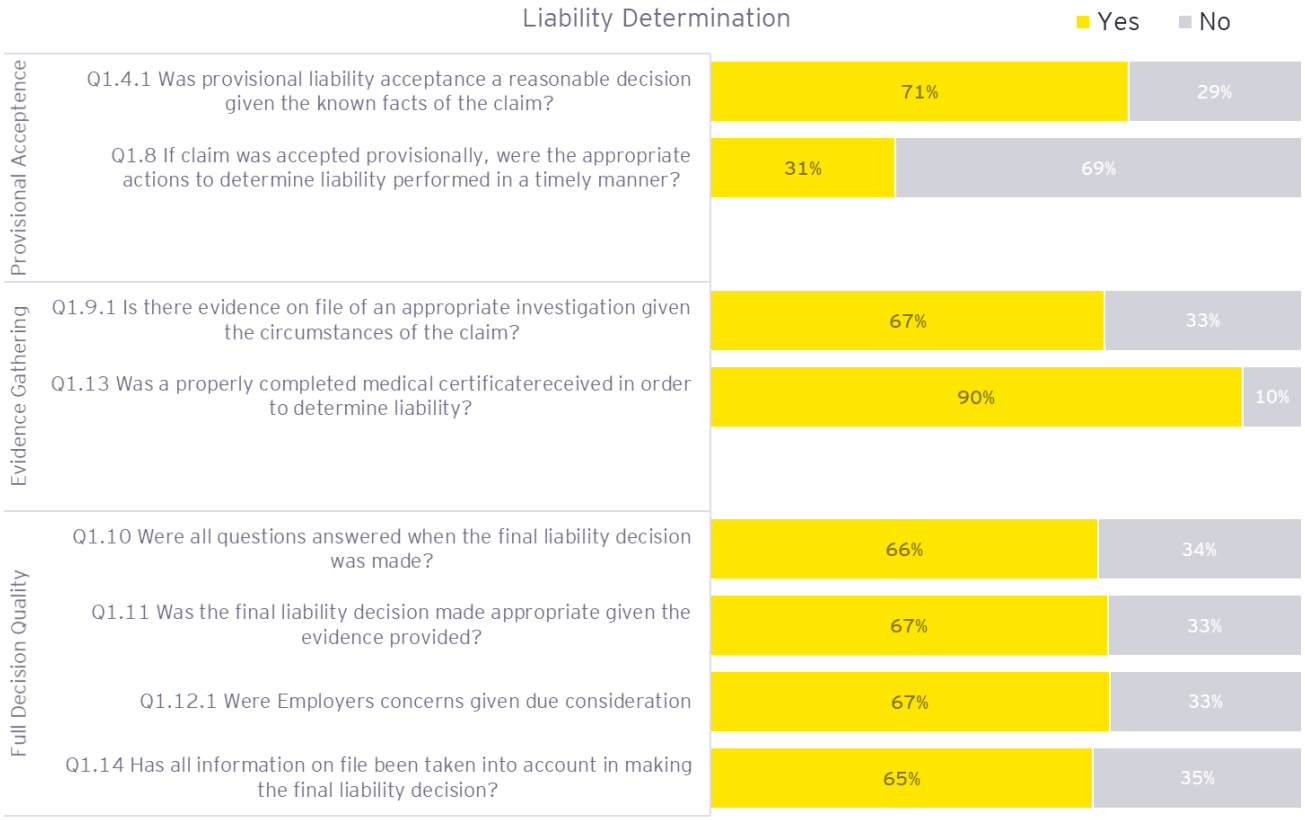
5.1 Key findings

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

- Consistent with the findings from the 2019 review and the 2020 Q1 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 120 claims reviewed, 80 (67%) were accepted provisionally. For the 2020 Q1 review this percentage was 78%
  - For 35 of these claims (44%), it was considered there was sufficient information available at notification to accept liability (that is, the worker was a worker who suffered an injury at work and employment was a substantial contributing factor. The employer did not express any concerns with the claim). There appeared to be no need to accept the claims provisionally. The use of provisional liability in these cases leads to a letter being sent to the injured worker outlining their entitlements under the period of provisional liability and that their claim will be investigated prior to liability being accepted. For these 35 claims, it was considered that there was nothing to investigate and no investigations were carried out
- 52 of the 80 claims ultimately had liability accepted (some claims were closed without liability being accepted). The average time to liability acceptance was 92 days or 13 weeks. In many cases this was outside the parameters of provisional liability (provisional liability may be paid for a period up to 12 weeks of weekly compensation)
- For approximately 20% of these 52 claims, it was considered that there remained unanswered questions at the time of liability acceptance. Primarily, these questions revolved around concerns raised by the employer or a lack of clarity around the incident that led to the injury
- Section 5.4 shows that for approximately one third of the claims reviewed, the reviewers raised concerns with the quality of the liability decision. This percentage for the 2020 Q1 review was approximately 45%
- Section 5.5 discusses the psychological injury claims assessed. There were some improvements noted for these claims between the 2020 Q1 review and the 2020 Q2 review. However, there are still a number of concerns with the management of these more complex claims, primarily surrounding the causation between employment and injury and with the injury management planning of these claims.

5.2 Detailed results

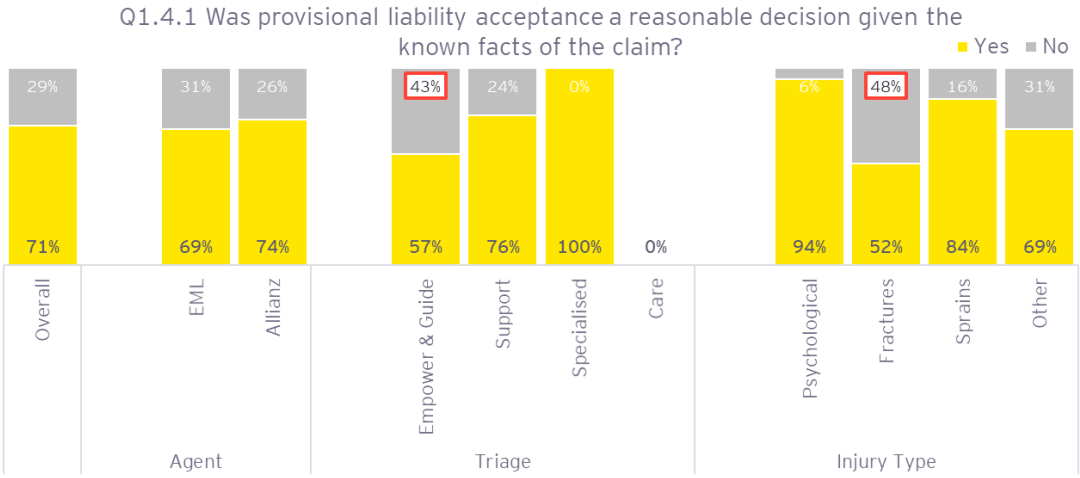
The key questions asked, and the responses recorded, for the 120 claims reviewed are summarised in the following graphic:



5.3 Provisional liability

In each of the 2019 review of the initial 2018 claim cohort, the 2020 Q1 review and the 2020 Q2 review, it has been found that a large proportion of claims are being accepted provisionally (up to 80% of claims).

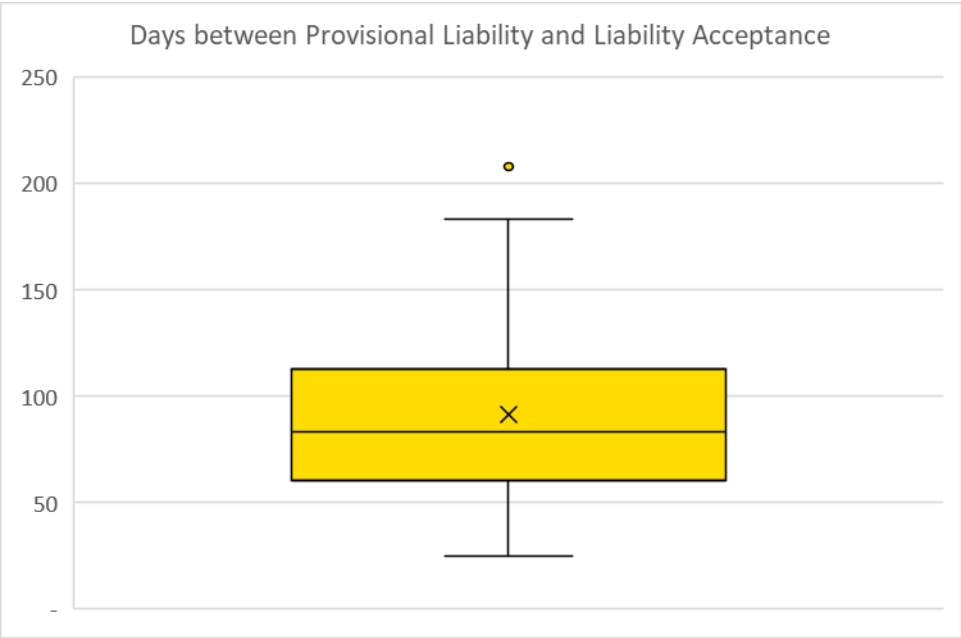
From the following graphic, it can be seen that claims triaged to Empower & Guide were considered to have a lower level of "correct" provisional liability being used, and similarly the "fracture" injury type.



In many cases, it was considered that the claims that were accepted provisionally and which could have been accepted outright were straightforward injuries that the employer confirmed occurred as a result of employment.

There were 52 claims that were accepted provisionally and ultimately had liability accepted (some claims are closed without liability being accepted). We assessed the timeliness of the decision to liability acceptance. This analysis is presented in the following graphic.

On average the number of elapsed days between provisional liability acceptance and full acceptance was 92 days (13.1 weeks), with the maximum being 208 days (29.7 weeks). For 35 of the 52 claims (67%), it was considered that the decision to accept liability was not made in a timely manner (that is, it was inconsistent with the provisional liability timeframes).



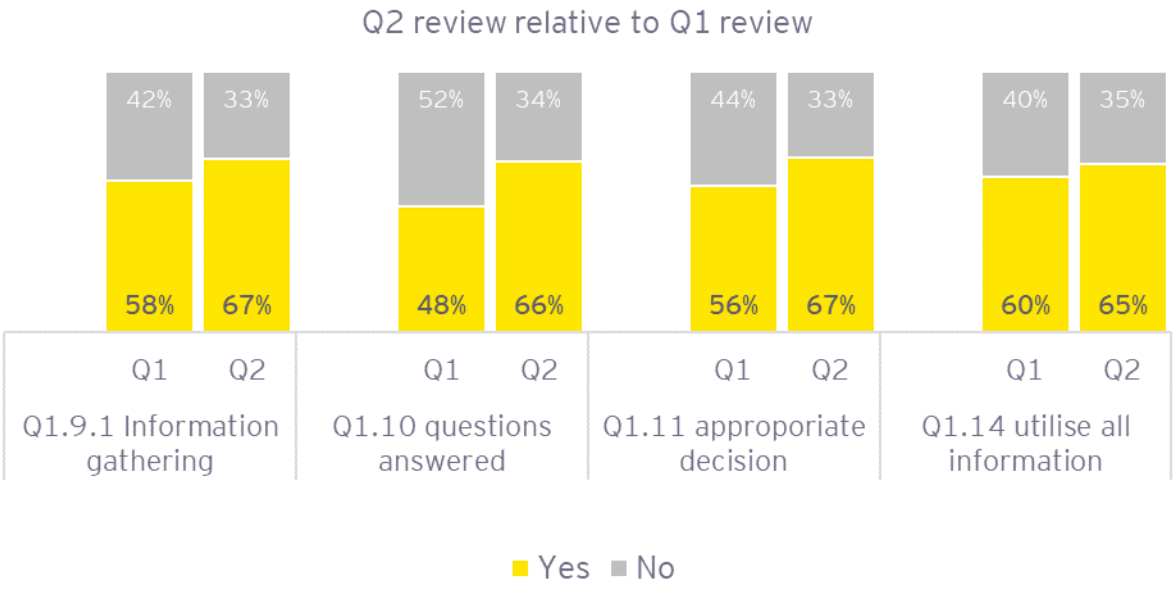
For 10 of the 52 claims (19%), it was considered that there remained unanswered questions or incomplete investigations when the final liability decision was made. This has been a key finding of all three reviews conducted to date. The main shortcomings identified included:

- The liability decision being made only because the specified period of provisional liability was about to expire
- Factual investigations were commissioned but not complete when the liability decision was made

- The medical facts of the injury were not clear and there was no evidence on file to support that further clarification was sort by the case manager or that further medical investigations were carried out.

