Compliance and Performance Review of the Nominal Insurer

State Insurance Regulatory Authority

December 2019

Part 1: Claims management

Building a better working world

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1. Executive Summary

In February 2019, the State Insurance Regulatory Authority (SIRA) commenced an integrated compliance audit and performance review of the NSW workers compensation Nominal Insurer (the NI or the NI scheme), which is managed by icare workers insurance (icare). EY has been engaged by SIRA to support the independent review being conducted by Ms Janet Dore.

The terms of reference (included in full as Appendix A) for the review include:

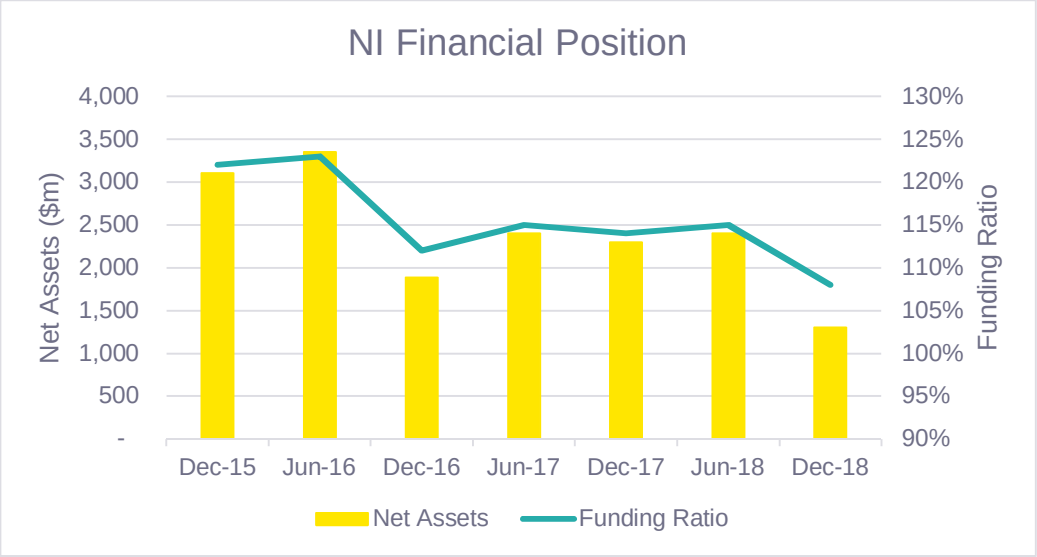
- An audit of compliance with relevant guidelines including the Market Practice and Premium Guidelines (MPPGs), and
- A performance review in relation to claims management, return to work outcomes and other objectives under the legislation

This report covers the second item in the terms of reference and examines the new claims operating model of the Nominal Insurer. EY's scope is outlined in section 1.1.

SIRA has legislative objectives in regard to the NSW workers compensation system. The primary objectives are ensuring the financial viability of the system and ensuring its effectiveness in returning claimants to work. The NI, as by far the largest insurer in the system, is clearly the key insurer in achieving these objectives for the system.

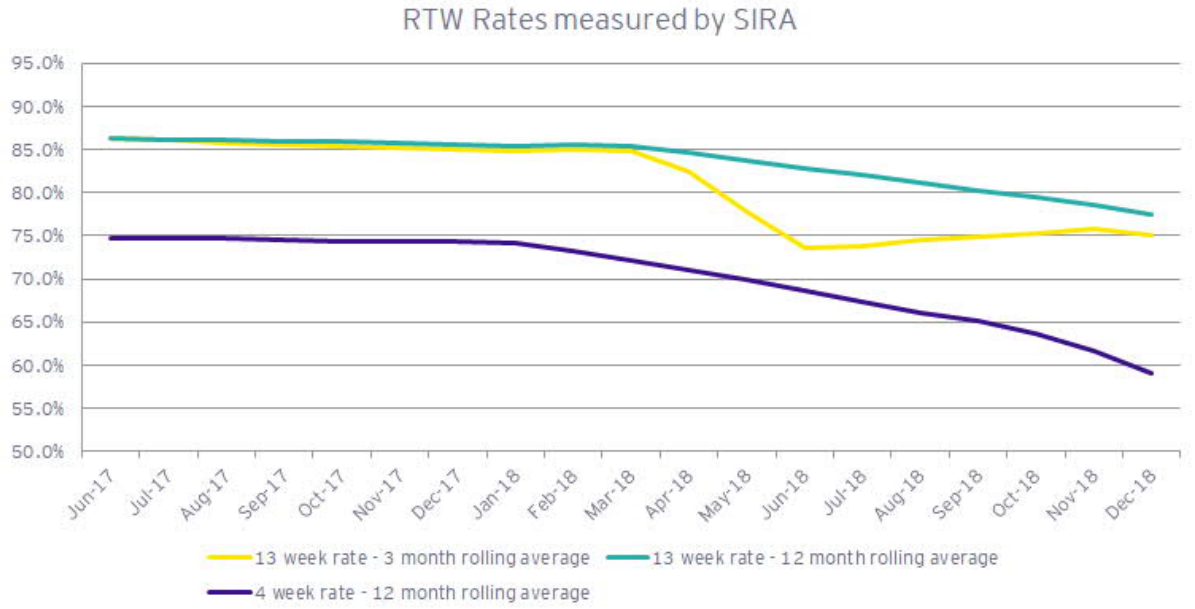
The financial position of the NI has been deteriorating since 2016. This is best seen by the deterioration in the NI's funding ratio (the ratio of assets over liabilities) since December 2015, as highlighted in Figure 1 (the financial position is assessed with the liabilities at an 80% probability of adequacy as per the NI's accounts).

Figure 1: NI's financial position



The effectiveness of the NI, as measured by the return to work (RTW) rates achieved, has also been deteriorating as can be seen in Figure 2.

Figure 2: NI return to work rates



The graph above shows 13-week RTW rates reducing by approximately 10% between March 2018 and December 2018. The 4-week RTW rates have also decreased since January 2018. The timing of the change in RTW experience coincides with the implementation of icare's new claims operating model which became effective at 1 January 2018.

1.1 Scope

SIRA commissioned EY to assist with the NI performance review. EY's scope is outlined in section 2.3. This report summarises the findings in regard to the NI's claims management. Findings relating to the NI's premium system and analysis of expenses are contained in separate EY reports.

The key focus of EY's scope is summarised as:

- Analysis of the new claims model outcomes for the 2018 accident year to identify areas where icare's new claims operating model and claims management processes under the new model since 1 January 2018 are producing significantly different outcomes when compared with previous scheme agents and claims management models
- Understand the key features of the operating model and the potential impacts of the model on current claims experience
- Assess the NI's claims management performance and its impact on RTW and the financial sustainability of the NI scheme
- Identify the benefits and risks to the performance of the NSW workers compensation system arising from icare's implementation changes to the NI's claims operating model.

1.2 Methodology

To assess icare's new claims operating model and the performance of EML as the appointed scheme agent[1] since 1 January 2018, EY conducted:

- A desktop review of documentation supplied by icare. This documentation was focused on the NI's claims operating model implemented on 1 January 2018 for claims reported on or after this time (although ultimately Allianz was also engaged to manage some new claims)

[1] Scheme agent and service provider are used interchangeably throughout the report

- A range of data analysis based on claims data extracted from the claims database that the NI supplies SIRA (the data extract was as at 31 March 2019). Detailed results are provided in appendices C through H
- A claims file review of 122 claims managed by EML, Allianz and GIO conducted by personnel with significant personal injury claims management expertise. Detailed results are provided in appendix I.

An outline of EY's methodology is contained in section 2.5 of this report.

1.3 Background

Claims management is the most important function carried out by the NI. The outstanding claims liability, approximately $15bn as at 31 December 2018, is the largest liability on the NI's balance sheet and claims related expenses account for approximately 70% of all premium collected. That is, of the $2.3bn in premiums written in the 2017/18 financial year, approximately $1.6bn was paid directly to or for the benefit of injured workers.

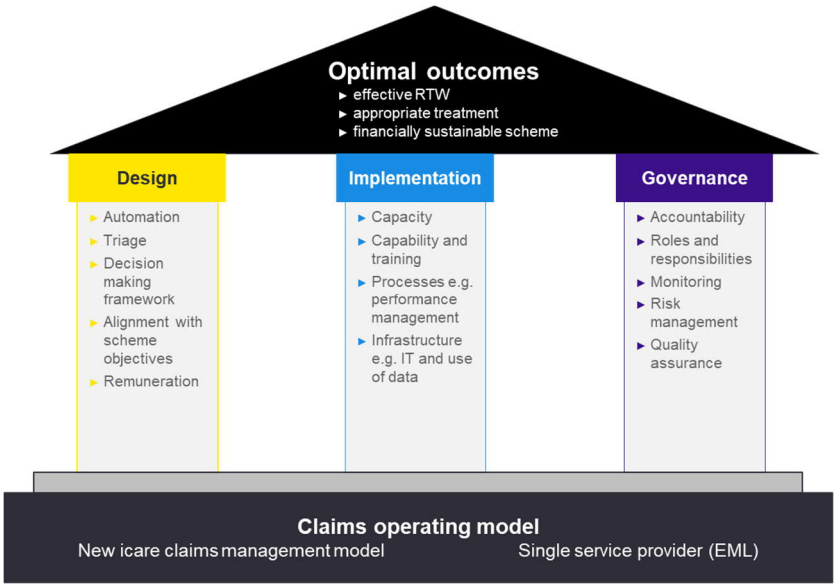
At the start of 2018, icare introduced a new claims operating model for the NI. This included appointing EML as the scheme agent to manage new claims from 1 January 2018. The NI scheme receives approximately 90,000 claim notifications per annum or 60,000 claims that ultimately receive weekly or medical payments.

The intention of the new claim operating model was to improve the experience and outcomes of injured workers. Philosophically, icare believes it is moving from an adversarial model to an empowered model in which:

- Customers are empowered
- Empathetic customer service is provided
- Return to work/life is facilitated
- Partners are extensions of icare
- Straight through processing is applied where possible
- Resources are attending to claims in greatest need.

In any workers compensation scheme, the claims operating model is the foundation of achieving a financially sustainable and effective scheme that returns claimants to work as quickly as possible. In changing the previous claims operating model, icare still needed to ensure the outcomes achieved by the new model met the legislative objectives of the NSW workers compensation system. As such, the design, the implementation and the governance of the new claims operating model needed to ensure these primary aims were met. Figure 3 is a graphical representation of the three key pillars required of the claims operating model to ensure optimal claimant and scheme outcomes are achieved.

Figure 3: The NI claims operating model is the key to success



1.4 Key Findings

The key findings of this review are that a number of factors related to the new claims operating model implemented by icare in January 2018 have adversely impacted claimant outcomes. This includes icare moving to a single service provider via a contracted arrangement with EML as the scheme agent to manage new claims.

The review found evidence that there were weaknesses with the design of the claims operating model that have been compounded by difficulties with implementation of the model, and a governance framework that was not fully operational during 2018. This appears to have led to deteriorating RTW rates, excessive claim payments (both weekly and medical) and generally poor claims outcomes for injured workers.

In summary, the following key issues with respect to the design, implementation and governance of the claims operating model were identified:

- The claims file review indicates that during 2018, the triage model designed by icare did not accurately allocate claims to the most appropriate triage category. Approximately 40% of the files reviewed were allocated into the wrong support category and thus delayed the necessary treatment that injured workers required

- The RTW outcomes of the 2018 claims cohort were impacted by inaccuracies of the triage system combined with the design of the Empower and Guide segments. During 2018, these segments did not assign injured workers a dedicated case manager and this resulted in passive case management and a lack of timely intervention to ensure these claims received the most effective treatment

- EML was encouraged to focus on recruiting staff with customer service skills and this appears to have resulted in a lack of focus on recruiting the skills and experience required for the technical case management of personal injury claims

- EML's financial incentives (refer to section 3.2.4) do not appear to encourage or reward technical case management nor encourage case managers to be active participants in the claims management process. The claim file review found little evidence that claims managers were challenging a claimant's entitlement to workers compensation benefits. This appears to have led to claims being paid without the appropriate due diligence or investigation

- During 2018, it appeared that the claims operating model lacked an effective governance structure that would have enabled icare to identify and rectify the key issues identified by this review.

It appears that icare's less adversarial approach to claims management, and other elements of the design and implementation of the model, are manifesting in a lack of due diligence and investigation into areas such as liability causation, claimant history, effective treatment and ongoing weekly payments. Best practice case management ensures that validly injured workers receive the support they require yet also applies a challenging mindset to questionable claims, ensures factual investigations are thoroughly carried out and applies the necessary scrutiny to proposed medical decisions and procedures. The claims file review identified a number of instances where these principles were not being followed (refer to appendix I for the full findings of the claims file review).

The following sections outline the issues identified with each of the three key elements of design, implementation and governance.

1.4.1 Design of the claims operating model

The following table sets out the design elements of the claims operating model that appear to be impacting the claims outcomes of the scheme.