5.4 Quality of final liability decision

The last four questions shown under the figure in section 5.2 relate to thoroughness of decision making, the full use of information available and addressing the concerns of employers. All four questions show that approximately two thirds of the claims reviewed were considered to have these areas appropriately addressed. While this is still an area to be addressed, the results have improved relative to the 2020 Q1 review, as shown in the following figure.



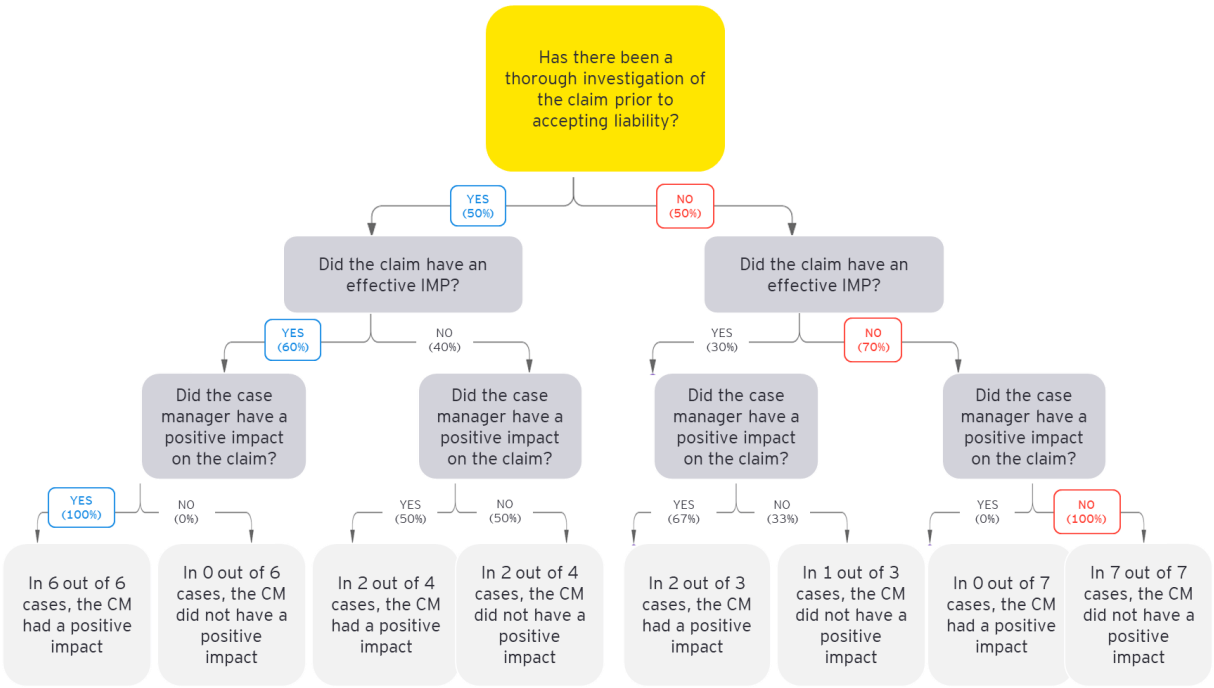
For the approximately one third of claims where there were concerns with the final liability decision, these concerns were similar in nature to previous reviews and include:

- Factual investigations were begun, and the reports were either not actioned or were not completed by the time the final liability decision was made
- Further medical investigation was required to confirm causation between employment and workplace injury
- There were 14 claims (12%) where the employer expressed some concern with the injury and, based on the evidence available on the claim file, the concerns were not addressed (3 of these were psychological injury claims)
- There were 9 claims where the medical certificate was incorrectly completed. Three of these related to psychological injury claims where there was no diagnosis and the medical certificate simply stated "stress". Other areas of concern related to illegible certificates and/or unsigned certificates.

5.5 Psychological injury claims

During this 2020 Q2 review, 20 psychological injury claims were reviewed, including 3 PTSD claims and the remainder being some form of stress/anxiety/depression. The previous reviews have been critical of the management of the psychological injury claims reviewed.

This review has seen some improvement in both the initial liability investigations and case management of the claims. The following tree diagram provides a summary of the claims reviewed. It shows that there is a correlation between the initial investigations of the injury and the subsequent management of the claim.



The analysis shows that there is a correlation between the thoroughness of the initial claim investigation and the outcomes achieved on the claim. The left branch of the tree above shows that of those claims that were thoroughly investigated, the majority had an effective injury management plan and an overall positive result for the injured worker. Conversely the right hand side of the tree shows that, of those claims that were not thoroughly investigated initially, most had an ineffective injury management plan and ultimately a poor outcome for the injured worker.

Some of the concerns that are evident in the 10 less well managed claims included:

- Factual investigations were begun but either not completed prior to the final liability decision or the reports did not appear to have been considered when the final liability decision was made
- There were a number of cases where the injured worker did not appear to be motivated to cooperate with the treatment plan and there did not appear to be any evidence of the case manager taking action to address this lack of engagement
- A lack of communication from the case manager with the worker and service providers to coordinate and progress the claim.

6. Triage of claims

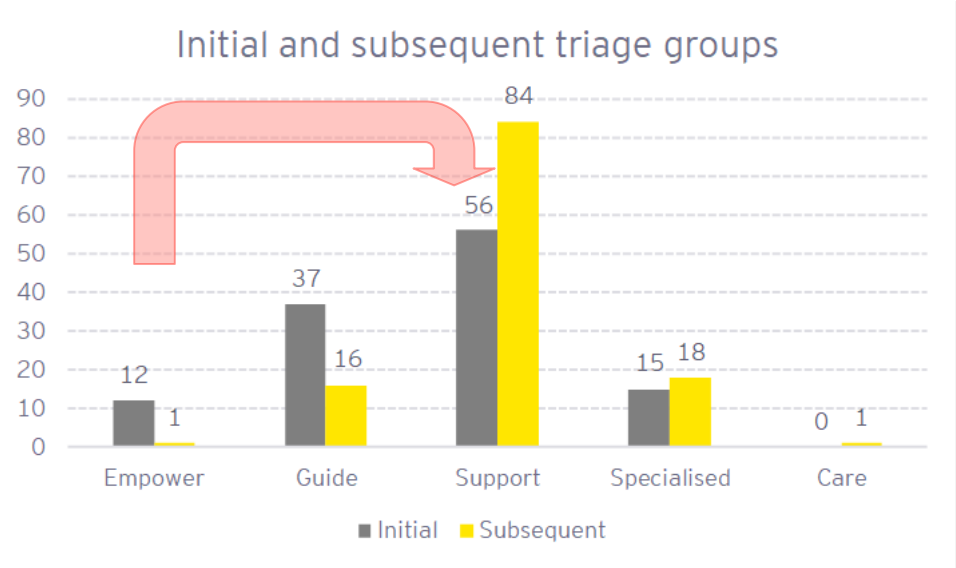
6.1 Key findings

The key findings regarding the triage of claims are:

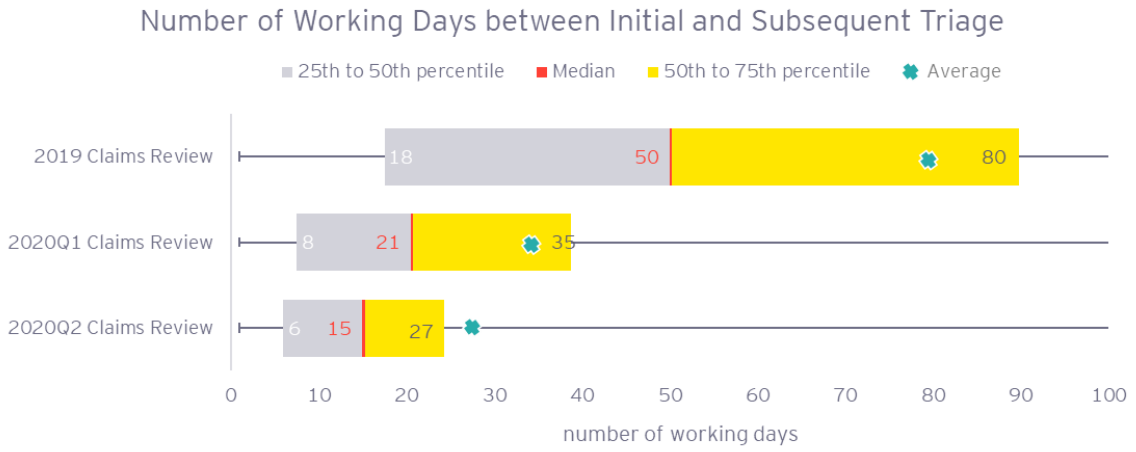
- For this review, 85% of claims reviewed were ultimately in either Support or Specialised (psychological injuries). This is primarily due to the review concentrating on claims with a significant injury
- For this review, 68% of claims reviewed remained in the original triage category (For the 2020 Q1 review this percentage was 59%)
- One of the key findings of the 2019 review was that claims were being wrongly triaged and not remedied in a timely manner. This 2020 Q2 review and the 2020 Q1 review have found that the time taken to move claims to the correct level of support (i.e. to re-triage the claims) has continued to reduce
- The average time to re-triage for this review was 27 days (reduced from 80 days at the 2019 review)
- It is still found that 47% of the claims reviewed were not re-triaged in a timely manner.

6.2 Detailed results

The following graphic shows that the majority of claims reviewed ended up in the "Support" category. The majority of claims reviewed that started as Empower or Guide were ultimately moved to Support. This is a similar result to previous reviews, however it is the timeliness of the re-triage that is important.



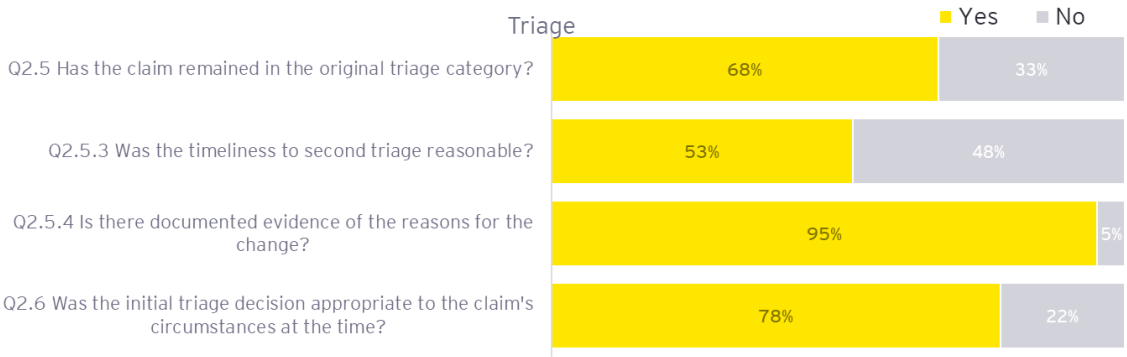
The following graphic shows the number of days taken for the claims to be moved to the necessary segment. The graphic shows the data for the three reviews conducted to date.



The above graphic shows that the average number of days taken to re-triage injured workers has continued to improve:

- The average has decreased from 80 days to 35 days to 27 days (from the 2019 review to the 2020 Q1 review to the current 2020 Q2 review respectively)
- The averages are impacted by a number of claims that took an excessive amount of time to be re-triaged. As a result, it is also useful to look at the median which has decreased from 50 days to 21 days to 15 days (from the 2019 review to the 2020 Q1 review to the current 2020 Q2 review respectively).

The key questions asked, and the responses recorded, for the 120 claims reviewed are summarised in the following graphic:



The main points to note from the analysis include:

- 68% of the claims reviewed have remained in their original triage category. This is an improvement from 59% at the previous 2020 Q1 review
- There was a differential between the two claims agents for the question regarding claims remaining in the original triage category, with 78% of EML claims remaining in the original triage category but only 48% of Allianz claims
- 48% of claims reviewed were not considered to be re-triaged in a timely manner. We understand that the claims in Guide should be moved after 14 days, although this requirement was only introduced in September 2019. A number of the claims in the sample had injury dates prior to September 2019

- 78% of claims were considered to be triaged into the appropriate category given the information available at the time. This is approximately the same level of accuracy as the 2020 Q1 review. It was considered that this decision making was more accurate for EML (86%) relative to Allianz (63%).

7. Injury management

7.1 Key findings

Injury management was one of three main areas of concern identified during each of the reviews. The key findings regarding injury management for the 2020 Q2 review are:

- Consistent with the findings from the 2019 review and the 2020 Q1 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 workers' changing circumstances
- Only 52% of IMPs complied with section 45 of the 1998 Act or standard 12 of SIRA's standards of practice
- For the 2020 Q2 review, more data was collected on the shortcomings of the IMPs. This analysis showed that the main reasons that IMPs were not appropriate was:
    - The employer was not kept informed of the significant requirements documented within the IMP
    - The IMP did not include goals (or actions to achieve goals that were specified) that were reasonably likely to lead to a return to work
- One of the key findings of the previous reviews was that there has been a lack of pro-activity on the part of some case managers, leading to ineffective injury management. This review found that case managers were effective in the management of the workers' injuries in 68% of the files reviewed. (For the 2020 Q1 review this percentage was 61%.)

Regarding the use of workplace rehabilitation providers (WRPs), the review found that overall, there was appropriate use of WRPs. Section 7.7 discusses the effectiveness of WRPs. It was found that the timeliness of appointment of a WRP was a key indicator of success. For those claims where the appointment was not considered timely, the WRP was nearly always ineffective.

Another finding of this 2020 Q2 review, was that one reason for the ineffectiveness of both case managers and WRPs was a lack of cooperation of the injured worker and/or nominated treating doctor (NTD) with meeting the requirements of the injury management plan. The actual numbers of these cases was not accurately captured at this 2020 Q2 review, however, there were approximately 16 claims or 13% where the reviewers comments indicated that this was an issue (better data on these types of cases will be collected for the subsequent reviews). In these cases, the case manager and/or the WRP need to be more pro-active with injured workers and NTDs to achieve a good outcome. In some cases, it was observed that the opposite occurred.

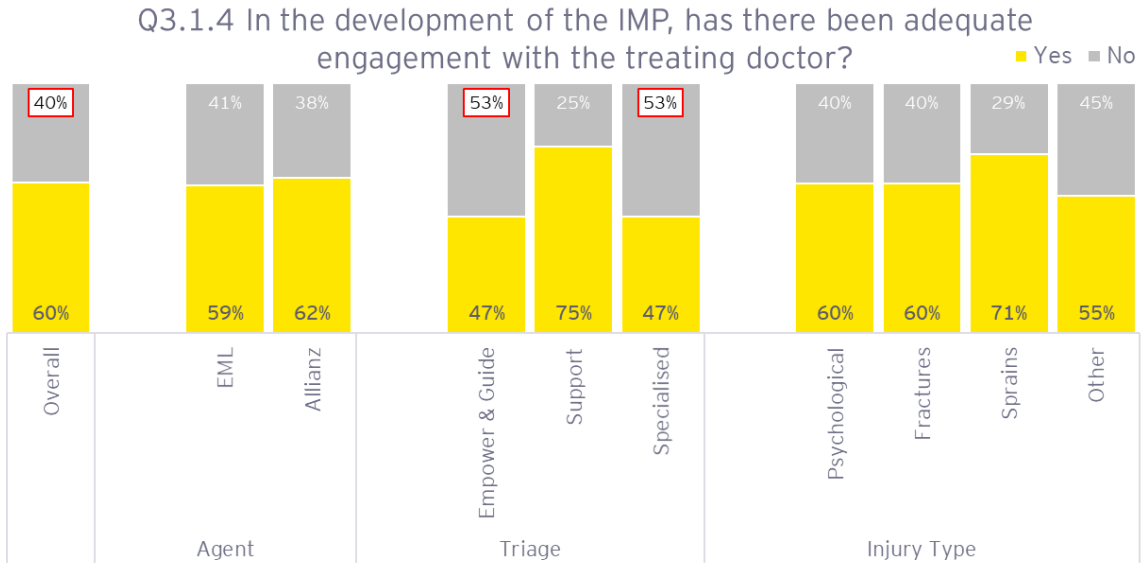
7.2 Detailed results

The key questions asked, and the responses recorded, for the 120 claims reviewed are summarised in the following graphic:


Injury management
Yes
No
IMP
Q3.1.1 Was a treatment and injury management plan (IMP) prepared /applied for the worker?
85%
15%
Q3.1.2 In the development of the IMP, has there been adequate engagement with the worker?
73%
27%
Q3.1.3 In the development of the IMP, has there been adequate engagement with the employer?
65%
35%
Q3.1.4 In the development of the IMP, has there been adequate engagement with the treating doctor?
60%
40%
Q3.2.1 Was the preparation of the IMP timely?
73%
27%
Q3.3.5 Does the IMP fulfil the requirements of Section 45 of the 1998 Act and standard 12 of SIRA's standards of practice?
52%
48%
Q3.7 Is there evidence that the injured workers work capacity has been taken into account within the IMP?
59%
41%
Q3.8 Is there evidence that the plan has been adhered to and reviewed/assessed on an ongoing basis in line with timelines in the plan or event driven?
55%
45%
Q3.9 Are the decisions and the rationale supporting the injury management decisions clearly documented on the case record?
71%
29%
Employer
Q3.5 Is there evidence of Employer involvement in getting the injured worker back to work? - e.g. discussion of suitable duties, traineeship, alternative employment etc.
72%
28%
Rehab provider
Q3.6.1 Was this the right decision given the circumstances of the injured worker?
95%
5%
Q3.6.2 Was the rehab provider used appropriately?
73%
27%
Q3.6.3 Were all parties kept properly appraised during the rehabilitation process, in a timely manner?
90%
10%
Q3.6.4 Has the case manager been pro-actively involved in the management of the claim during the rehab process?
77%
23%
Q3.6.6 Was the appointment of the rehab provider timely?
75%
25%
Q3.6.7 Has the rehab provider been effective in helping the injured worker RTW?
46%
54%
Case manager
Q3.10 Has the case manager been pro-active and effective in the management of the workers injury?
68%
33%

7.3 Engagement with nominated treating doctor (NTD)

Between the 2020 Q1 and 2020 Q2 reviews, the sample of claims reviewed showed that engagement of case managers with the worker and employer improved, however engagement of case managers with the treating doctor remains problematic.



We note the following on the graphic above:

- In only 60% of files reviewed was there considered to be adequate consultation by the case manager with the NTD in formulating the injury management plan. In some cases, it was evident that the case manager had attempted to engage with the NTD, in other cases there was no evidence of this engagement
- It was evident that in some cases, the NTD appeared to be purposely not cooperating with the case manager.

7.4 Results relative to the Q1 review

Relative to the sample of files reviewed during the 2020 Q1 review, we make the following observations

- This sample indicated better interaction of workers, the employer and the NTD in formulating the injury management plan
- There was no increase in compliance with section 45 of the 1998 Act or with standard 12 of SIRA's standards of practice; we elaborate on this further below
- A workplace rehabilitation provider is correctly being appointed (or correctly not being appointed) to a high percentage of claims (95%). However, the WRP was only considered effective in approximately 50% of cases; the reasons for this are elaborated on below
- This sample of claims indicated a greater percentage of case officers (68%) being pro-active in the management of the claim.

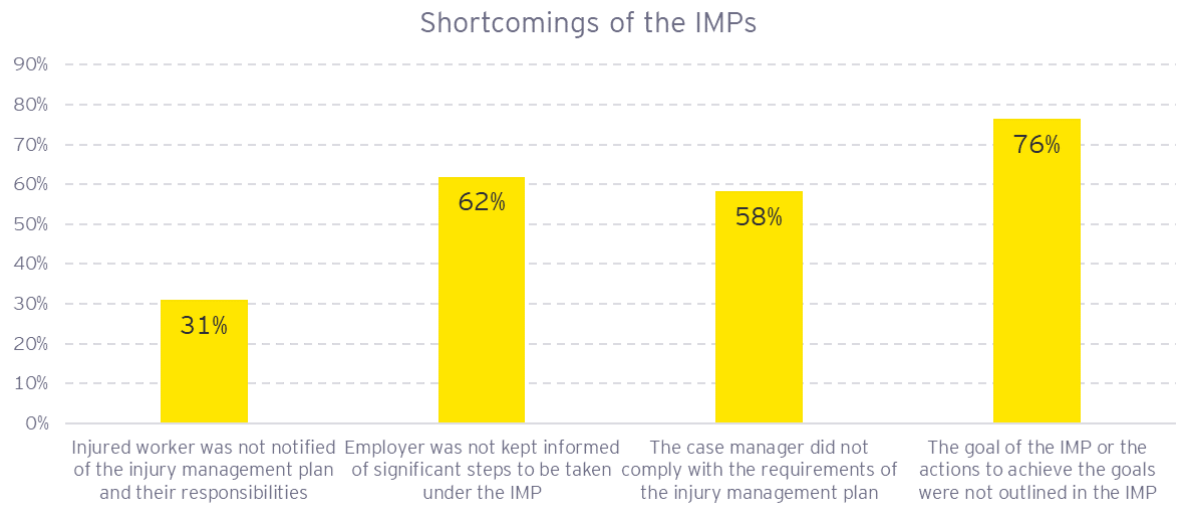
7.5 Relative performance between EML and Allianz

For the same questions shown in section 7.2 above, the following graphic shows the relative performance of EML and Allianz. The key observations of this comparison are:

- For all the Allianz claims reviewed, an IMP was developed and in 95% of cases this was done in a timely manner
- The decisions made with regard to injury management and the rationale for the decisions was better documented for the Allianz claims
- In terms of compliance of injury management plans, there was little difference between EML and Allianz
- For Allianz claims, WRPs were considered more effective relative to the EML cohort (refer to section 7.7).

7.6 Appropriateness and effectiveness of Injury Management Plans (IMPs)

For this 2020 Q2 review, further data was collected on any shortcomings of the IMPs reviewed. The following graphic summarises the IMPs reviewed against the requirements of section 45 of the 1998 Act and standard 12 of SIRA's standards of practice.