Table 1: Design elements	
Observations	• The automatic triaging of claims into 5 different claims management segments (through a combination of a triage algorithm and review by triage specialists) was based on a limited amount of detail regarding the injured worker and their circumstances at the time of claim lodgment • The decision-making framework established between icare and EML seems overly complex and potentially burdensome for a case manager to comply with • There is a deliberate intent to accept claims provisionally with the aim of starting treatment immediately • The scheme agent contract with EML contains limited incentives to ensure that EML's objectives are aligned to the system's objectives • The single agent model has reduced competitive tension in the system and reduced the ability to compare outcomes across scheme agents
Findings	• The claims file review indicated that the triage algorithm was incorrectly assigning injured workers to cohorts where the support levels were inadequate, and it was taking too long to rectify this and to subsequently provide the appropriate case management that these claims required • The Empower and Guide segments of the claims operating model do not allocate a case manager to claims. This aspect of the model does not appear to give proper consideration to the need for and benefits of injured workers, case managers and employers working collaboratively together • Provisional liability is now being used for the majority of claims, resulting in additional work for case managers, reduced urgency with claim liability decisions and less rigour being applied to case management in the early stages • The combination of the use of provisional liability and the triage algorithm not being accurate was compounding. The intent of the "Empower" and "Guide" segments was minimal intervention by case managers, with the assumption that these claims would resolve themselves within a matter of weeks. However, when claims were accepted provisionally and triaged into what turned out to be the wrong support cohort, they were left unattended in the belief that injured workers would return to work with minimal intervention. This is a fundamental issue with the design of the claims operating model • The decision-making framework between icare and EML has not been effectively implemented. The claims file review found no evidence of EML

Table 1: Design elements	
	seeking icare approval for the delegated spending levels detailed in the decision-making framework (e.g. for rehab spend above $10,000[2]) • The claims file review also found no evidence of icare monitoring delegated spend levels or other aspects of compliance with the decision-making framework • The scheme agent contract with EML does not appear to incentivise EML to be an active participant in the claims management process. In addition, with one dominant agent, there is little or no competitive tension in the NI scheme that may otherwise assist icare to drive improved performance of the scheme agent
Impact	• RTW rates have deteriorated at early durations (4, 13 and 26 weeks), indicating that injured workers are not receiving the treatment and support they require to return to work as quickly as previous claim cohorts (refer to Appendix F for full detail)

1.4.2 Implementation of the claims operating model

The following table sets out the implementation elements of the claims operating model that are impacting claims outcomes of the scheme.

Table 2: Implementation elements	
Observations	• Documentation indicates that EML has struggled to keep up with the demand for resources and recruitment has lagged behind required staffing levels (FTEs were behind budget by approximately 40 as at November 2018). As a result, caseloads have been higher than expected when the claims operating model was designed • Part of the recruitment focus of EML, mandated by icare, was on customer service skills rather than personal injury case management skills • icare's Nominal Insurer Single Platform (NISP) system was not operational until February 2019. Prior to this, EML's claims management system, EMICS, was used for claims management. While it was not within the scope of this review, it was difficult to ignore the shortcomings of EMICS during the claims file review[3] • There is an increasing number of primary psychological injury claims observed in the last 18 months (refer to appendix E for full details). These claims are the most difficult in terms of initial liability acceptance and then ongoing management. The claims file review identified mixed performance in regard to the management of psychological injury claims • In addition, there is an increasing number of physical injury claims that are receiving psychological services, possibly indicative of secondary psychological injuries • Although only a small number of claims managed by Allianz and GIO were reviewed, there was a marked difference in the performance between each of the three scheme agents
Findings	• In regard to psychological injury claims. the claims file review highlighted variability in the experience of EML's case managers. Some claims were handled very well while others were handled very poorly. This has substantial ramifications for both the injured worker and the cost to the NI scheme • The performance difference between each of the three scheme agents appeared to be primarily driven by pro-active initiatives taken by Allianz and GIO when compared with EML

[2] Key component of the decision making framework was for EML to have certain payments approved by icare above defined thresholds

[3] Full results of the claims file review are included as Appendix I and some broad observations are made on the various IT platforms used by the scheme agents EML, Allianz and GIO. No claims currently managed on the NISP were reviewed for this review

Table 2: Implementation elements	
	• Many aspects of the claims reviewed under the single service provider model indicated a lack of technical case management expertise. This included: o Lack of investigation of a claimant's past employment claims and medical history o Not recognising the existence of conditions that were unrelated to the claimant's employment o For a number of psychological injury claims, there was often enough doubt regarding the alleged psychological condition and any events which arose out of, or in the course of, the claimant's employment to warrant further investigation or challenge o Not requesting an IME when evidence suggested it may be warranted o Not recognising when submitted treatment expenses were either not related to the work related injury or where treatments were excessively expensive. The term "reasonable necessary" expenses seems to be interpreted as not challenging any form of treatment or its associated expense. There were numerous instances in which this interpretation appeared generous o A lack of awareness of when it would be beneficial to appoint a rehabilitation provider and in cases where a rehabilitation provider was appointed, then ceding all management of the claim to the rehabilitation provider • EMICS appears to be cumbersome and does not lend itself to effective and efficient case management. One example is that there is no central index of the documents on file. It was difficult to look at a claim file and understand its lifecycle to date (for example, it was difficult to locate certificates of capacity or prior communication with the injured worker).
Impact	• During 2018, maximum caseloads were being exceeded due to EML being under-resourced from the inception of the new model • The file review found a lack of investigation of liability decisions and a lack of scrutiny of the treatments being prescribed and invoiced. The file review also identified that injured workers were not getting the support they require in an appropriate timeframe due to a lack of pro-activity on the part of the service provider. This, in part, is likely a result of the high caseloads experienced by EML during 2018 • Aspects of EMICS functionality are particularly problematic for claims in the "Empower" and "Guide" cohorts that do not have a dedicated case manager.

1.4.3 Governance of the claims operating model

The term governance is being used in a broad sense to mean governance of the claims operating model by icare, monitoring of the scheme agent EML's performance and identification and subsequent rectification of claims management issues that are adversely impacting outcomes for injured workers.

The following table sets out the governance elements of the claims operating model that are impacting claims outcomes of the NI scheme.

Table 3: Governance elements	
Observations	• There is an array of committees and forums, each with substantial membership, described to govern the relationship between icare and EML (shown in section 5.2). • A post implementation review conducted by PwC found that the operational and governance committees were still not fully established by November 2018 • Key KPIs to govern EML's performance and conformance to icare's operating model do not appear to be well defined or currently operational

Table 3: Governance elements	
	• As previously mentioned, there is a relatively extensive decision making framework in place between icare and EML
Findings	• The decision-making framework between icare and EML does not appear to be being adhered to or enforced • There was no evidence identified to support icare challenging any payments made by EML or effective monitoring of the decision-making framework • There were a number of instances identified where weekly payments were being made: o without reference to reimbursement schedules o inconsistent with certificates of capacity o with incorrect calculations o in line with reimbursement schedules but for amounts above the calculated PIAWE amount • There were a number of instances identified where payment was made for diagnostic services that were either not required for the injury sustained or were ordered multiple times for the same claimant • In a number of cases, medical and weekly payment limits appear to have been exceeded and liability decisions made outside of the mandated timeframes. This was particularly notable whilst claims were in provisional liability. • As previously mentioned, claims triaged into an inappropriate support category were not being efficiently identified and remedied • In summary, there was little evidence found of icare effectively monitoring the key aspects of claims management. Effective monitoring could have identified many of the issues listed above and led to them being remedied • During the claims file review, a range of claims from across the period since the new operating model was implemented were reviewed and there was limited evidence found of improvement in claims management across that time.
Impact	• Overall, the claims file review indicates that there is potential for substantial claims leakage within the NI scheme. That is, arguably unnecessary payments being made that are not resulting in better outcomes for injured workers. This is leading to increased claims costs for the scheme without any commensurate improvement in outcomes for injured workers • Appendices G and H outline increasing trends in weekly and medical payments • Although icare does have a QA program, there was no evidence identified that its findings are making it back to frontline staff and resulting in better case management • There was no evidence identified to support icare having effective monitoring in place to identify non-compliance with the claims operating frameworks that they had established.

1.5 icare's response

A draft version of this report was provided to icare to allow for factual accuracy checking and any other comments. The comments provided by icare have been considered for the final report. While icare did not agree with all the findings in the report regarding the design of the claims operating model, icare did recognise there had been a number of implementation issues with the new claims operating model that have led to poor claims management practices and which have impacted on the RTW results of the Nominal Insurer. We understand that icare has implemented a number of initiatives to improve performance. More detail on these initiatives are outlined in section 6 of this report.

Most of these initiatives have occurred following the review period covered by this report. As a consequence, the effectiveness of any of those initiatives has not been reviewed as part of the scope of this report.

1.6 Conclusions

In January 2018 icare introduced a new claims operating model and appointed EML as the single scheme agent. The analysis shows that the experience of the cohort of claims under the new model has been materially worse than the proceeding accident periods across a number of key metrics. EY's scope of work and, as a consequence, the claims file review, focussed on this cohort of claims. The results show poor claims management practices across a number of key areas of the claims lifecycle.

It is our view that icare's new claims operating model, combined with the appointment of EML as the single scheme agent under the new model, has been the main reason for the deterioration experienced in short term RTW rates. Based on the findings of the claims file review and our experience with similar reviews across other Australian jurisdictions, we believe there are issues with the design of the new operating model, its implementation and the governance framework established to monitor the new operation. In summary:

- The RTW outcomes of the 2018 claims cohort were impacted by inaccuracies of the triage system combined with the design of the Empower and Guide segments. These segments do not assign injured workers a dedicated case manager and this has resulted in passive case management and a lack of timely intervention to ensure these claims received the most effective treatment

- A lack of personal injury case management experience of EML's case managers leading to a lack of pro-active decision making and a passive approach to managing claims. This was being compounded by EML staffing levels that have lagged behind budgeted FTEs since the implementation of the claims operating model, leading to high case loads

- Overlaying this is a lack of effective governance (monitoring of experience, early recognition of problems and feedback to EML) in order to identify and rectify the problems identified by this review.

The poor experience of the 2018 cohort of claims has not yet had a material impact on the financial position of the NI. The deterioration in the funding ratio illustrated in the introduction is primarily due to:

- A greater number of injured workers from the pre-2012 cohort remaining on benefits than originally assumed when the 2012 legislation was introduced

- The impact of the 2015 reforms, which extended medical benefits for injured workers subject to section 39

- A reduction in the risk free discount rate that impacts the liabilities and is not fully hedged on the asset side

- A significant increasing trend in medical payments that began in 2016.

The deterioration in the RTW rates for the 2018 cohort already means that there are more injured workers remaining on benefits than at the equivalent time for prior periods. If this 2018 cohort cannot be remediated, then inevitably there will be a material flow on impact to the outstanding claims liability (i.e. total future claims payments will be more than originally expected). This impact will be compounded if the issues identified with the claims management continue and impact subsequent accident periods. Notably the experience of the 2019 accident year is also at risk.

As stated, icare has introduced a range of measures to address a number of the identified problems. The effectiveness of these initiatives has not yet been assessed.

1.7 Reliances and Limitations

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.

The conduct of this Review has been dependent on the provision of information, including documentation and consultations with relevant stakeholders. The data received and relied upon for this review is outlined in Appendix B. In undertaking this review, reliance has been placed upon information supplied in the consultations and documentation, and has been used without independent verification.

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.

Refer to section 7 for complete Reliances and Limitations.

2. Background, Scope and Methodology

2.1 Introduction

In February 2019, SIRA commenced an integrated compliance audit and performance review of the NSW workers compensation Nominal Insurer (the NI or the scheme), which is managed by icare workers insurance (icare).

The terms of reference for SIRA's review include:

- An audit of compliance with relevant guidelines including the Market Practice and Premium Guidelines (MPPGs), and
- A performance review in relation to claims management, return to work outcomes and other objectives under the legislation

The review will be undertaken for SIRA by an independent expert, Ms Janet Dore, and supported by EY and authorised officers of SIRA. The Terms of Reference for the review are to consult with stakeholders and undertake analysis of data to provide findings in relation to the NI's compliance and performance, in particular to:

- Assess NI compliance with the MPPGs and identify any unintended consequences, risks and priorities for improvement in SIRA regulation of the premiums of the NI
- Identify the benefits and risks to the performance of the NSW workers compensation system arising from icare's implementation changes to the NI operating model and supporting digital platforms
- Assess the NI's performance in relation to return to work outcomes, claims management (including guidance, support and services for workers, employers and health service providers), customer experience and data quality and reporting.

The Independent Reviewer, Ms Dore, and EY will present on their independent findings to the SIRA Chief Executive and Board.

2.2 Background

Key issues that have arisen during the last three years include:

- Deterioration in claims experience, including increasing payments in relation to medical costs and weekly benefits, and deterioration in return to work (RTW) rates
- Increasing NI scheme expense levels
- Reducing NI scheme funding position
- Concerns around compliance with Market Practice and Premium Guidelines (MPPGs) and other premium practices, as evidenced by poor policyholder feedback
- Data quality issues
- Governance and risk management issues.

Over this period, icare has embarked on a significant transformation that includes:

- Consolidation of its insurance policy and claims service functions, previously administered by five scheme agents – Allianz, CGU, EML, GIO and QBE on icare's behalf – and the appointment of EML, together with Allianz and GIO, to continue as scheme agents beyond 31 December 2017
- Selection of EML as the key partner that will manage all new claims from 1 January 2018, whilst GIO and Allianz will manage the run-off of older claims
- icare taking a more prominent role in the worker's compensation ecosystem, including managing all policy transactions in-house and hosting the NISP
- Implementation of a customer-centric Return to Work and Support service model that streams claims into service segments to meet customer needs based on claim complexity. icare has stated that the service model is enabled by technology which allows the customer to choose

how they engage with icare, including advanced telephony through call centre capability and an ability to self-serve using a single system and portals.

The complete terms of reference are included as Appendix A to this report.

2.3 EY's scope

The scope of EY's services for this review are contained in a letter to Mr Darren Parker dated 16 May 2019. 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. The terms and conditions covering this engagement are as set out in Contract Agreement SIRA//6358/2016 between EY and SIRA commencing on 20 April 2017.

This report contains our conclusions from the review into the claims management of the NI scheme. EY's scope is summarised below.