We note the following from the graphic above:

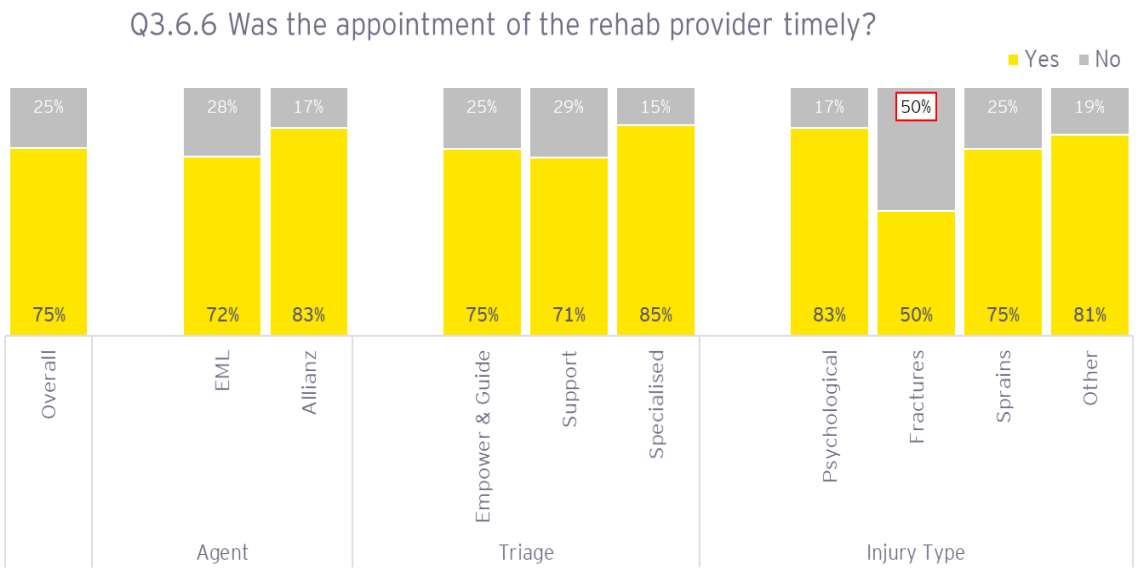
- For 55 of the claims reviewed, it was considered that the IMP had one or more of the four shortcomings highlighted in the graphic above
- For 76% of the 55 claims reviewed, the IMP did not clearly articulate a goal or have actions tailored to the goals
- For 58% of the 55 claims reviewed, the case manager did not comply with the requirements of the IMP
- For 62% of the 55 claims reviewed, the employer was not kept informed of the significant steps to be taken under the IMP

Claims in the sample that were identified as being well managed were correlated with having injury management plans that were considered effective and updated with the significant events of the claim.

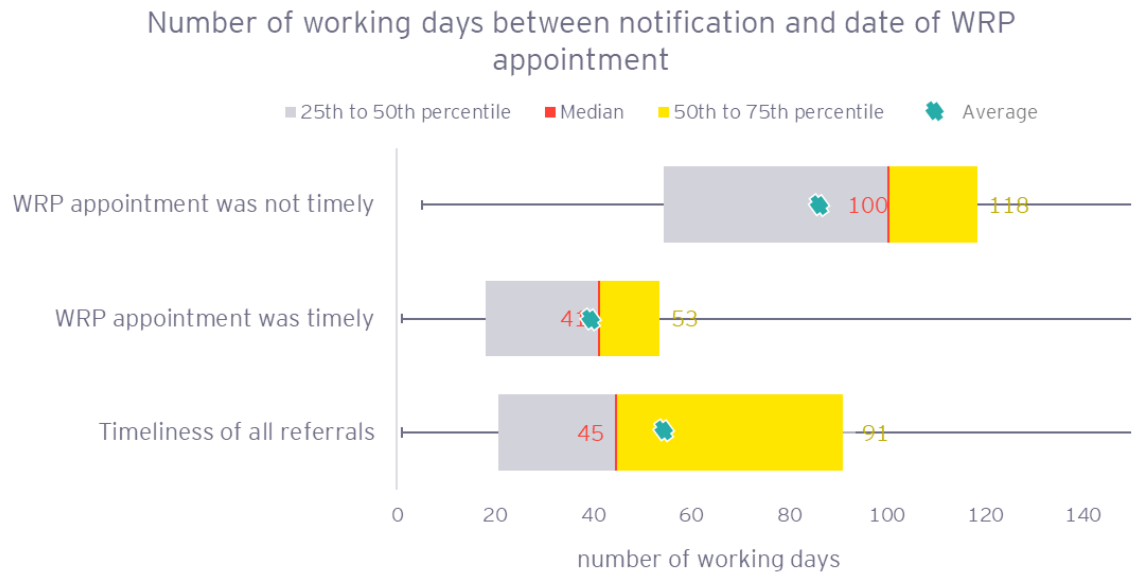
7.7 Workplace rehabilitation providers (WRPs)

For the majority of claims reviewed, the decision to appoint or not to appoint a WRP was considered to be correctly made. However, there were a number of issues identified with the timeliness of appointment of WRPs and the effectiveness WRPs.

The following two graphics present the findings of the review with regard to timeliness of appointment of WRPs.

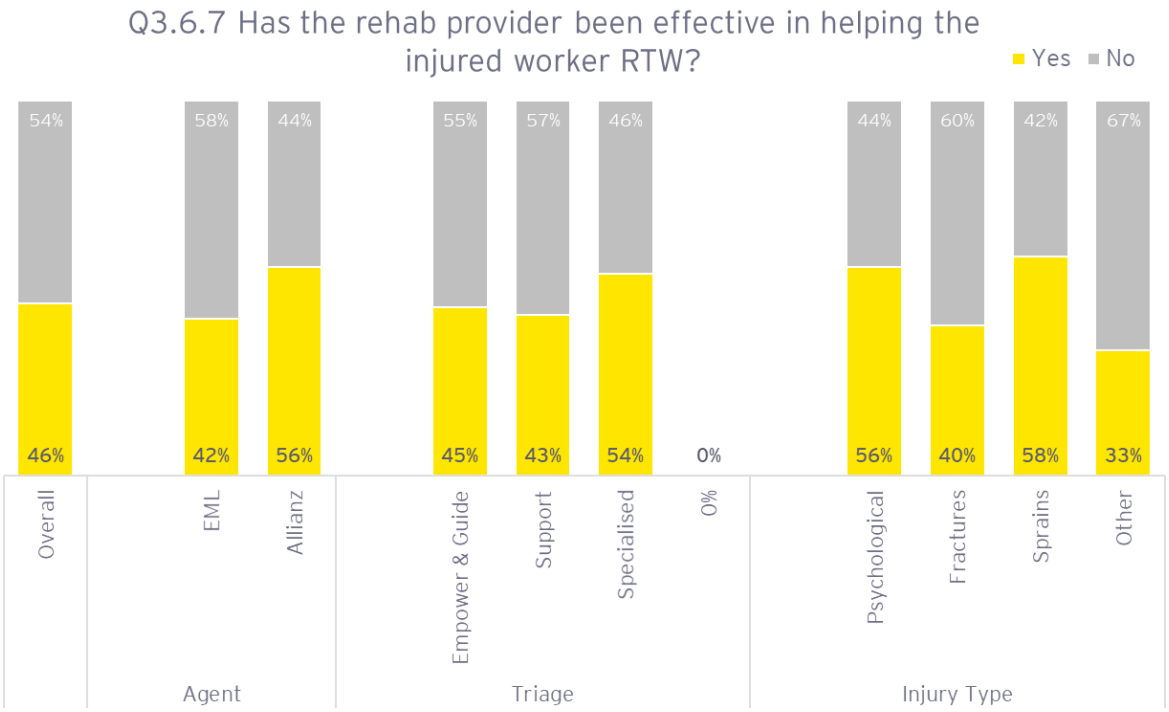


It was found that the appointment of the WRP was timely in 75% of cases, with Allianz considered to perform slightly better than EML. The timeliness of appointment was considered to be good for psychological injury claims (83%) but poor for fracture claims (50%).

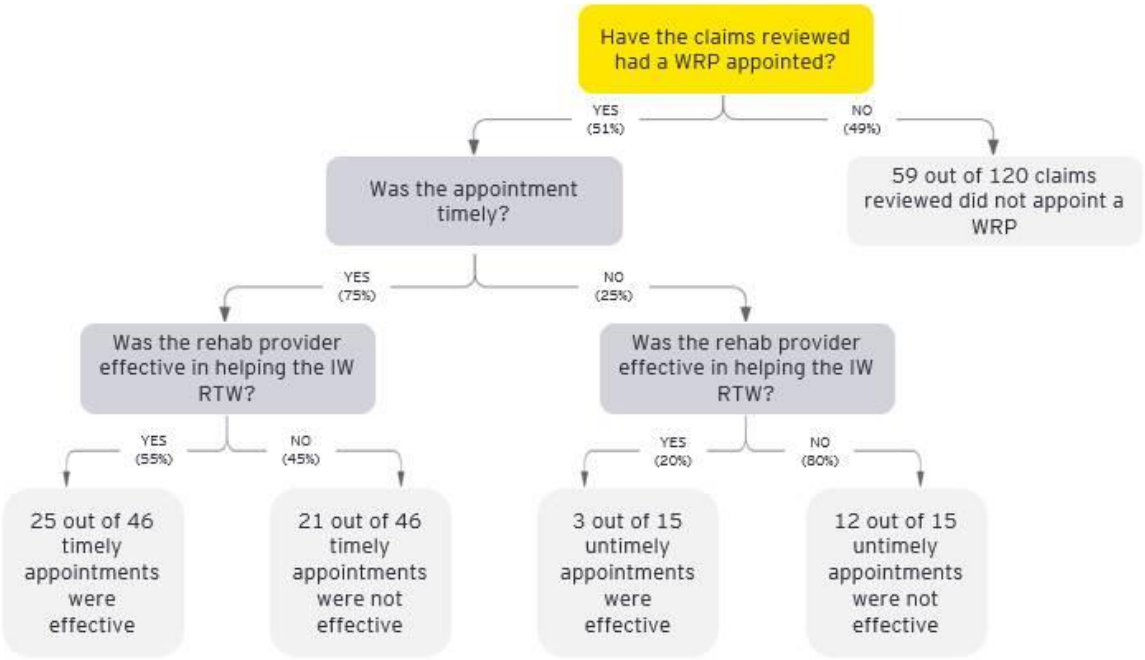


The graphic above shows that for those claims where it was considered that the WRP appointment was timely, the average time to appointment of the WRP was 42 work days. However, where it was considered that the WRP appointment was not timely, the average time to appointment of the WRP was 100 work days.

The following graphic indicates the effectiveness of WRPs in assisting with increasing work capacity and/or return to work.



The following tree diagram summarises the intersection between timely appointment of the WRP and effectiveness of the WRP.



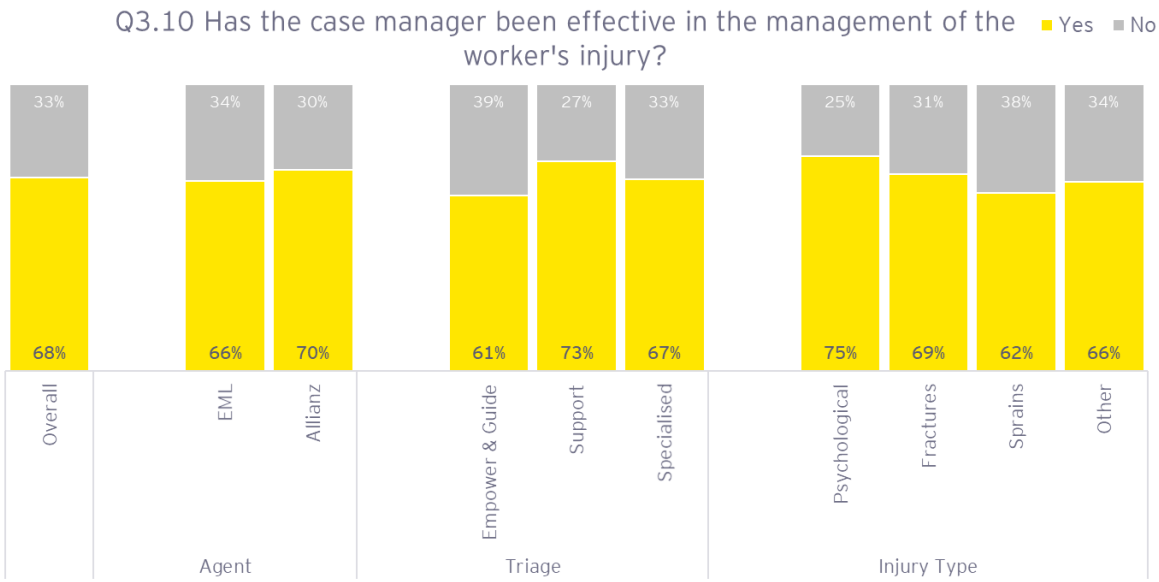
There were a number of reasons identified for the assessment that the WRP was ineffective:

- Timeliness – In 25% of cases, the appointment of the WRP was not considered timely. For this subset of claims, the WRP was considered ineffective in 80% of cases, with the primary reason being the late appointment of the WRP
- For the subset of claims where the appointment of the WRP was considered timely, the ineffectiveness of the WRP decreases to 45%

- The primary reasons for ineffectiveness of WRPs included:
  - The injured worker was not cooperating with the rehabilitation process
  - Poor performance on the part of the WRP (based on the documentation contained in the claim file, it appeared that there was a lack of communication and clear strategy on the part of the WRP)
  - The injuries are complex and to date, the WRP has not proven successful in increasing capacity.