Analysis of data

Conduct a quantitative analysis of the new claims model outcomes for the 2018 accident year against prior years at the same stage of development. This would include analysis of:

- Payments by benefit type
- Claim numbers reported
- Number of active claims
- Return to work rates
- Rates of service / service provider use
- Use of provisional liability
- Acceptance of psychological injury claims.

Such analyses would identify areas where icare's claims management model. including moving to a single service provider via a contracted arrangement with EML from 1 January 2018, are producing significantly different outcomes when compared with previous scheme agents and claims management models.

This analysis will be utilised to:

- Assess the NI's claims management performance and its impact on RTW and the financial sustainability of the NI scheme
- Identify the benefits and risks to the performance of the NSW WC system arising from icare's implementation changes to the NI claims operating model.

This analysis also informed the selection of a stratified random claims sample for the claims file review.

Desktop review

Conduct a desktop review of icare's claims management model, to understand the key features of the model and the potential impacts of the model on current claims experience.

Documents and monitoring reports reviewed include (a full list is contained in Appendix B):

- Reviews and/or research icare conducted when designing the model
- icare's documentation of the model including the triaging methodology
- EML's deed – including remuneration, Service Level Agreements and claims management instructions that EML is required to comply with
- Operation of icare's medical panel
- Statistics monitored by icare such as the number of claims going into each of icare's defined levels of care and the number of times claims change categories after initial categorisation
- A review of the metrics icare is using to measure the success of EML and the new claims model.

Claim file review

The results of the experience analyses and desktop review were used to develop criteria that were used to select a random sample of files to review, which represented a cross-section of claims being managed by EML (the majority of claims reviewed), as well as Allianz and GIO claims, across the first year of the new model.

The review was conducted by three experienced claim file reviewers (including one reviewer from SIRA). The review involved:

- Developing a consistent set of evaluation criteria to assess claims / files
- Reviewing the sample of claims / files based on this evaluation criteria and recording the findings
- Consolidating the individual review findings and distilling key themes
- Documenting the detailed review for each claim / file.

The review encompassed 122 claim files, including 92 from EML, 15 from Allianz and 15 from GIO. Full results of this review are included as appendix I.

2.4 Not in scope

One issue that became apparent during the review was EML' EMICS system. While not in scope of this review, it became evident that this system was having an impact on the viability and effectiveness of the NI claims operating model.

During the claims file review, EML's EMICS system was used for the majority of the claims reviewed. The system did not appear to have any master data catalogue for each file and as such, it was difficult to understand the actions that had taken place on a claim file. This would be especially burdensome for those claims in the Empower or Guide segments, where there is no dedicated claims manager, thus making it difficult for a new claims manager to understand what has previously occurred in relation to a particular claim.

We understand that ultimately, the NISP will replace this system. We have not reviewed or had exposure to the NISP. SIRA should consider reviewing the NISP once it is fully operational to ensure that it will overcome the problems identified with EMICS.

2.5 Methodology

Data analysis

The data analysis was conducted on CDR data extracted at 31 March 2019. The primary aim of the analysis was to compare claims performance of the 2018 accident year to the performance of prior periods at the same stage of development. This analysis necessarily concentrated on the first four development quarters of each accident year, since the 2018 year has not developed further than this.

The main experience items that were analysed included:

- The use of provisional liability
- Claims incidence rates
- Incidence of psychological injury
- RTW rates
- Weekly payments and weekly active claims
- Medical payments and medical active claims.

This analysis is presented in appendices C through H.

Claim file review

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. This 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 triage
- Use of provisional liability
- Liability decisions
- Ongoing liability and work capacity assessment
- Injury management and return to work
- Medical treatment and costs
- Weekly benefit assessment and payments.

Once each questionnaire was completed, all results were collated and analysed. These results are summarised and presented in appendix I of this report. These results and the results of the desktop review and data analysis completed by EY led to the conclusions presented in this report on the performance of icare's claims operating model and scheme agent for the 2018 year.

Claims sample

A stratified random sample of 122 claims was selected for the claim file review. The strata used for the sampling were:

- Date claim reported between 1 January 2018 and 31 January 2019 and claim open status
- Liability status of provisional, accepted or denied
- Injury type of fracture, sprains, psychological injury or other
- Weekly benefits duration of <1 week, 1-4 weeks, 4-13 weeks, 13-26 weeks or 26+ weeks

In the first instance, this sample produced 4 claims with a primary psychological injury. It was thought that reviewing only 4 of these claims would not allow meaningful conclusions to be drawn, and this sample size was increased to 20 psychological injury claims prior to the commencement of the file review. The rest of the sample was re-drawn based on the above strata (excluding the 20 psychological injury claims).

2.6 Data

The full list of data and documents used for this review is included as Appendix B.

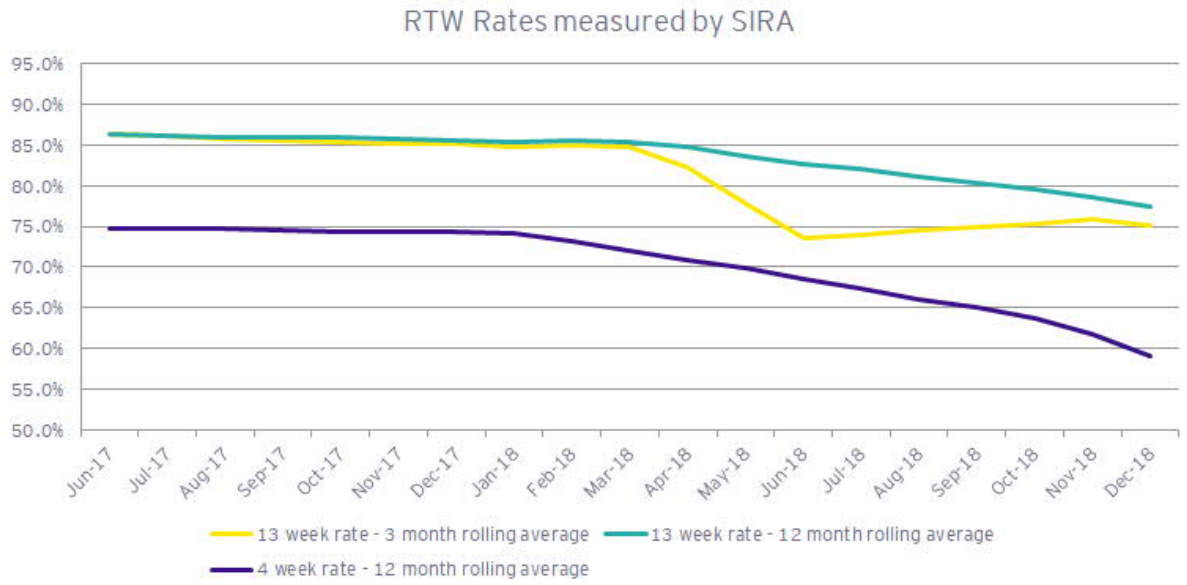
For the quantitative analyses, CDR data as at 31 March 2019 was used. The claims header file and the payment transaction file were predominantly used.

3. Design of icare's claims operating model

3.1 Key conclusions

The review has identified a number of design issues with icare's claims management model that are leading to poor claimant outcomes. These poor claimant outcomes are manifesting primarily in deteriorating RTW rates as shown in Figure 4 (refer to Appendix F for more detail). RTW rates are a key indicator of the effectiveness of any workers compensation scheme.

Figure 4: RTW rates assessed by SIRA



The design elements of concern include:

- The triage algorithm is incorrectly assigning injured workers to cohorts where the support levels are inadequate, and it is taking too long to recognise this and to subsequently provide the appropriate case management
- Provisional liability is now being used for the majority of claims, resulting in additional work for case managers, reduced urgency with claim liability decisions and less rigour being applied to case management in the early stages. Many workers compensation claims are straightforward, and liability could be accepted immediately with minimum further investigation
- The intent of the "Empower" and "Guide" segments is minimal intervention by case managers (there are no dedicated case managers assigned within these two segments), with the assumption that these claims would resolve themselves within a matter of weeks. It appears from the claims file review that the combination of incorrect triage and the acceptance of claims provisionally results in delayed investigations and delays in some claims receiving the treatment and support they require. We view this as a weakness with the design of the model
- The decision-making framework between icare and EML has not been effectively implemented
- The scheme agent contract with EML does not appear to incentivise EML to be an active participant in the claims management process. In addition, with one dominant agent, there is little or no competitive tension in the NI scheme that might otherwise assist icare to drive improved performance of a scheme agent

3.2 icare's claims management model

3.2.1 Summary of model

icare has developed a segmented model with the aim of allocating resources to those claims most in need, allowing straight through processing where possible and focusing on return to work and life. To this end, the model triages claims into 5 categories. These are summarised in the following table, where each category's characteristics are also summarised.

Table 4: Triage Support Categories

Category	Definition	Case Load[4]	Estimated percentage of all claims
Empower	Low risk injuries where recovery is expected within 2 weeks	Individual case managers not allocated. Effective case loads are not known	60%
Guide	Low risk injuries where recover is expected between 2 to 4 weeks	Individual case managers not allocated. Effective case loads are not known	20%
Support	Injuries with significant risk factors that could result in incapacity of more than 6 weeks	Target 65 Actual 72	15%
Specialised	Complex injuries, fatalities and injuries caused by traumatic events	Target 35 Actual 42	4%
Care	Injuries requiring extreme support	Unknown	1%

According to the documentation provided, characteristics of the model include:

- Triage engine – The triage engine automatically triages claims into the categories above based on basic claim information
- Light touch processing – Treatment approvals are either processed automatically or escalated to staff members based on level of risk. For "low risk" treatments, an automatic approval is generated and sent to the service provider
- Invoice payments – Invoices are "read" into the system using optical character recognition; business rules then decide if the invoice is to be paid or not. This frees up claims staff from having to scrutinise invoices
- Event based review of claims – claims are automatically triggered for review when specific events for that claim are due to occur (this includes time based events)
- Customer service – icare's research "consistently shows that an empathetic, non-adversarial approach to claims management produces better outcomes for both employers and injured workers. Delays are avoided, disputes are less likely, workers recover more quickly and the cost to organisations of lost time decreases". icare's documentation indicates there was a preference for EML hiring staff with customer service skills and experience rather than personal injury case management skills and experience
- Injury management plans – these are automatically generated for the Empower, Guide and Support segments, and are updated when significant new information is received
- Liability decisions – frontline staff are empowered to accept provisional or full liability; a technical specialist must be involved if reasonable excuse is to be applied or liability declined
- Provisional liability – icare expects that claims within the Empower and Guide segments will resolve within the provisional liability timeframes (12 weeks of weekly payments) and limits (previously $7,500 of medical payments, now $10,000). Hence if a claim is triaged into Empower or Guide and accepted provisionally, the required services can be supplied to an injured worker without a full liability decision
- Medical Support Panel (MSP) – purpose is to speed up decision making by avoiding unnecessary Independent Medical Examinations (IMEs). The MSP can recommend an IME review. The MSP cannot recommend that a treatment, service or claim be disputed

[4] Actual caseloads as at May 2019

- Use of IMEs – staff are expected to make reasonable attempts to clarify the issue with the treating doctor. icare also requires that referrals to the MSP are considered prior to an IME. This is not included within the decision-making framework but is prominent within the documentation regarding the model
- Service provider (EML) – The service provider is viewed as an extension of icare. Legally, EML has been contracted as a service provider and icare has an entity (IC1) that is the scheme agent.

3.2.2 EML as the sole service provider (scheme agent)

A key component of the new claim model described above was the appointment of EML as icare's primary service provider. The language is deliberate – icare views EML as a service provider and not as a scheme agent. As such, icare established an entity ("IC1") that is legally the scheme agent. IC1 then contracts EML as a service provider to provide claims management services.

The intent was to move away from the previous structure of having 5 scheme agents that were responsible for all underwriting and claims operations. The single provider model is intended to increase consistency of customer experience and claims outcomes, simplify claims operations and effectively manage claims costs.

Philosophically, icare believes it is moving from an adversarial model to an empowered model in which:

- Customers are empowered
- Empathic customer service is provided
- Return to work/life is facilitated
- Partners are extensions of icare
- Straight through processing is applied where possible
- Resources are attending to claims in need.

3.2.3 Decision making framework

EML's delegated authority is set out in a document entitled "Decision Rights Framework Feb 2019". The framework documents the decisions that EML is entitled/required to make in relation to claims and the decisions that must be escalated to icare.

EML is given authority to approve reimbursements up to a "statutory" level. The "statutory" level is defined as amounts above which icare approval must be sought. One example given is EML can approve rehabilitation spend up to $10,000 but must seek icare approval above this level. It is not clear if there are other examples.

EML is allowed to make all liability decisions (with the exceptions noted below), although a "technical specialist" must be involved if a reasonable excuse may be applied or a claim disputed.

The exceptions to the above are determining liability on "fatality claims, significant claim events, complex behaviour claims or claims where liability is "disputed". icare is responsible for these decisions.

There are a number of other areas where EML is required to refer decisions to icare.

3.2.4 Remuneration of EML

Traditionally within personal injury schemes in Australia, scheme agents have been remunerated by a combination of fixed remuneration (somewhere between 80% and 100% of costs), variable remuneration (the remaining component) based on meeting agreed service level agreements and incentive remuneration that attempts to incentivise scheme agents to perform in certain areas such as RTW or reducing long term liabilities.

Many personal injury schemes in Australia use an outsourced claims management model. This model has often presented the challenge of aligning the objectives of the outsourced claim provider with the objectives of the scheme. The most frequently used tool to attempt this has been the contractual arrangements used to remunerate the scheme agents. The challenge of structuring remuneration has been consistent across all jurisdictions in Australia.