7.8 Effectiveness of the case manager

The final question relating to injury management is, based on the evidence available within the claim file, "Has the case manager been pro-active and effective in management of the worker's injury?" The results are presented in the following graphic.



Overall, it was considered that in 68% of the claims reviewed, the case manager had been pro-active and effective. For the 2020 Q1 review, this percentage was 61%. There appears to be little difference in this percentage between the various triage categories or injury types reviewed.

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. Often a lack of pro-activity on the part of the case manager will result in the injury management drifting along and achieving a poor outcome for the injured worker.

8. Medical management

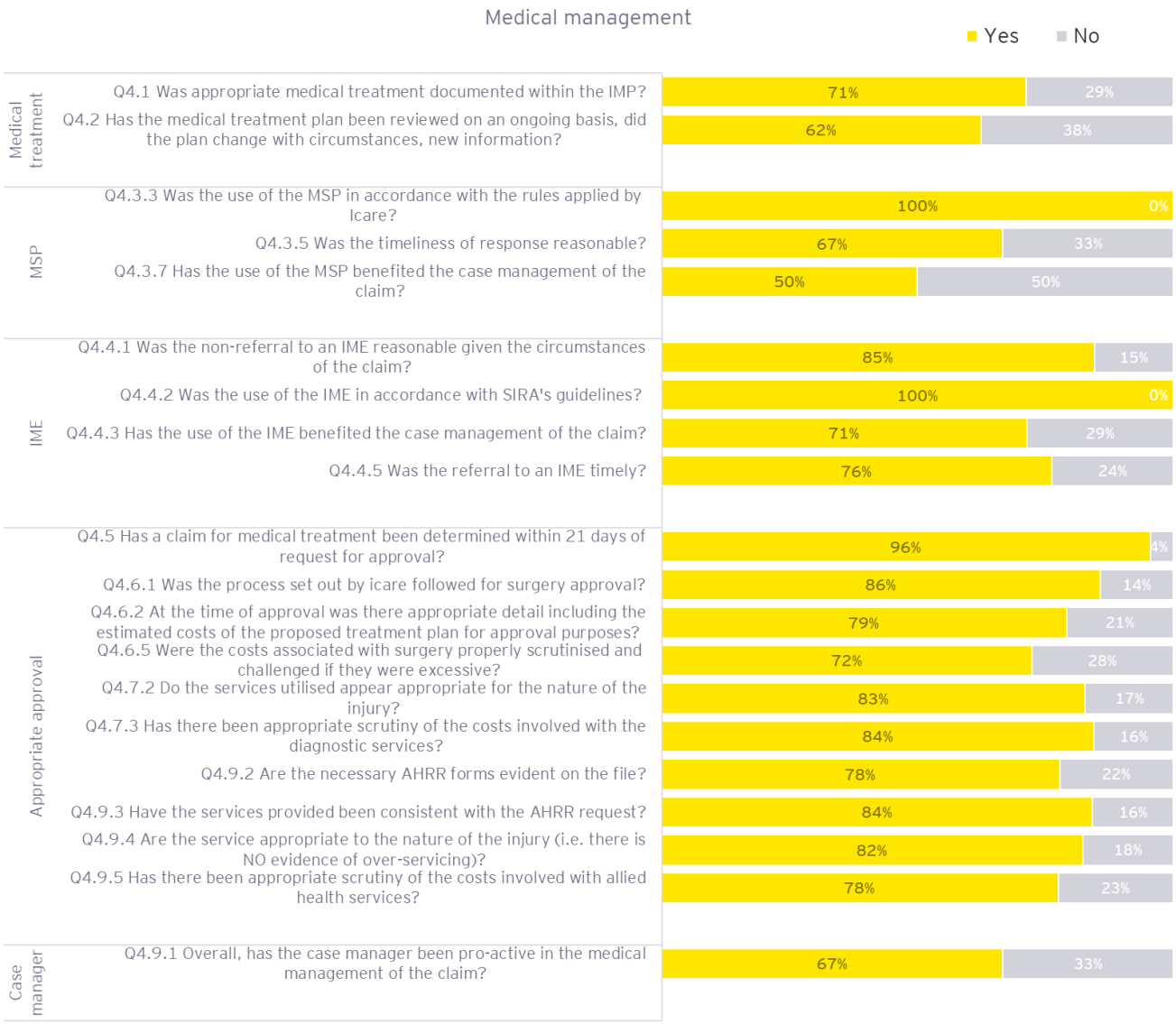
8.1 Key findings

The key findings regarding medical management are:

- It was considered that appropriate medical treatment was documented within the IMP in 71% of the claims reviewed (this is an increase from 47% for the 2020 Q1 review)
- Consistent with findings from the previous reviews, there was very limited use of the Medical Services Panel (MSP). Out of the 120 claims reviewed, only 7 claims (6%) involved the MSP in the approval of treatment. This is consistent with the 2020 Q1 review
- Out of the 120 claims reviewed, 21 claims (18%) were referred to an Independent Medical Examiner (IME). This is an increase from 11% at the 2020 Q1 review:
    - All 21 referrals were considered to be in accordance with SIRA's guidelines
    - In 76% of these cases, the referral to the IME was considered timely
    - In 71% of these cases the referral to the IME was considered to have benefited the management of the claim
    - For the remaining claims not referred to an IME, this decision was considered reasonable in 85% of cases. This meant that there were 15 claims where it was considered that the claims would have benefited from a referral to an IME
- Surgery was required in 49 claims (41%). A number of surgeries appeared to be excessively expensive and we are seeking advice from SIRA on the coding and invoicing of these cases
- 59 of the claims reviewed had had some form of diagnostic services. The scrutiny of diagnostic services was assessed, and it was found that there was appropriate scrutiny in 84% of the files reviewed. For the 16% of cases where the scrutiny was not considered appropriate, in most cases the findings related to the injured worker having multiple MRI services or MRI services that did not appear necessary given the nature of the injury
- 80 of the files reviewed had some form of Allied Health service. It was considered that in 78% of cases, there had been appropriate scrutiny of the services involved. For those claims where it was concluded there was insufficient scrutiny (22%) of the services provided, the reasons included a combination of the following:
    - Seemingly excessive physiotherapy visits with no improvement in capacity
    - No Allied Health Recovery Request (AHRR) forms on file or treatment continuing beyond the AHRR forms that were on file.

8.2 Detailed results

The following graphic summarises the key outcomes of the medical management review of the 120 claims:



8.3 Results relative to the 2020 Q1 review

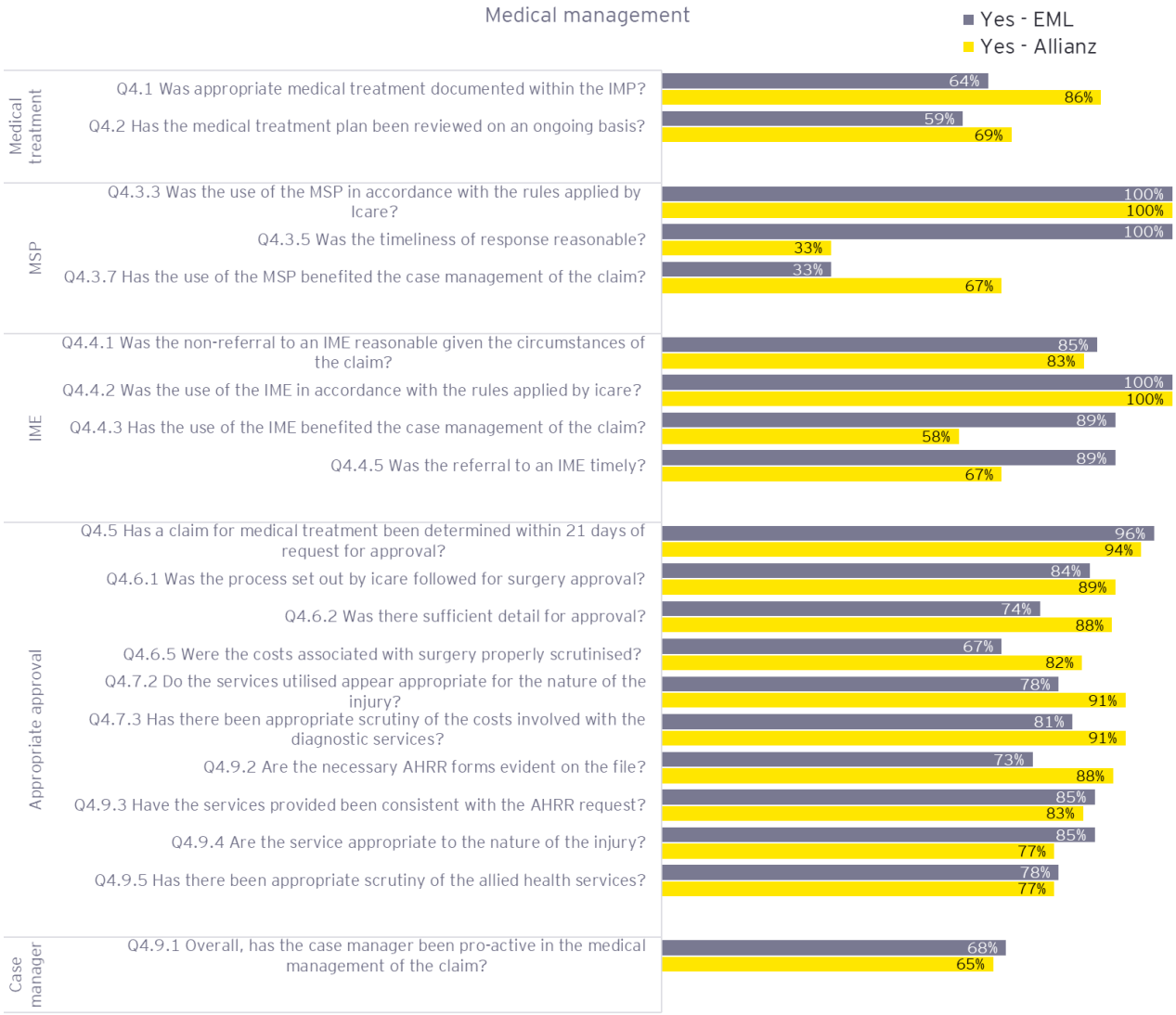
Relative to the files reviewed for the 2020 Q1 review, the main areas of difference include:

- Documentation of appropriate medical treatment within the IMP had improved from 47% to 71%
- The non-referral of a claim for an IME was considered appropriate in 85% of claims reviewed (relative to 70% of claims for the 2020 Q1 review). There was also greater utilisation of IMEs to good effect in this sample of claims compared with the 2020 Q1 sample (21 of the claims reviewed)
- Only 7 claims reviewed had been referred to the MSP, which is too small a sample to draw any conclusions.