These challenges have involved:

- Managing the outsourced providers profit motive against the objectives of the scheme
- Balancing remuneration between fixed, variable and incentive remuneration
- Using incentive remuneration to drive the desired behaviour

Historically there have been many examples of scheme costs getting out of control due to poor governance of outsourced claims providers and misalignment of objectives between the scheme and the outsourced provider

The following table outlines the remuneration arrangements between icare and EML:

Table 5: EML Remuneration

Component	Description	Value
Annual Operating Fee	An amount equal to the actual operating costs for the provision of services. A budget is required to be submitted at the start of each calendar year. Corporate overheads limited to 10% of operating costs	87.0% of total remuneration possible
Annual Service Fee[5]	Amounts to 10% of the Annual Operating Fee	8.7% of total remuneration possible
Annual Outcome Fee	An amount up to 4.8% of the Annual Operating Fee. The annual outcome fee has three components	
1. Operating expense outcome measure	Measures actual operating cost against expected operating cost. If actual >103% of expected then this component is zero Amounts to 50% of the Annual outcome fee	2.1% of total remuneration possible
2. Net promoter outcome measure (NPS)	NPS target = 240 which is calculated as the maximum of: - the NPS of the service provider - the NPS of injured workers Amounts to 25% of the annual outcome fee	1.0% of total remuneration possible
3. Return to work outcome measure (RTW)	RTW is measured using work status code at 26 weeks and 104 weeks Amounts to 25% of the annual outcome fee	1.0% of total remuneration possible
Total		100%

[5] Effectively a profit margin

The remuneration summary above shows that the only incentive remuneration available to EML that relates to the effectiveness of its claims management is the RTW outcomes measure which amounts to 1% of total remuneration. In other words, there does not appear to be any significant attempt through remuneration to align EML's objectives with the NI scheme objectives.

3.3 Key findings from the claims file review

Our review has identified a number of design issues that we believe are impacting negatively on the claims outcomes being achieved by icare.

3.3.1 Triage

Evidence from the claims file review shows that the current triage process has been ineffective in allocating claims to the correct level of support.

The following tables summarise the initial triage decisions made on the 122 claims reviewed and the subsequent movement of these claims to other levels of support (no claims from the "care" category were reviewed). The triage decision was not available for 17 claims reviewed.

Table 6: Numbers of claims transitioning from one category to another

Transition:	EMPOWER	GUIDE	SUPPORT	SPECIALISED	UNKNOWN
EMPOWER	14	1	33	0	0
GUIDE	0	8	12	1	0
SUPPORT	1	0	15	1	0
SPECIALISED	0	0	0	19	0
UNKNOWN	0	0	0	0	17

Table 7: Percentage of claims transitioning from one category to another

Transition:	EMPOWER	GUIDE	SUPPORT	SPECIALISED	UNKNOWN
EMPOWER	29.2%	2.1%	68.8%	0.0%	0.0%
GUIDE	0.0%	38.1%	57.1%	4.8%	0.0%
SUPPORT	5.9%	0.0%	88.2%	5.9%	0.0%
SPECIALISED	0.0%	0.0%	0.0%	100.0%	0.0%
UNKNOWN	0.0%	0.0%	0.0%	0.0%	100.0%

The tables show that of the files reviewed, almost one in every two claims was initially triaged into the wrong level of support. As an example, of the 48 claims reviewed were initially triaged into the Empower category (i.e. expected to resolve within 2 weeks), only 14 or 29% remained in the Empower category. The remainder were moved to a higher level of support and the majority (33 claims or 69%) moved to the support category (not expected to resolve within 6 weeks).

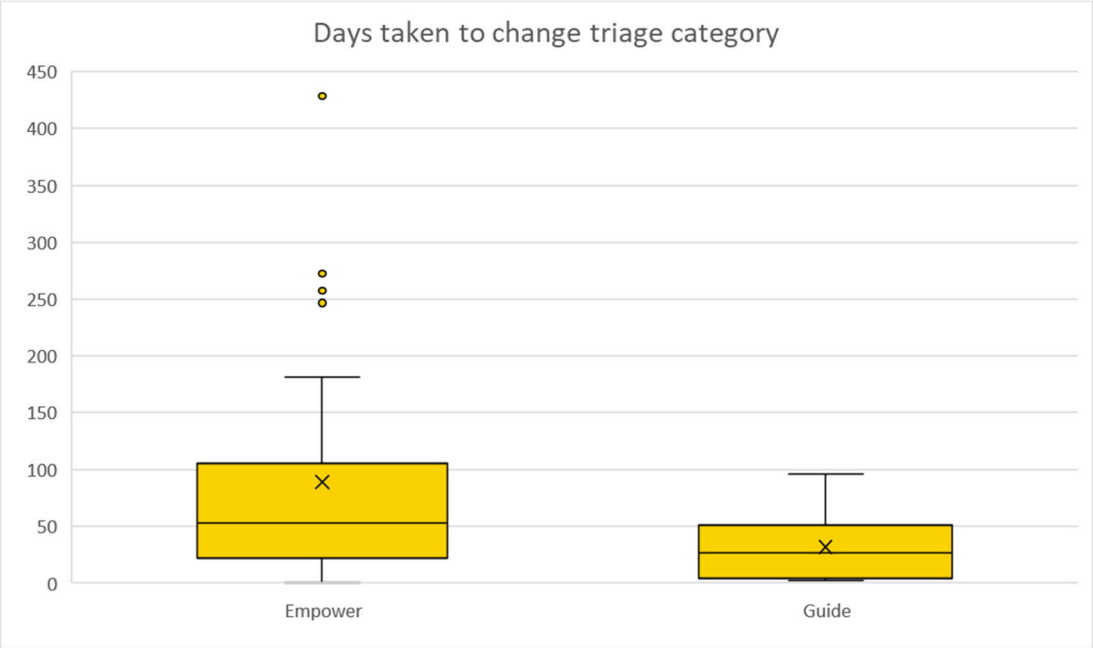
We do note that of the 20 psychological injury claims reviewed, the majority were triaged into the correct category (18 went to specialised, 1 went to support and 1 we could not identify).

Compounding this initial wrong classification, we identified from the file review that the time taken to move the claims to the required level of support is substantial. The following graph shows the claims in the Empower and Guide segments and the time taken to move them to a higher support level. The "box and whisker" plots show:

- For the Empower claims, it took on average 90 calendar days to move the claims; more than 25% of claims in the sample took more than 105 days and there were 4 outliers that took more than 250 days

- For the Guide claims, the triage category change happened faster, with an average of 32 days; more than 25% of the sample took more than 50 days.

Figure 5: Time taken to change triage category

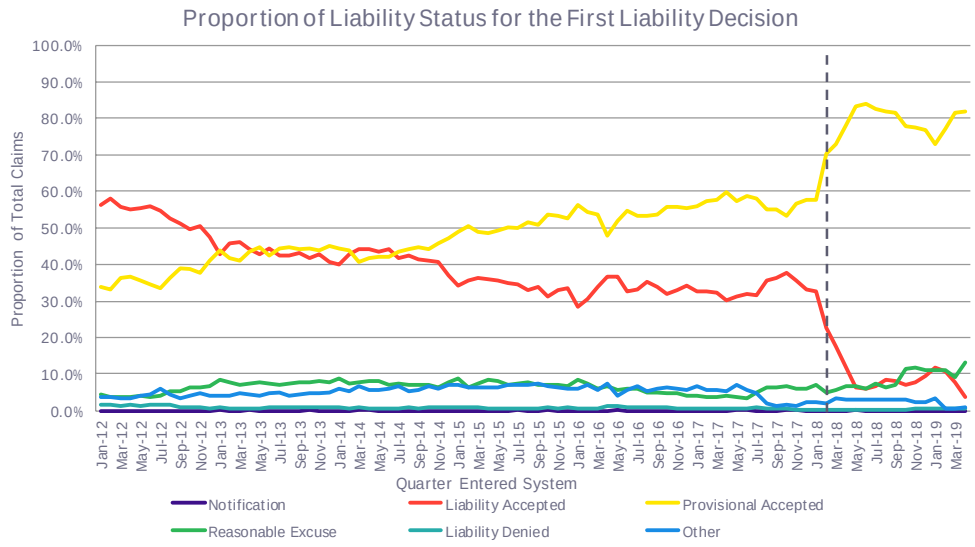


The consequences of incorrect triage are that claims are not given the optimal level of case management, and any necessary treatment is being delayed while these claims are in the incorrect level of support. The Empower and Guide cohorts have no dedicated case manager. Injured workers have to deal with multiple case management contacts over the course of the claim life while in these triage categories.

3.3.2 Use of provisional liability

The increased use of provisional liability is likely exacerbating the problem outlined in the previous section with the triage process. There is a clear and significant increase in the use of provisional liability since the implementation of the icare claims model. This is illustrated in Figure 6 (further detail is shown in Appendix C).

Figure 6: Proportion of claims by first liability decision



On face value, the use of provisional liability should not have an adverse impact on claims outcomes. In fact, it is often argued that it is beneficial, since treatment can begin earlier while further liability investigations are being carried out. However, this assumes that claims in provisional liability are receiving effective case management. It is a design feature of the new model that claims in the Empower and Guide categories do not receive active case management.

The model is established such that if claims enter the Empower and Guide segments when accepted provisionally, it is expected that they will return to work without further intervention and no need to accept liability or investigate the claim further. However, from the analysis in the section above, we know that a significant proportion of claims in these segments have not been triaged correctly and do actually require more support. It is apparent that if a claim is accepted provisionally and triaged into Empower or Guide, it may effectively be left there until someone realises there is a problem. This may not be until benefit entitlements under provisional liability expire at 12 weeks or later.

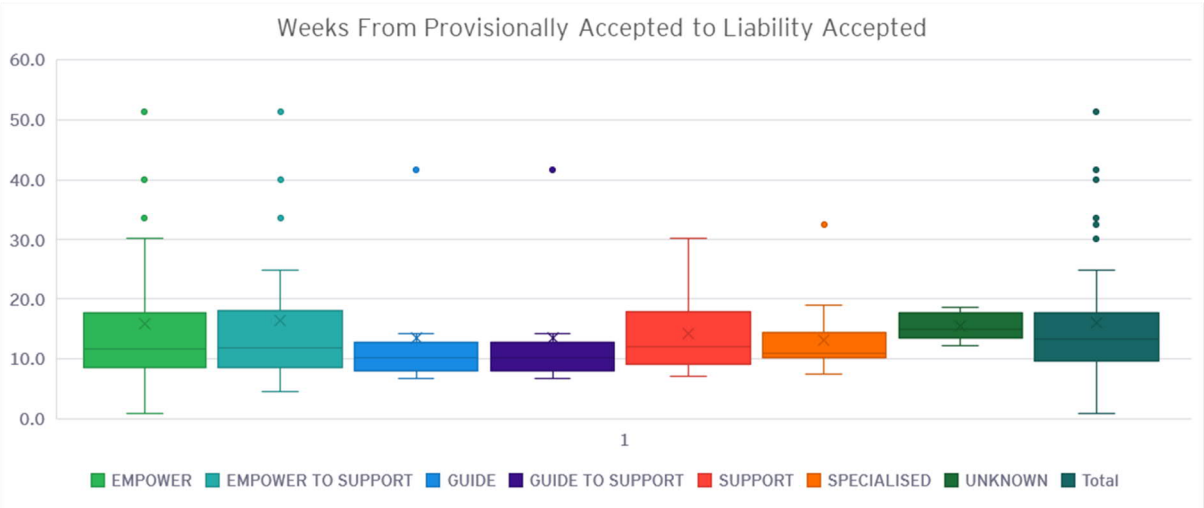
The following table shows for the provisional liability (PL) claims reviewed, the proportion of claims where liability was accepted.

Table 8: Time to acceptance of liability

Initial Triage	Total Number of Claims	Number of PL claims	Proportion of files reviewed with PL	Liability subsequently accepted	Proportion of Acceptance
EMPOWER	48	48	100.0%	36	75.0%
- EMPOWER TO SUPPORT	33	33	100.0%	27	81.8%
GUIDE	21	18	85.7%	12	66.7%
- GUIDE TO SUPPORT	12	10	83.3%	9	90.0%
SUPPORT	17	12	70.6%	9	75.0%
SPECIALISED	19	19	100.0%	19	100.0%
UNKNOWN	17	16	94.1%	5	31.3%
Total	122	113	92.6%	81	71.7%

The following graph shows the range of time taken to accept liability in terms of the number of weeks until the liability decision was made. The graph shows that there were a number of claims that sat in provisional liability acceptance for up to 52 weeks prior to a liability decision being made.

Figure 7: Number of weeks to make a liability decision from provisional acceptance



3.3.3 The decision-making framework between EML and icare

We found no evidence during the claim file review of the documented decision-making framework between EML and icare being adhered to or enforced. There were a number of areas of non-compliance identified. This was particularly evident in the following areas:

Rehabilitation payments

There were a number of files (7 claims from 57 that had a rehab provider appointed) where the total payments made to rehab providers exceeded the "statutory" limit of $10,000, without approval being sought from icare. Equally, there did not appear to be evidence of any mechanism where icare was monitoring or recognising these breaches.

Provisional liability payments

There were a number of files where the total medical payments exceeded $10,000. There were also instances where injured workers received greater than 12 weeks of weekly payments while still on provisional liability. These are legislative breaches rather than breaches of the decision-making framework.

Figure 8 shows medical payments made while claims were on provisional liability. In just under 10% of files reviewed, the amount paid exceeded the statutory maximum amount of $10,000.

Figure 8: Medical payments while on provisional liability

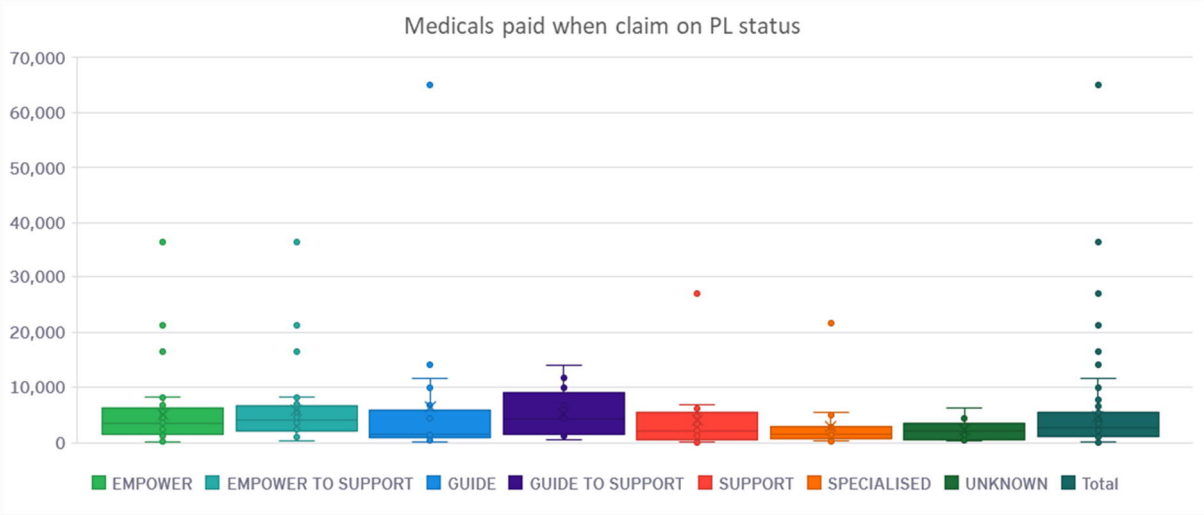
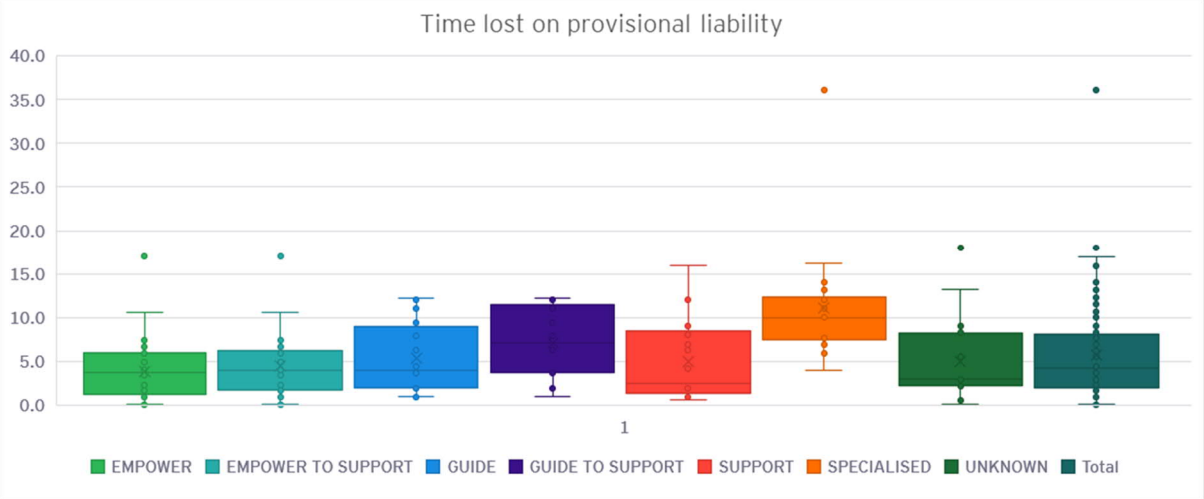


Figure 9 shows the number of weeks of weekly benefits paid to claims while on provisional liability. Similar to the experience for medical payments compliance, approximately 10% of files reviewed received more than 12 weeks of weekly benefits.

Figure 9: Number of weeks of weekly benefits paid on provisional liability



The Medical Services Panel and use of IMEs

The decision-making pathway for the use of the MSP and the use of IMEs lacks clarity. According to icare, case managers have the right to request an IME. However, some icare documentation seems to indicate that consideration should be given to asking the MSP in the first instance. From the claim file review, there was limited use of IMEs even though there were a number of cases where this course of action was warranted.

In addition, to request a review of a claim file by the MSP appears to be a cumbersome process. An application with significant documentation needs to be assembled and lodged with the MSP. This might take a case manager 3 to 4 hours to complete. This appears to have discouraged the use of the MSP.

Summary

The decision-making framework appears largely ineffective and icare does not appear to have any system / monitoring in place to ensure it is being adhered to. While the principles behind the decision-making framework may appear sound, it does introduce a frictional cost for EML. It becomes more difficult for EML to apply the principles of sound technical case management. In addition, there appears to be limited incentive for EML to follow the processes established by icare.

EML's remuneration is largely fixed. The variable components are aimed largely at containing operational expenses. EML is therefore "incentivised" to follow the simplest, most efficient path of accepting and paying claims. Applying sound technical case management takes time and effort, however there is little financial incentive for EML to make the effort required to improve RTW outcomes.

4. Implementation of icare's claims operating model

4.1 Key conclusions

The review has identified implementation issues with icare's claims management model that have led to poor claimant outcomes. The implementation problems appear to have primarily manifested themselves through a passive and reactive approach to case management.

The implementation problems identified include:

- EML has been under-resourced from the inception of the new model, with maximum caseload targets being exceeded, leading to a risk that EML is adopting a passive approach to claims management. We have observed instances of a lack of investigation of liability decisions and a lack of scrutiny of the treatments being prescribed and invoiced. A number of claims were assessed without taking due consideration for the existence of conditions which were unrelated to the claimant's employment. Additionally, there appeared to be insufficient investigation of the claimant's past employment history. On occasions, a claimant's past medical history was acquired but either not relied upon or properly assessed when challenging an entitlement to workers compensation benefits
- Psychological injury claims have been on the increase, including an upward trend in physical injuries receiving psychological treatment (indicative of secondary psychological injury). This is highlighted in figures 10 and 11 (full detail is included in appendix E). Alleged work-related stress was prevalent in a number of claims reviewed. In a high proportion of claims involving stress, there appeared to be a questionable relationship between a claimant's alleged psychological condition and any events which arose out of, or in the course of, the claimant's employment. There were a number of matters in which an allegation of misconduct on the part of the employer was not subject to challenge. This was particularly the case in relation to Section 11(A) of the Workers Compensation Act 1987

Figure 10: Primary psychological injury claims

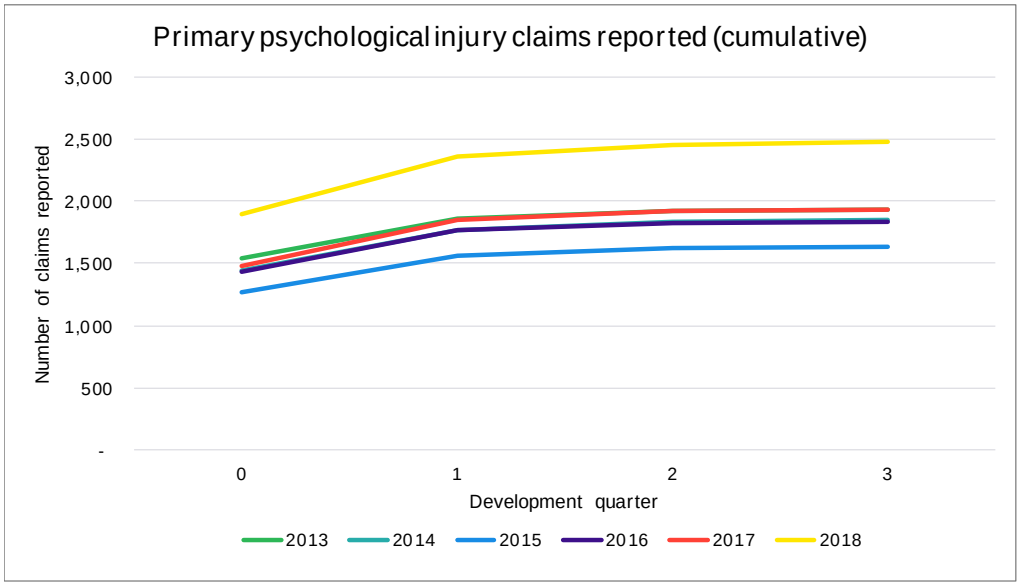
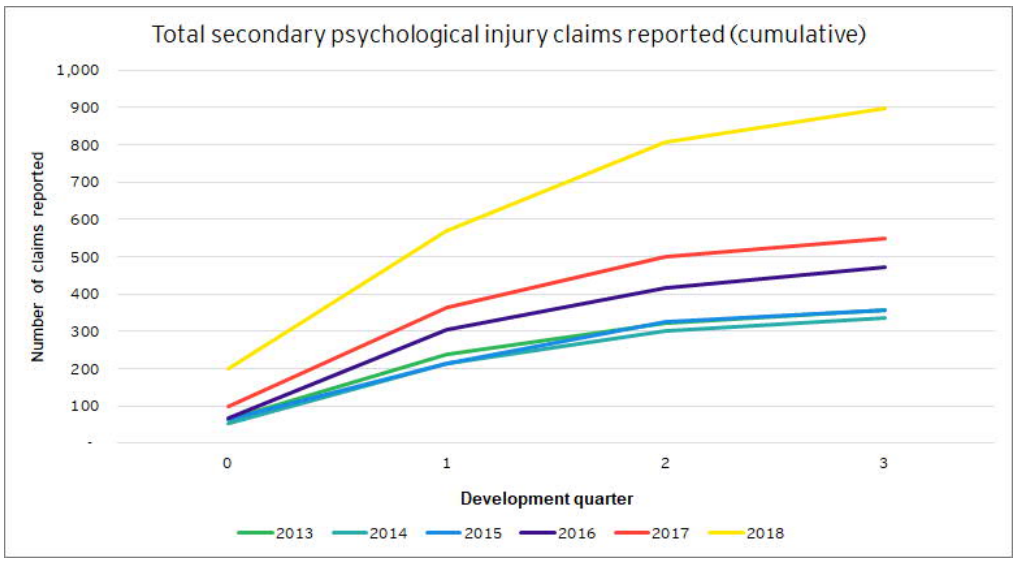


Figure 11: Number of indicative secondary psychological injury claims



- The experience level of case managers, in regard to personal injury case management, appears to be impacting claimant outcomes and scheme performance. As noted above, the claim file review indicated a lack of personal injury case management expertise. There appears to be a lack of challenge from case managers which has resulted in excess payments, and there is also a lack of proactivity, resulting in injured workers not getting the support they require in an appropriate timeframe
- The IT system in use during the period of the review does not readily lend itself to effective and efficient case management. One such example is that there is no central index of the documents on file. It is therefore difficult to look at a claim file and understand its lifecycle to date (for example, it is difficult to locate certificates of capacity or communication with the injured worker to date). This becomes particularly problematic for claims in the "Empower" and "Guide" cohorts that do not have a dedicated case manager. When a "new" case manager opens a file, it almost impossible for them to efficiently understand what has been happening with that claim.

4.2 Post Implementation Review

Towards the end of 2018, PWC was commissioned to conduct a post implementation review of the new claims model. The results of this review were contained in a report titled "PwC review of new claims model Dec 2018"[6], dated December 2018. The review determined there were performance issues with the model including:

- "The workforce has been below approved capacity since commencement due to recruitment delays, there are some gaps in capability, compliance with defined processes has generally improved over time but performance is inconsistent and the underlying technology does not fully support the new way of working. As a result, whilst improvement is continuing, KPIs and target outcomes are yet to be fully achieved. As the service model is yet to stabilise, the initial design and intent of the model is in parts yet to be fully tested"
- "The governance model underpinning the new claims model has not yet been fully implemented"
- "Delivery challenges have had an impact on the level of trust between EML and icare"
- PwC identified three main root causes of the underperformance, including:
  - Lack of efficiency at scale – in summary EML has struggled to achieve the scale required to effectively manage the volume of claims received as the sole scheme agent
  - Governance not fully implemented – we return to this problem in section 5 of this report

[6] We note that the full PwC report has not been supplied. Only an extract of the report has been supplied

- Issues with reporting accuracy and lack of insight – there does not appear to be a "single source of truth" when it comes to reporting metrics, which is causing tension between icare and EML.

4.3 Related findings from the claims file review

After conducting the claims file review, we have formed a similar view to PwC in regard to the implementation of the new claims model. In our view, the two biggest implementation issues that are impacting claimant outcomes (apart from the triage and provisional liability design issues described in section 3) are capacity and capability:

- PwC's report indicated that towards the end of 2018, EML actual staff numbers were 40 FTEs below approved levels. This deficiency has been at this level since the start of the new model
- PwC's report also stated that there were capability gaps among EML staff, especially with technical specialists; in particular, "preference was given to the candidates with customer service experience over claims experience resulting in Day 1 capability gaps in claims knowledge".

Following the claims file review, it is our view that these two issues are behind many of the deteriorating outcomes being experienced by the NI scheme – a lack of technical case management expertise compounded by under-resourcing leading to passive claims management. These observations manifested themselves in a number of areas, as discussed below.