8.4 Relative performance between EML and Allianz

For the same questions as shown in section 8.2, the following graphic indicates the relative performance of EML and Allianz. The key callouts of this comparison include:

- Documentation of appropriate medical treatment within the IMP was performed better by Allianz (86% versus 64%)
- The timeliness of referral to an IME was considered better in the case of EML (89% to 67%)
- Overall, it was considered that the scrutiny of diagnostic and allied health costs was performed better by Allianz where, across a range of questions, Allianz was performing appropriate scrutiny in approximately 90% of cases whereas EML was approximately 80%.



8.5 Use of an independent medical examiner (IME)

For this 2020 Q2 review, 21 of the claims reviewed had been referred to an IME. Of the remaining 99 claims, it was considered that 15% of these (15 claims) would have benefited from an IME.

The primary reason for this was that the period of incapacity appeared inconsistent with the nature of the injury.

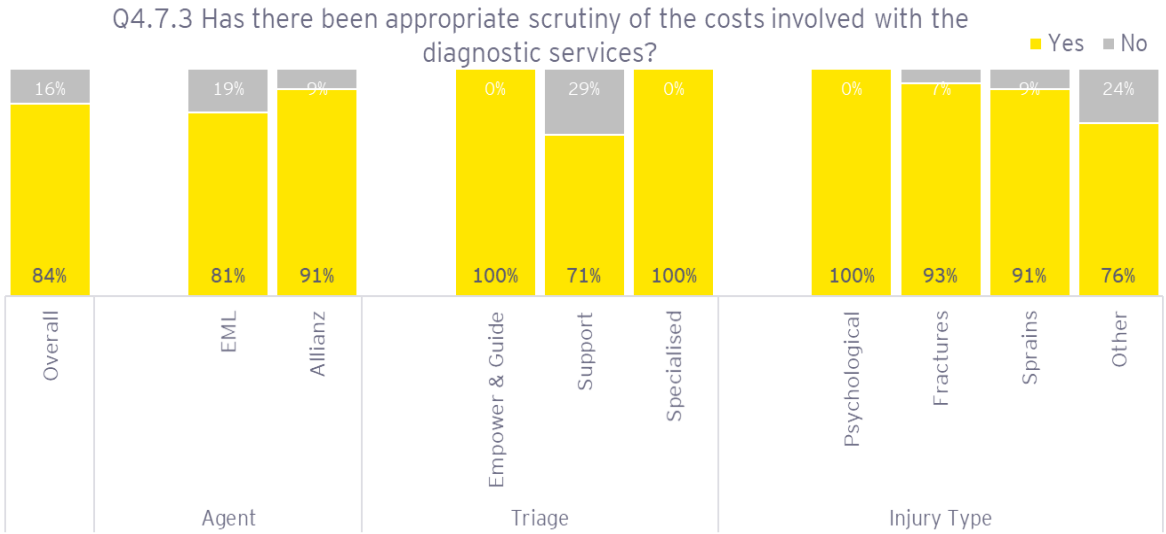
There were also a number of cases where there was evidence that an IME was being considered by the case manager but it had not been actioned. In each of these cases, the reviewers considered that this was the appropriate course of action.

For the 21 cases that were referred to an IME, it was considered that the referral had benefited the progress of the claim in 71% of cases. In the cases where this was not the case, the reasons included:

- The injured worker failed to attend the appointments
- The IME was conducted prior to factual investigations being completed, and so the IME did not have a complete picture of the circumstances of the claim.

8.6 Monitoring of diagnostic services

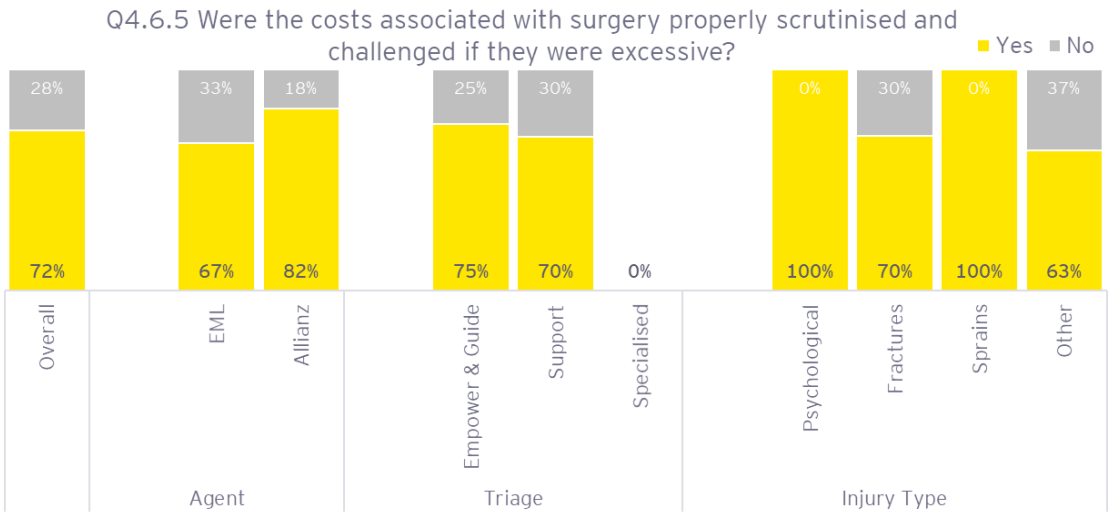
For this 2020 Q2 review, 59 of the claims reviewed had had some form of diagnostic services. The scrutiny of diagnostic services was assessed and it was found that there was appropriate scrutiny in 84% of the files reviewed.



For the 16% of cases where the scrutiny was not considered appropriate, in most cases the findings related to the injured worker having multiple MRI services; in one case an injured worker had 5 MRIs. In a number of cases, it appeared that an MRI was used to confirm a fracture when an x-ray had or could have been used to perform the same task.

8.7 Monitoring of surgery costs

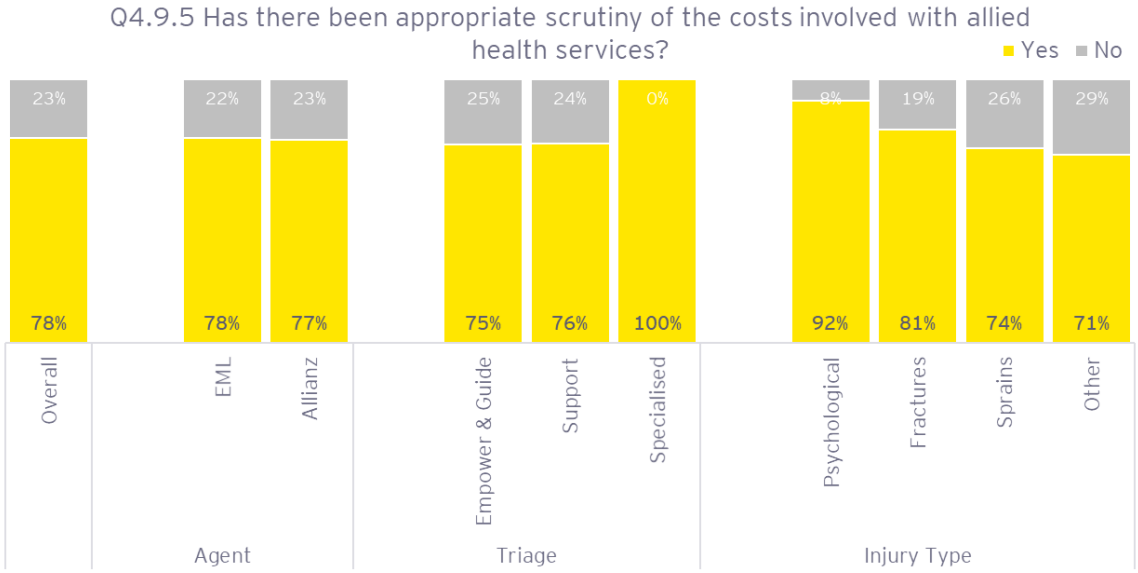
For this 2020 Q2 review, in 49 of the claims reviewed, the injured workers underwent surgery. The scrutiny of surgery costs was assessed and it was found that there was appropriate scrutiny in 72% of the files reviewed.



For the 28% of claims where it was assessed that there was insufficient scrutiny of the costs incurred, the costs charged appeared excessive relative to other similar surgeries. SIRA has been requested to look at these examples to ascertain if the invoicing and coding of the surgery costs was appropriate.

8.8 Monitoring of allied health costs

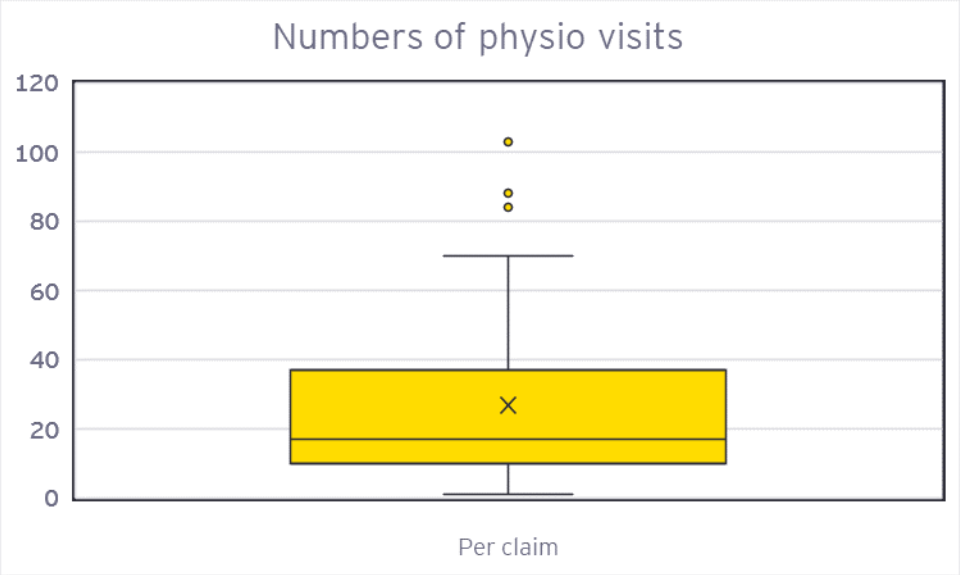
For this 2020 Q2 review, 80 of the files reviewed had some form of Allied Health service. It was considered that in 78% of cases, there had been appropriate scrutiny of the services involved.



For those claims where it was concluded there was insufficient scrutiny of the services provided, the reasons included a combination of the following:

- Seemingly excessive physiotherapy visits with no improvement in capacity
- No AHRR forms on file or treatment continuing beyond the AHHR forms that were on file.

The following graphic shows the distribution of physiotherapy visits for claims that received physiotherapy services. The average number of services provided was 27 and the maximum number was 103. 18% of claims reviewed were receiving two or more services per week.