The assessment of liability was the most obvious area impacted by the capability gap. From the claims file review of 122 claims, there was evidence found on 31 claims (25%) that employers had lodged some form of concern regarding the acceptance of liability. There were only 14 instances where the employer's concerns were thoroughly investigated. That is, there were 17 claims (14% of the total sample) where the concerns of the employer were not investigated and liability was accepted. The nature of the concerns raised by the employers included:

- A number of claims were assessed without taking due consideration of the existence of conditions which were unrelated to the claimant's employment
- Employers believed that their actions were reasonable under section 11A of the Workers Compensation Act 1987 (that is, no compensation is payable under this section of the Act in respect of a psychological injury that was wholly or predominantly caused by reasonable action taken or proposed to be taken by or on behalf of the employer with respect to transfer, demotion, promotion, performance appraisal, discipline, retrenchment or dismissal of workers or provision of employment benefits to workers)
- There was insufficient investigation of the claimant's history. On occasion, a claimant's past medical history was acquired but not relied upon when challenging an entitlement to workers compensation benefits.

Effectiveness in assessing new claims was hampered by the frequent absence of claims forms completed by both the employer and employee. The claim file reviewers considered that the absence of claim forms was an impediment to the accumulation of information such as a claimant's occupation, period of employment, existence of witnesses, claims histories and suspicious items[7].

Another area of concern was psychological injury claims. Figures 10 and 11 above and Appendix E show analysis that clearly illustrates increasing trends in both primary and secondary psychological injury claims. For the claims file review, 20 claims with a primary psychological injury were reviewed. Of the remaining 102 physical injury claims, another 20 claims were identified that had a secondary psychological injury. Hence, in total, the file review assessed 40 claims of injured workers that had some form of psychological injury.

[7] It is also worth noting some agents (Allianz) adhere to the use of claim forms whereas others do not (EML).

Table 9 shows that of the 40 claims assessed with a psychological injury, the case management practices of the agent were assessed to have had a positive impact on 26 of the claims and a negative impact on 14 of the claims. The assessment of a positive or negative impact was made after reviewing the decisions on the claim file and the current circumstances of the injured worker. The notes we have on the negatively impacted claims are extensive.

Table 9: Psychological injury claims

Nature of Injury	Positive Outcome	Negative Outcome
Primary	14	6
Secondary	12	8
Total	26	14

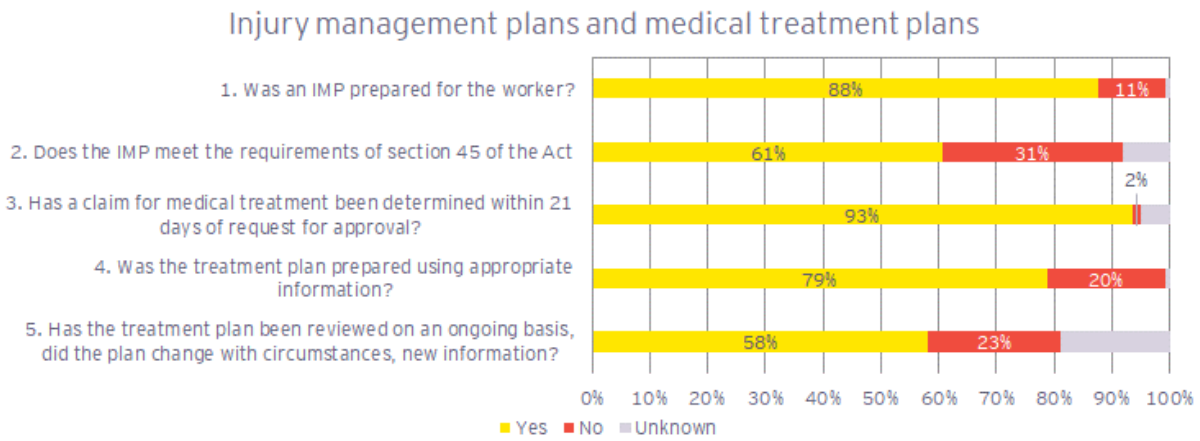
Some of the themes can be summarised as:

- A number of claims were accepted provisionally and it then took the maximum (or in some cases more than the maximum) time to make a full liability decision. During this time there was insufficient communication with the injured worker
- Often the injuries and medical conditions of these injured workers were complex and causation between the injury and employment was unclear. In a number of these cases, an IME could have been used to clarify these issues and to assist in getting a complete picture of the injured workers medical condition; however no IME was sought
- The injury management plans being used were effectively templates and not updated as the seriousness of the claims emerged (also see following section)
- Instances where section 11A of the Act should have at least been investigated but were not.

In summary, just under half of the psychological injury claims reviewed suffered from a lack of thorough technical case management that, if applied, would have achieved better outcomes for the injured worker and the scheme. We do note that some claims did exhibit a high level of good quality technical case management (primarily those claims that were triaged into the “specialised” category) and these claims, for the most part, achieved a positive outcome.

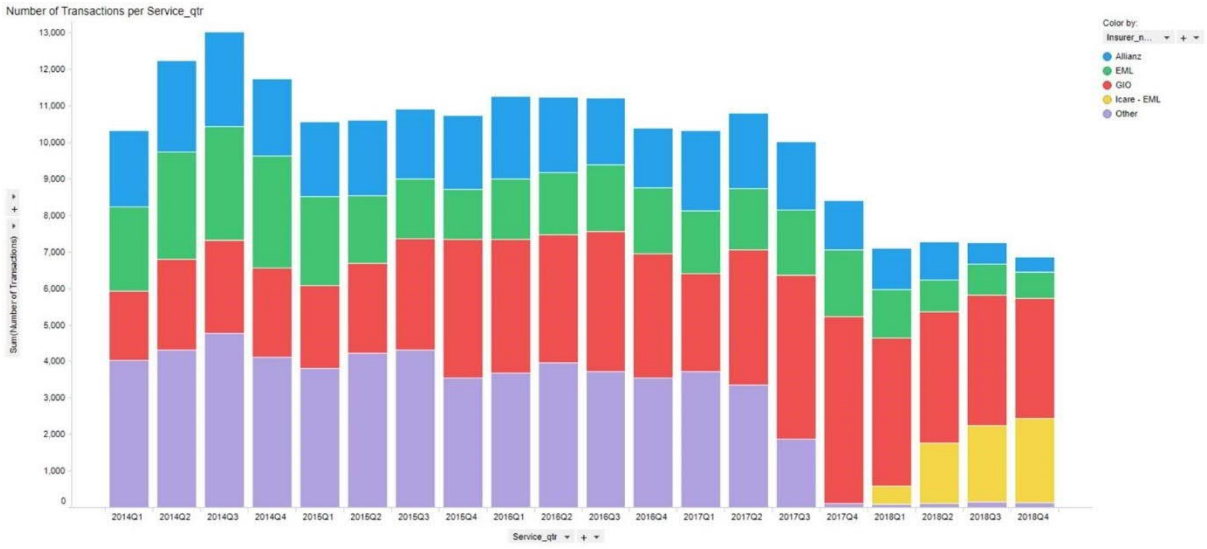
Thirdly, injury management plans (IMPs) existed on all claims in which one was required (7 days continuous incapacity). However, in most cases they were extremely generic and often not suited to the unique circumstances of the claim. Furthermore, there was ample evidence of the injury management plan (and especially the medical treatment components) not changing with circumstances. There was an overwhelming lack of proactivity taken by case managers. The technical administration of the IMP was frequently taken on by the employers, rehabilitation providers or treating doctors. This is an abrogation of the case manager’s responsibility and at times, led to claims being misdirected. The results of the claims file review are set out in the figure below.

Figure 12: Use of injury management plans - claim file review findings



Finally, the medical services panel (MSP) is a recent innovation and is designed to assist in determining the need for proposed treatment and the need for an independent medical examination (IME). It requires case managers to complete what appear to be time consuming processes to engage the MSP which, in many cases, should be unnecessary for a proficient case manager. Only a handful of files reviewed referred matters to the MSP, and so it is difficult to draw conclusions about the MSP's effectiveness. The claims file review did identify a number of instances where referral to an IME was warranted. The use of IMEs has declined considerably in the previous 12 months. This can be seen in the following figure and is consistent with icare's philosophy of being less adversarial. Historically, the number of IMEs per quarter has averaged approximately 10,000. Since the introduction of the new claims operating model, this number has reduced to approximately 7,000 per quarter.

Figure 13: Decrease in number of IMEs



In summary, the observations above can best be summarised as a lack of proactive technical case management by the case managers. This is likely to be a consequence of both capacity and capability constraints that is resulting in a lack of both attention to and thorough investigation of claims. The capacity and capability required to manage claims with a questioning and challenging mindset is greater than that required to accept and administer claims. This will be further impacted by the onerous nature of some the processes implemented by icare.

5. Governance of the new model and EML

5.1 Key findings

In summary, there was little evidence identified of icare effectively monitoring the key aspects of claims management. Effective monitoring could have identified many of the issues listed in this report and led to them being remedied sooner. During the claims file review, a range of claims from across the period since the new operating model was implemented were reviewed and there was little evidence found of improvement in claims management across that time.

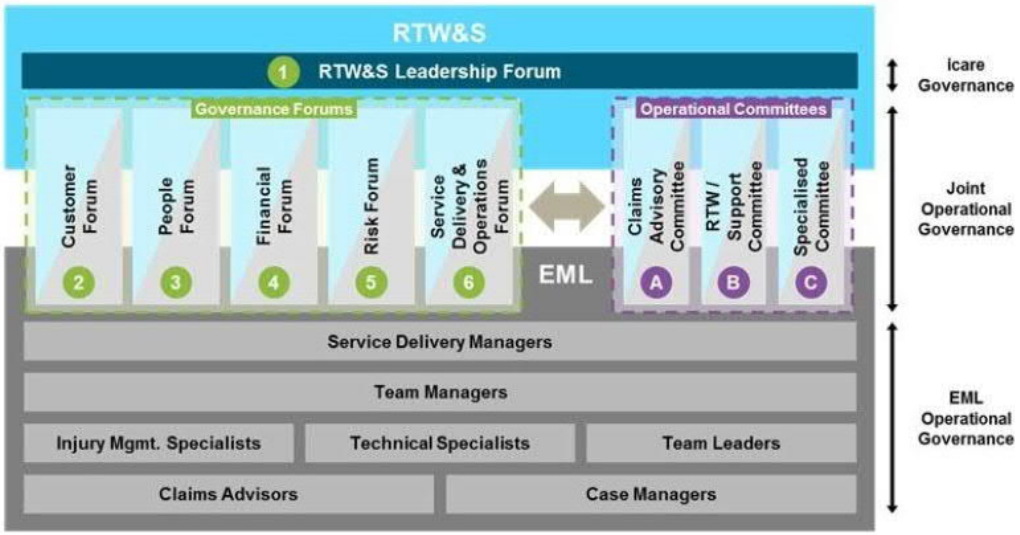
Issues identified during the claim file review that indicate a lack of governance included:

- The decision-making framework between icare and EML does not appear to have been adhered to
- There was no evidence found of icare challenging any payments made by EML or attempting to identify any other breaches of the decision-making framework
- There was evidence found that weekly payments were being made:
  - without reference to reimbursement schedules
  - inconsistent with certificates of capacity
  - with incorrect calculations
  - in line with reimbursement schedules but for amounts above the calculated PIAWE amount
- There was evidence found of paying for diagnostic services that were either not required for the injury sustained or were ordered multiple times for the same claimant
- Some examples were identified of a lack of compliance with the legislation. This is particularly notable whilst claims were in provisional liability. In some cases, medical and weekly payment limits were exceeded and liability decisions were made outside of the mandated timeframes
- Claims triaged into an inappropriate support category were not efficiently identified and remedied.

5.2 Governance structure

It appears that a complex governance model to oversee the EML operation was established at the commencement of the model. Pictorially the governance model is shown in the following graphic.

Figure 14: icare / EML governance model



The three operational committees operate as “working groups” with a segment focus on reviewing operations and conducting analyses. These committees appear to be joint committees between icare and EML.

There are six governance forums with responsibility to monitor KPIs, request actions from the appropriate committee and review and endorse decisions proposed by the committees. Issues can be escalated to the leadership forum.

PwC’s review of the new claim model conducted in December 2018 found that the governance model was not properly implemented and was inefficient. Specifically:

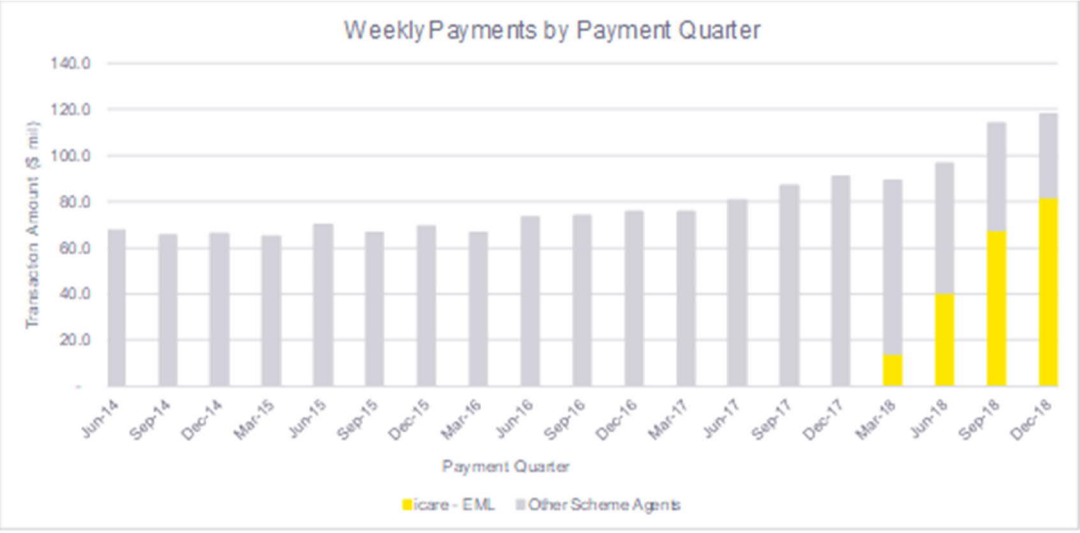
- operational committees were not completely established
- governance forums had too many participants
- decision making within the forums and committees was slow and inefficient
- issues were being raised but not resolved in a timely manner
- trust between the parties was being eroded.

Issues with operational reports were also identified, in particular “insufficient granularity, details and insights in operational reports to fully qualify issues and identify root causes”. There was also a finding regarding a lack of a single source of truth and as such, reports differed in the messages being delivered. In addition, while there was a QA framework in place, QA outcomes were not flowing back to frontline teams.

5.3 Related findings from the claims file review

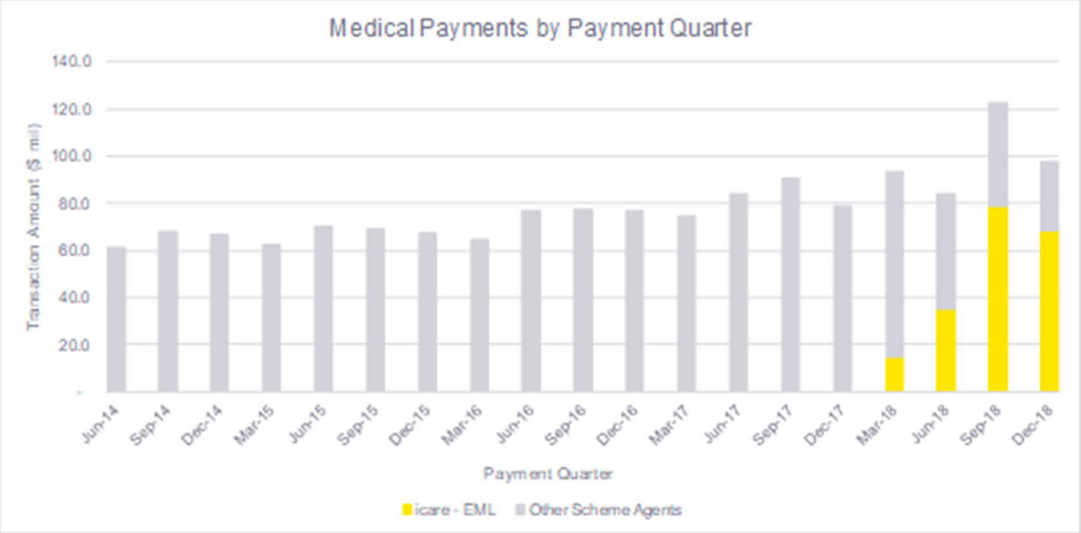
The technical analysis performed highlighted a number of concerning trends. In particular, increasing weekly payments (refer to figure 15 and appendix G) and increasing medical spend (refer to figure 16 and appendix H). After conducting the claims file review, it is evident that a lack of governance of EML’s operations is one of the causes of these trends.

Figure 15: Weekly payments per payment quarter



Note: Payments only include the latest 8 accident quarters for the corresponding payment quarter. For example, Dec-18 payment quarter includes payments from accident quarter Mar-17 to Dec-18, Sep-18 payment quarter includes payments from accident quarter Dec-16 to Sep-18 and etc

Figure 16: Medical payments per payment quarter



Note: Payments only include the latest 8 accident quarters for the corresponding payment quarter. For example, Dec-18 payment quarter includes payments from accident quarter Mar-17 to Dec-18, Sep-18 payment quarter includes payments from accident quarter Dec-16 to Sep-18 and etc

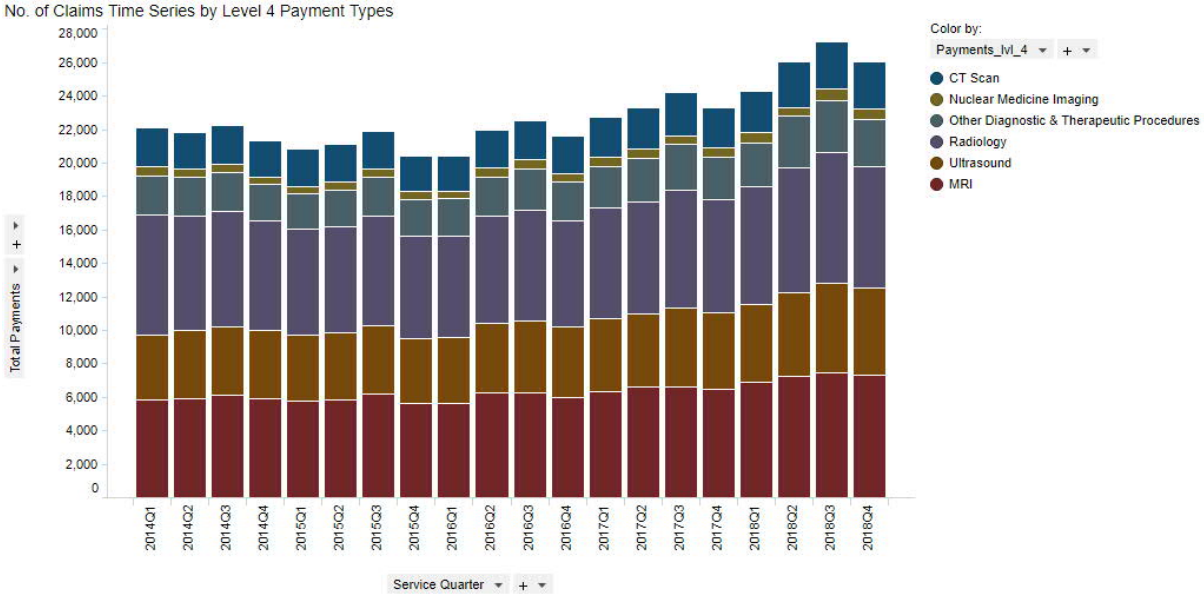
5.3.1 Lack of scrutiny of medical treatments and invoices

There were many instances of excessive or unnecessary medical treatment (and diagnostics) being prescribed and paid for without appropriate scrutiny. For non-surgical medical treatments, there were 22 claims (close to 20% of the sample) identified where there was insufficient scrutiny of paid amounts. Many of these related to allied health sessions, diagnostic tests or prescription drugs. The term "reasonably necessary" expenses seems to be interpreted as not challenging any form of treatment or its associated expense, i.e. effectively automatic approval. There were numerous instances in which this interpretation was seemingly generous. Of particular note are:

- Excessive diagnostic tests being conducted, especially MRI scans. Not only were MRI scans being conducted with no apparent need, there were also instances where multiple MRI scans were conducted on the same injured worker only days apart
- Amounts being paid for treatment that were unrelated to the work related injury
- There appeared to be large amounts of prescription drugs being prescribed without any due scrutiny
- Surgical costs often appeared to be excessive for the procedures being performed.

The following figure shows the recent trend in diagnostic services being performed within the NI scheme. The figure shows that the average number of diagnostic services performed was approximately 22,000 per quarter up to 2016, and this has increased to approximately 26,000 services per quarter with the upward trend beginning in 2017.

Figure 17: Increase in diagnostic services



5.3.2 Weekly payments made without due scrutiny

The file review identified 17 claims where there was insufficient information recorded on the claims file in order to determine PIAWE, and 20 claims were identified where weekly payments were not made at the appropriate rate. There were many reasons for this including:

- No or insufficient evidence of reimbursement requests from the employer (11 instances)
- Payments not consistent with work capacity according to the certificate of capacity on file (7 instances)
- Incorrect PIAWE calculations
- Payment of reimbursement schedules for amounts above the calculated PIAWE amount.

5.3.3 No evidence of utilisation of decision making framework

There was no evidence found on any file reviewed where icare was involved in making a decision to pay amounts in excess of statutory limits. This was most notable in terms of rehabilitation costs, where amounts in excess of $10,000 need to be approved by icare.

Appendix I summarises further findings from the claims file review.

6. icare's response

We received feedback on our draft report from icare and that feedback has been considered in the final report. icare's response detailed a number of initiatives that they have implemented during 2019. The initiatives either post-date this review or the impacts would not have been noticeable on the claims reviewed. A number of these initiatives are aimed at improving some of the design shortcomings of the operating model and the overall standard of claims management. These initiatives are set out in the table below.

Table 10: List of icare initiatives

Issue being addressed	Initiative
Stabilising service delivery while EML scales to capacity	• Expanded the authorised provider pilot to 150 large employers so they remain with Allianz or GIO. This will be further expanded in 2020, giving more employers greater choice • Established an internal claims team of 86 staff to support EML • icare are managing the portfolio of claims of some employers
Triage and segmentation	• In April 2019, icare changed the underlying triage model from a simple linear model to a tree based analytic model using machine based learning • In September 2019, icare introduced changes to the segmentation model. This included reducing the number of service segments from five to four. In addition, dedicated case managers will be appointed for all claims with forecast time lost of greater than two weeks
Use of the MSP and IMEs	• The use of Guidewire streamlines, to some extent, access to the MSP • An MSP operations manual was released to scheme agents (February 2019) to clarify expectations • Making the MSP available on-site to scheme agents
Governance and active oversight	• Guidewire (claims) was released in February 2019 and allows more real time reporting • Exception reporting was expanded in April 2019 to increase claims oversight • Project Pathway was established in July 2019 to focus on stabilising the EML support centre • Began issuing daily exception reports from August 2019 • Three conduct risk reviews conducted since January 2019, predominantly addressing recurring themes of processing delays
Decision rights framework	• The launch of the Guidewire claims system has allowed greater monitoring and exception reporting. This led to a review and simplification of the decisions rights framework
EML incentives	• EML's KPIs have been enhanced to include greater focus on RTW for calendar year 2019 • Additional incentives for RTW have been designed for the template contracts for Allianz and other potential Authorised Providers
Recruitment	• icare has added 40 FTE in February 2019 to assist with the transition to Guidewire • Added 70 FTE in May 2019 to address a backlog in documents processing • Added 50 FTE in June 2019 to adjust for changes to the segmentation model • Project Pathway initiated in July 2019 has focused on activity to reduce turnover within EML
Capability	• During 2019 icare expanded its training role, including e-learning, train-the-trainer and face to face training

	• In July 2019 icare expanded communities of practice focused on injury management and technical specialists • In July 2019, Project Pathway embedded call coaching in the support centre
RTW concerns	• During 2019 icare commenced a portfolio review across all segments to uplift EML capability, focus is on the 2018 cohort of claims • During 2019, icare increased focus on work capacity decisions to support decisions at earlier claim durations • Project Pathway has a focus on improving capability through systems, process and workflow improvements • Reviewed the rehabilitation approval process to more readily identify claims requiring workplace rehabilitation
Medical outcomes	To address increasing medical expenses, icare introduced a number of initiatives in 2019 including: • Incorporating medical coders into the claims process to confirm surgical invoices match services performed and reviewing hospital and anaesthetic services for leakage • Reinforcing claims escalation pathways and establishing an injury management specialist community of practice to ensure consistent decision making
Provider outcomes	• The new claims system has validations to restrict payments outside of gazetted rates • Initiatives due in Q1 2020 include recovery activities by scheme agents and enhancement of system controls to deal with duplicate payments

It is beyond the scope of this report to review the effectiveness of these initiatives. SIRA may wish to consider conducting a follow-up claims file review to assess if the baseline standard of claims management found during this review has been improved by the initiatives outlined by icare.

7. Reliances and Limitations

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

The scope of EY's services for this review are contained in a letter to Mr Darren Parker dated 16 May 2019. The letter sets out the terms of the engagement of Ernst & Young (EY, we) by the State Insurance Regulatory Authority (SIRA) to provide the services specified in the Scope section of that letter. The terms and conditions covering this engagement are as set out in Contract Agreement SIRA//6358/2016 between EY and SIRA commencing on 20 April 2017.

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 conduct of this Review has been dependent on the provision of information, including documentation and consultations with relevant stakeholders. The data received and relied upon for this review is outlined in appendix B. In undertaking this review, reliance has been placed upon information supplied in the consultations and documentation, and has been used without independent verification.

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 A Terms of Reference

The complete terms of reference can be found at:

https://www.sira.nsw.gov.au/fraud-and-regulation/review-of-the-nominal-insurer/terms-of-reference-for-the-review-of-the-nominal-insurer

In summary, the terms of reference state:

Over 2018, SIRA has closely monitored and considered analysis of aspects of the compliance and performance of the NI scheme, including trends in liability valuations and costs, premium setting, operational reforms and risk management, return to work rates, data quality, customer complaints and concerns raised by business representatives, unions and other stakeholders.

In February 2019, SIRA will commence an integrated compliance audit and performance review including:

- an audit of compliance with relevant guidelines including the Market Practice and Premiums Guidelines (MPPGs) and
- a performance review in relation to claims management, return to work outcomes and other objectives and requirements under the legislation.

In establishing this Review, SIRA is exercising its authority and undertaking responsibilities under the State Insurance and Care Governance Act 2015, the Workplace Injury Management and Workers Compensation Act 1998 and the Workers Compensation Act 1987.

The Review is established, in particular, under the following legislative provisions:

- Sections 23 and 24 of the State Insurance and Care Governance Act 2015
- Sections 22 and 23 of the Workplace Injury Management and Workers Compensation Act 1998

This Independent Compliance and Performance Review is imperative given the materiality of the NI performance on the overall performance of the workers compensation system and SIRA's responsibilities as regulator of that system.