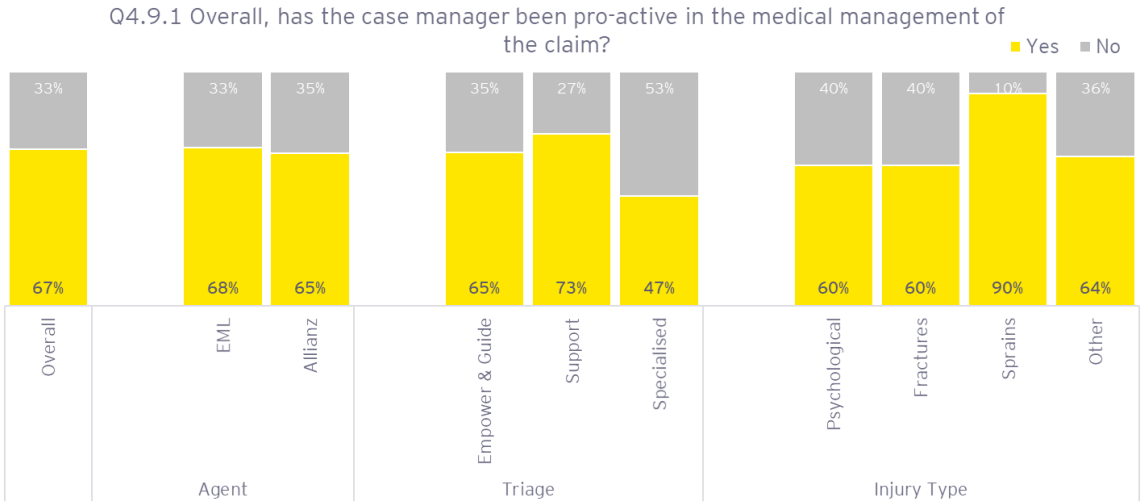


We were also able to ascertain from the files reviewed that of the total physiotherapy spend, approximately 11% was spent on non-treatment services (that is, report writing, case conferencing and travel).

For exercise physiologists, the percentage of non-treatment spend was 27%. Total spend on exercise physiologists was much less than on physiotherapists.

8.9 Effectiveness of the case manager

The final question asked under medical management is, based on the evidence available within the claim file, has the case manager been pro-active and effective in the management of the worker's medical treatment. The results are presented in the following graphic.



It was found that the case manager was effectively managing the medical treatment in 67% of cases. This result is consistent with section 7.8, where it was that the case manager was being effective in 68% of cases with regard to injury management.

9. Payment of weekly benefits

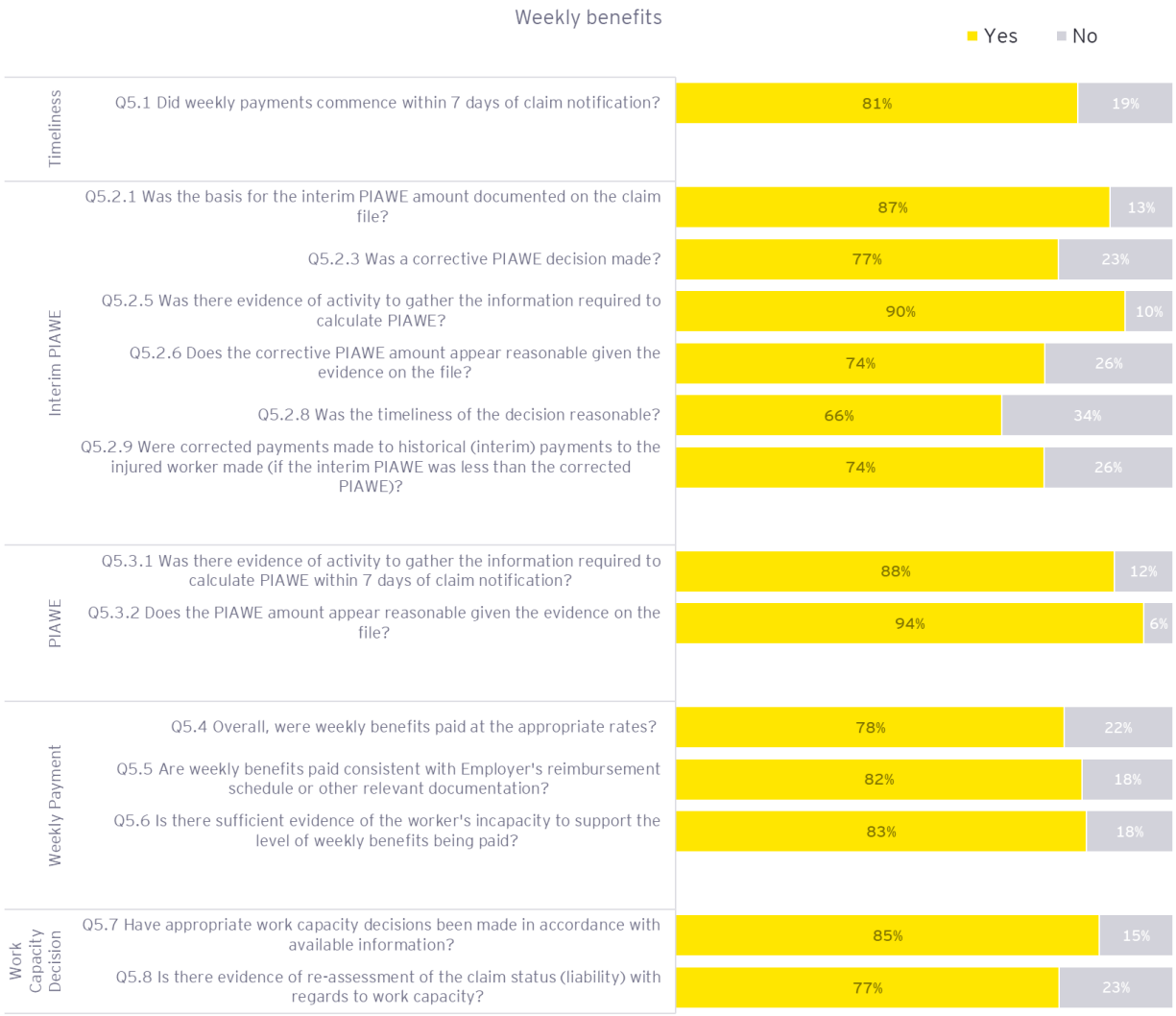
9.1 Key findings

For the claims reviewed, it appears that weekly benefits were paid at the correct rate in 78% of cases (for the 2020 Q1 review this was 65%). Weekly benefits are more likely to be incorrect in cases where an interim PIAWE was used (approximately 45% of files reviewed used an interim PIAWE).

- Where an interim PIAWE amount was used, corrective payments only appear to have been made in approximately 75% of the claims reviewed
- There appeared to be sufficient evidence of a worker's incapacity to support the level of weekly benefits being paid in 85% of files reviewed (s44B(1)(a) of the 1987 Act)
- The findings in regard to weekly payments have improved between the 2020 Q1 review and the 2020 Q2 review. This is at least partly due to the 2020 Q2 review including Allianz claims and as per section 9.4, Allianz have performed better than EML with the payment of weekly benefits.

9.2 Detailed results

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



9.3 Results relative to 2020 Q1 review

On the key questions in regards to the payment of weekly benefits:

- In 88% of the cases where PIAWE was calculated within the first 7 days, there was evidence of gathering the required information. For the 2020 Q1 review, this percentage was 80%
- In 85% of the files reviewed, it was considered that the appropriate work capacity to support the weekly benefits was evident on the file. For the 2020 Q1 review, this percentage was 56%
- In 78% of the files reviewed, it was considered that weekly benefits were paid at the appropriate rate. For the 2020 Q1 review, this percentage was 65%.

9.4 Relative performance between EML and Allianz

Some of the improvement noted in section 9.3 is likely the result of analysing a larger proportion of Allianz files in this 2020 Q2 review. The graphic below shows that in most areas, the reviewers considered that Allianz was performing better than EML.

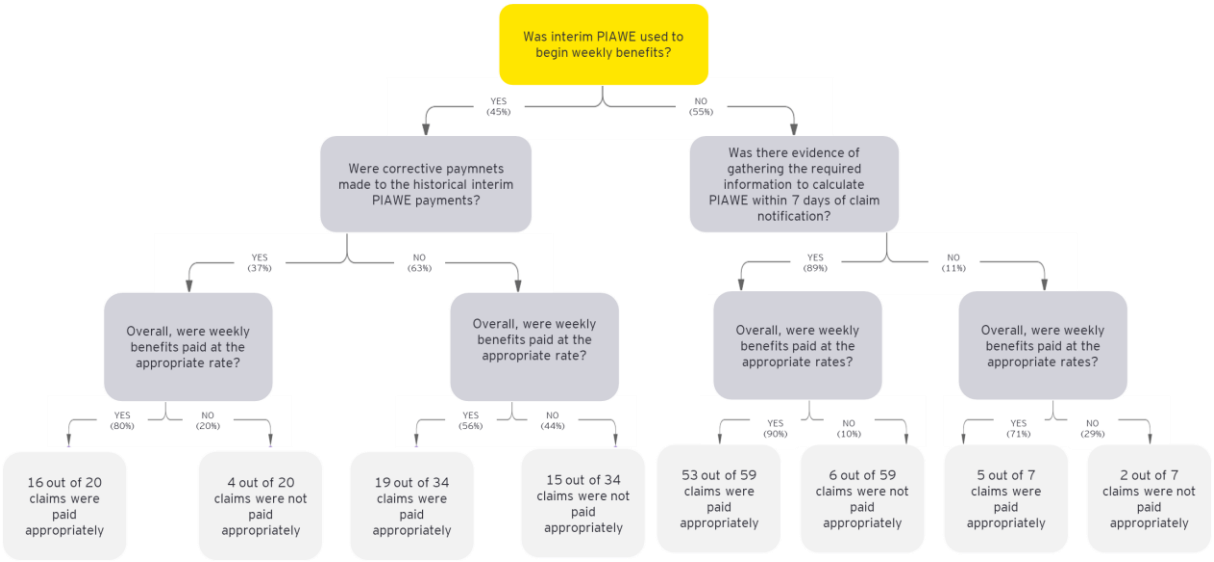
In relation to the three key questions noted in section 9.3:

- Gathering of required data within 7 days: Allianz 89%, EML 88%
- Appropriate work capacity on file to support the level of weekly benefits: Allianz 94%, EML 80%
- Payment of weekly benefits at the appropriate rate: Allianz 88%, EML 73%.


Weekly benefits
Yes - EML
Yes - Allianz
Timeliness
Q5.1 Did weekly payments commence within 7 days of claim notification?
79%
85%
Interim PIAWE
Q5.2.1 Was the basis for the interim PIAWE amount documented on the claim file?
84%
100%
Q5.2.3 Was a corrective PIAWE decision made?
76%
100%
Q5.2.5 Was there evidence of activity to gather the information required to calculate PIAWE?
90%
100%
Q5.2.6 Does the corrective PIAWE amount appear reasonable given the evidence on the file?
76%
50%
Q5.2.8 Was the timeliness of the decision reasonable?
67%
50%
Q5.2.9 Were corrected payments made to historical (interim) payments to the injured worker made (if the interim PIAWE was less than the corrected PIAWE)?
72%
100%
PIAWE
Q5.3.1 Was there evidence of activity to gather the information required to calculate PIAWE within 7 days of claim notification?
88%
89%
Q5.3.2 Does the PIAWE amount appear reasonable given the evidence on the file?
90%
100%
Weekly Payment
Q5.4 Overall, were weekly benefits paid at the appropriate rates?
73%
88%
Q5.5 Are weekly benefits paid consistent with Employer's reimbursement schedule or other relevant documentation?
75%
95%
Q5.6 Is there sufficient evidence of the worker's incapacity to support the level of weekly benefits being paid?
79%
90%
Work Capacity Decision
Q5.7 Have appropriate work capacity decisions been made in accordance with available information?
80%
94%
Q5.8 Is there evidence of re-assessment of the claim status (liability) with regards to work capacity?
74%
81%

9.5 Use of interim PIAWE

This review collected more data on the use of interim PIAWE as this was identified as an issue in the 2020 Q1 review. The following tree diagram summarises the findings



The key observations from this analysis are:

- 45% of the claims sampled used an interim PIAWE
- Where an interim PIAWE was used, 37% of these claims subsequently had a corrective PIAWE decision. 63% of these claims did not have a corrective PIAWE (in some cases a corrective PIAWE was not necessary as the interim PIAWE was confirmed to be correct)
- As previously stated, it was considered that for 22% of the files reviewed or 27 claims, weekly benefits were not being paid at appropriate rates. The analysis above shows that 19 of these 27 cases arose when an interim PIAWE was used (the left side of the tree)
- Where an interim PIAWE was not used, 58 of 66 claims were considered to have weekly benefits paid at the appropriate rate (the right side of the tree)
- In a small number of claims analysed during this 2020 Q2 review, there were a number that post-dated the simplifications made to PIAWE in October 2019. These claims used an agreement between the employer and injured worker as the basis for PIAWE and in all cases, weekly benefits appear to have been paid at the appropriate rate. Future reviews should begin to see a greater number of these examples

9.6 Concerns with the payment of weekly benefits

For the 22% of the sample where it was considered that weekly benefits were not paid at the appropriate rate, the main concerns included:

- Payments did not align to periods of incapacity
- Evidence of conflicting PIAWE amounts on file that did not appear to have been resolved
- Wrong drop-down periods appeared to have been applied.

For this category, icare has been informed of the claims where issues were identified, and we are awaiting responses to these queries.

10. Data quality

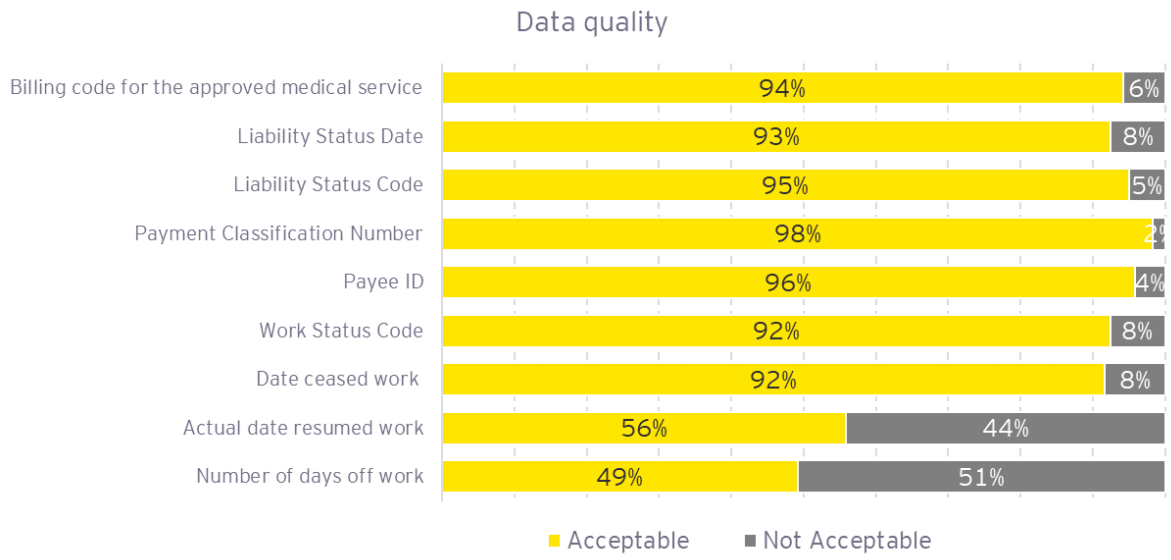
10.1 Key findings

During the 2020 Q2 review, a number of data fields were assessed for accuracy. All fields assessed showed better data quality than at the 2020 Q1 review.

- The data fields assessed as showing greater than 90% accuracy included:
  - Liability Status Date
  - Liability Status Code
  - Payment Classification Number
  - Payee ID
  - Work Status Code
  - Date Ceased Work
- The date resumed work and the number of days off work both showed poor data quality.

10.2 Detailed results

The detailed data fields and results from this 2020 Q2 review are shown in the following graphic:



11. Reliances and limitations

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.

The work that we have performed does not constitute an audit in accordance with Australian Auditing Standards or a review made in accordance with Australian Auditing Standards applicable to review engagements and, consequently, no assurance is expressed in the nature and content of any advice provided.

The conclusions in this report are based on a sample of 120 claims. While we believe that this sample is representative of the claims received by the Nominal Insurer, it is clearly a small proportion of the total claims received and the results may differ if a substantially larger sample was reviewed.

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.

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.

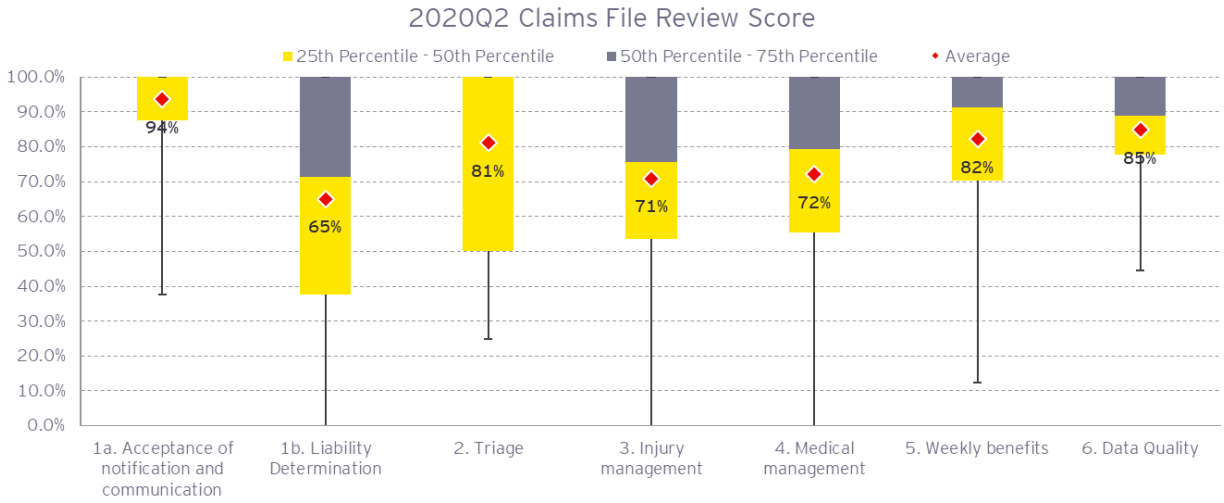
Not all questions were given a score. For example, the question "Did this claim involve surgery?" was not scored, however the subsequent question "Were the costs associated with surgery properly scrutinised?" was scored.

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 – the trends and movements in scores are more important; as further claims file reviews are carried out over time, it would be expected that the scores will increase as claims management improves.

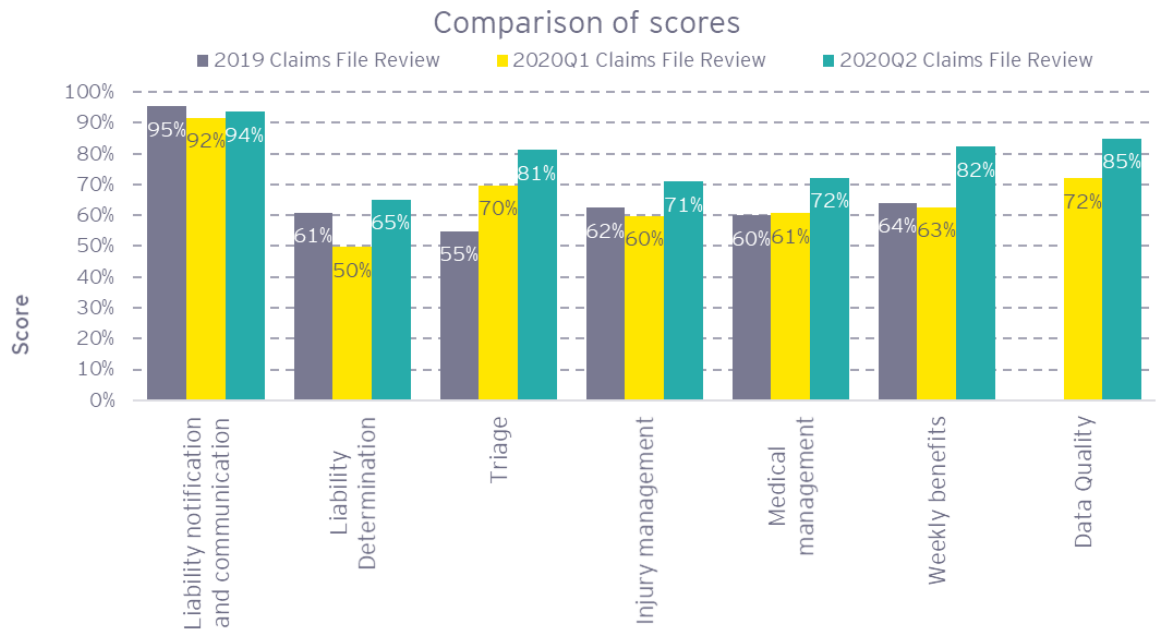
The scores for this review are shown in the following graphic.



The plots for each section can be interpreted as:

- The median score is where the yellow and grey boxes meet; an equal number of scores will be above and below the median
- Where the average (red diamond) moves further from the median implies that the scores are spread further on that side from the median
- 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 2020 Q2 review with those in the 2019 review and the 2020 Q1 review.



We have been able to statistically test the significance of the difference in scores between the 2020 Q1 and 2020 Q2 reviews.

The 2020 Q2 review consists of 80 EML claims and 40 Allianz and therefore to compare like with like, we have compared the 80 EML claims with the 85 EML claims from the 2020 Q1 review. The results are shown in the following table.

	2020Q1	2020Q2	p-value	Statistically different at 95% confidence interval
1a. Liability notification and communication	92%	93%	0.51	No
1b. Liability Determination	50%	62%	0.01	Yes
2. Triage	70%	87%	0.00	Yes
3. Injury management	60%	68%	0.09	No
4. Medical management	61%	69%	0.03	Yes
5. Weekly benefits	63%	78%	0.00	Yes
6. Data Quality	72%	85%	0.00	Yes

This table indicates that for "Liability notification and communication" and "Injury management", the results are not statistically different given the sample size and a 95% level of confidence. The results for the other categories can reasonably be labelled as "have improved" between 2020 Q1 and 2020 Q2.

We have also been able to test the significance of the differences between EML and Allianz and these results are shown in the following table.

	EML	Allianz	p-value	Statistically different at 95% confidence interval
1a. Liability notification and communication	93%	95%	0.52	No
1b. Liability Determination	62%	71%	0.15	No
2. Triage	87%	95%	0.02	Yes
3. Injury management	68%	77%	0.04	Yes
4. Medical management	69%	78%	0.13	No
5. Weekly benefits	78%	91%	0.00	Yes
6. Data Quality	85%	84%	0.79	No

This table shows that there is no statistical difference in the scores between EML and Allianz for:

- Liability notification and communication
- Liability determination
- Medical management
- Data quality.

Allianz did show statistically better scores than EML for:

- Triage
- Injury management
- Weekly benefits.

EY | Assurance | Tax | Transactions | Advisory

About EY

EY is a global leader in assurance, tax, transaction and advisory services. The insights and quality services we deliver help build trust and confidence in the capital markets and in economies the world over. We develop outstanding leaders who team to deliver on our promises to all of our stakeholders. In so doing, we play a critical role in building a better working world for our people, for our clients and for our communities.

EY refers to the global organization, and may refer to one or more, of the member firms of Ernst & Young Global Limited, each of which is a separate legal entity. Ernst & Young Global Limited, a UK company limited by guarantee, does not provide services to clients. Information about how EY collects and uses personal data and a description of the rights individuals have under data protection legislation is available via ey.com/privacy. For more information about our organization, please visit ey.com.

In line with EY's commitment to minimize its impact on the environment, this document has been printed on paper with a high recycled content.

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 dated 20 April 2017. We disclaim all responsibility to any other party for any loss or liability that the other 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.

ey.com