The review will be undertaken for SIRA by an independent expert, Ms Janet Dore and supported by independent actuaries Ernst and Young (EY) and authorised officers of SIRA.

Consistent with the objectives, functions, responsibilities and powers of SIRA under the State Insurance and Care Governance Act 2015, the WIM Act and the 1987 Act, the Terms of Reference for the review are to consult with stakeholders and undertake analysis of data to provide findings in relation to the NI's compliance and performance, in particular to:

- assess NI compliance with the MPPGs and identify any unintended consequences, risks and priorities for improvement in SIRA regulation of the premiums of the NI
- identify the benefits and risks to the performance of the NSW workers compensation system arising from icare's implementation changes to the NI operating model and supporting digital platforms
- assess the NI's performance in relation to return to work outcomes, claims management (including guidance, support and services for workers, employers and health service providers), customer experience and data quality and reporting.

The Independent Reviewer, Ms Dore, and EY will present on their independent findings to the SIRA Chief Executive and Board. The Independent Reviewer may also provide advice to SIRA on any other significant matters, emergent risks or opportunities detected during the review.

Appendix B Data

Document reference	Document name
Tab A1	Journey map – support specialised
Tab A2	Journey map – triage guide
Tab A3	Claims service model overview – March 2019
Tab B1	icare claims operating model vertical – McKinsey 2017
Tab B2	PwC new claims org Day 1 functional design and blueprint – August 2017
Tab C1	Program Aspire I post implementation review – Jan 2018
Tab C2	PwC 181204 review of new claims model – Dec 2018
Tab D	Decision rights framework – February 2019
Tab E	New claims org day 1 structure – August 2017
Tab F1 to F5	Details of training provided to EML staff
Tab G1 to G5	Examples of knowledge articles provided to EML
Tab H1 & H2	MSP operating model
Tab I1	icare new claims org chart
Tab I2	PI new claim org chart
Tab I3	EML RTWSS org chart
Tab J1	Agreements with outsourced providers
Tab J2	Nominal Insurer Legal Services Deed
Tab K1	Rehab Dashboard May 2019
Tab K2	CITC Dashboard Sept 18
Tab L1 to L8	Details of performance management of EML
Tab M1	Icare Qlik dashboard example
Tab M2	EML weekly dashboard
1	2018 EML and icare Deed
26	2018 SPA Schedule 4 (performance management and remuneration)
28	2018 SPA Appendix I (Service Standards) Execution Version

Appendix C Provisional Liability

Key Findings / Conclusion

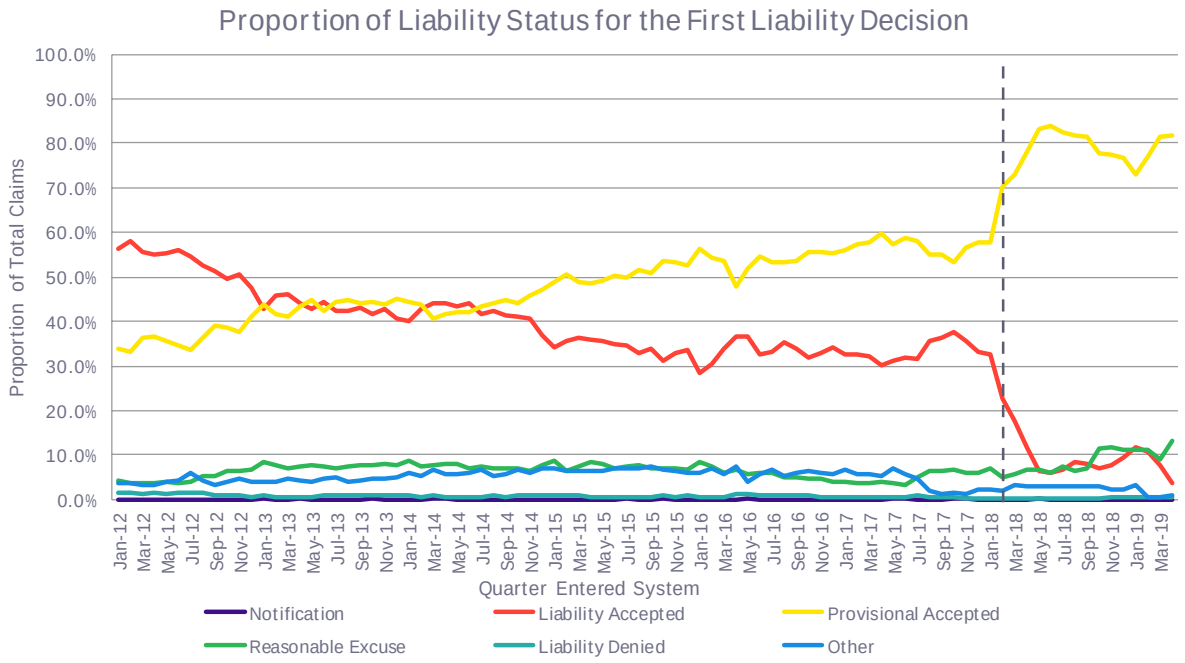
- Increasing use of provisional liability is a feature of the new claims model, by design. The intended objective of using provisional liability is to not delay services to support claimants while awaiting a liability decision
- The increased use of provisional liability within the new claims management model appears to have resulted in:
  - A lack of focus on provisional liability claims in the "empower" and "guide" triage segments, including limited proactive injury management
  - A significant increase in duration on benefits for these claims
  - A significant increase in medical, in particular, and weekly expenditure
  - Extra work for case managers on straight-forward matters where liability was clear and claims could have been accepted immediately
  - In some cases, payments and liability decisions being made outside of the legislated limits of provisional liability

Increased used of provisional liability

There has been a clear increase in the use of provisional liability, coinciding with implementation of the new claims management model. This increase was partly driven by SIRA through increased monitoring of legislative timeframes, however, there was also a model design element involved, namely ensuring injured workers could receive weekly and medical payment support as soon as possible to assist with their recovery.

The following graph showing the status of first liability decision demonstrates this change in approach.

Figure C.1: Proportion of claims by first liability decision



The proportion of claims for which the first liability decision was provisional acceptance has increased steadily since 2012, however, there was a marked increase in the first half of 2018. There is an offsetting movement in claims for which the first liability decision was liability acceptance, while reasonable excuse and liability denial have increased slightly over the same period.

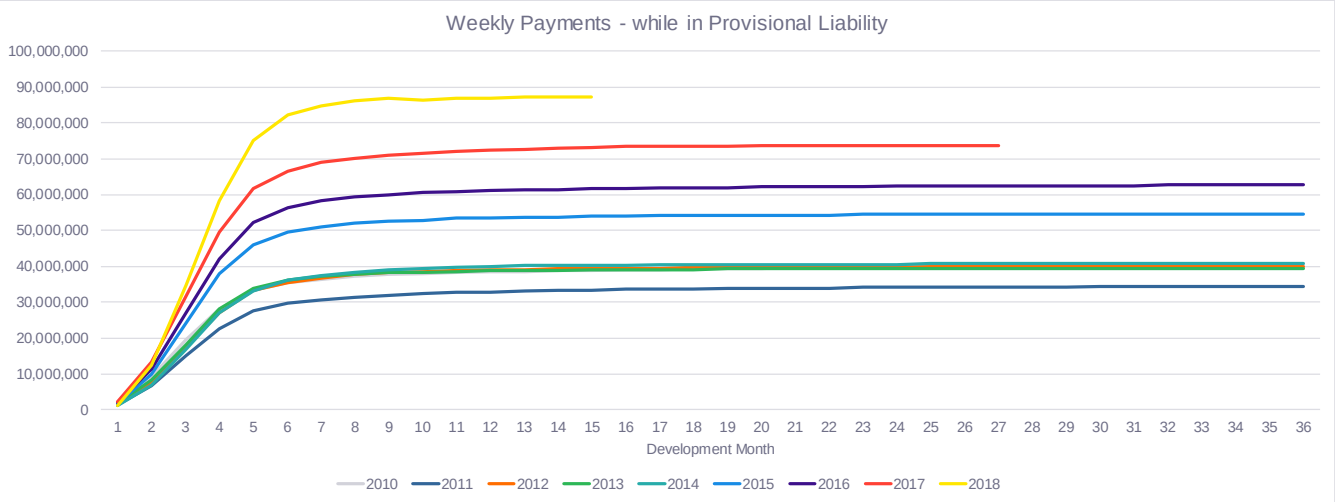
The consequence of this trend is that more claims are being given early access to medical benefits (up to $10k) and weekly benefits (where provisional acceptance includes weekly benefits up to 12 weeks)[8], prior to assessment of liability.

For those claims that had a first liability status of provisional acceptance, the vast majority close without any change to the liability status. For 2018, 61% of provisional acceptance claims were subsequently closed with no status change, while 17% remain open. Only 21% have been changed into liability accepted. Similar outcomes are evident for the 2017 (67% with first liability status of provisional acceptance were subsequently closed with no status change) and 2016 (68%) accident years.

Increase in duration and expenditure for claims in provisional liability

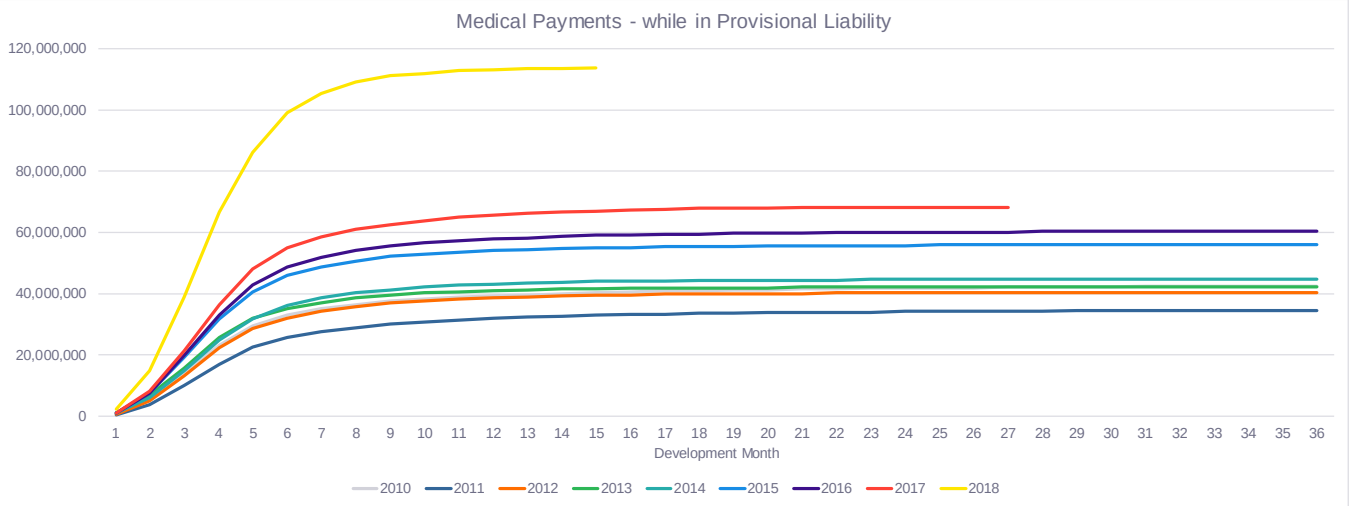
We have identified through various aspects of our review work that the use of provisional liability is resulting in significant weekly payments being made on provisionally accepted claims. The following two graphs show expenditure on weekly and medical benefits for claimants on provisional liability for each accident year.

Figure C.2: Weekly payments expenditure in provisional liability



[8] In line with the provisions in the workers compensation legislation (Workplace Injury Management and Workers Compensation Act 1998 No 86, Section 267, 275, 280) and associated guidelines, Workers compensation guidelines Requirements for insurers, workers, employers, and other stakeholders, December 2018.

Figure C.3: Medical payments expenditure in provisional liability



The following two graphs show duration on weekly and medical benefits for claimants on provisional liability for each accident year.

Figure C.4: Duration in provisional liability – medical and weekly

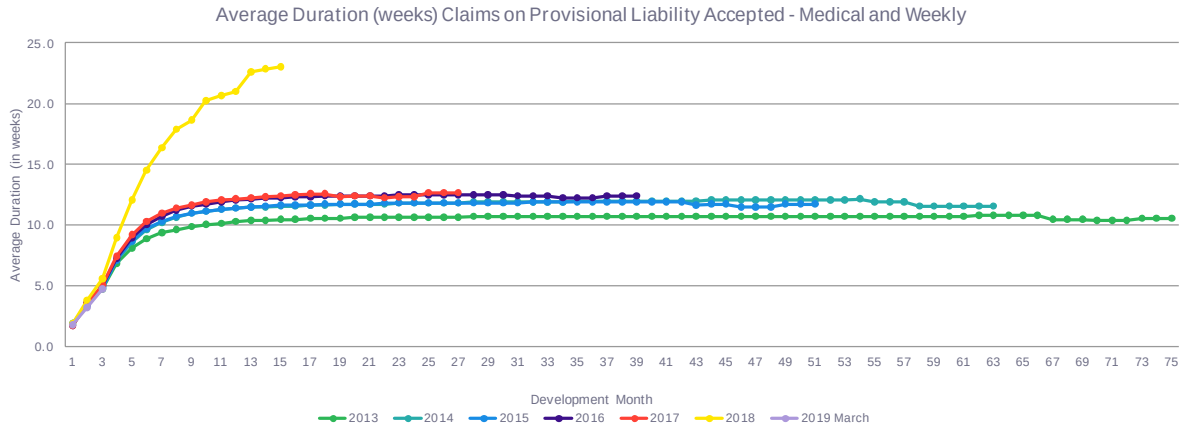
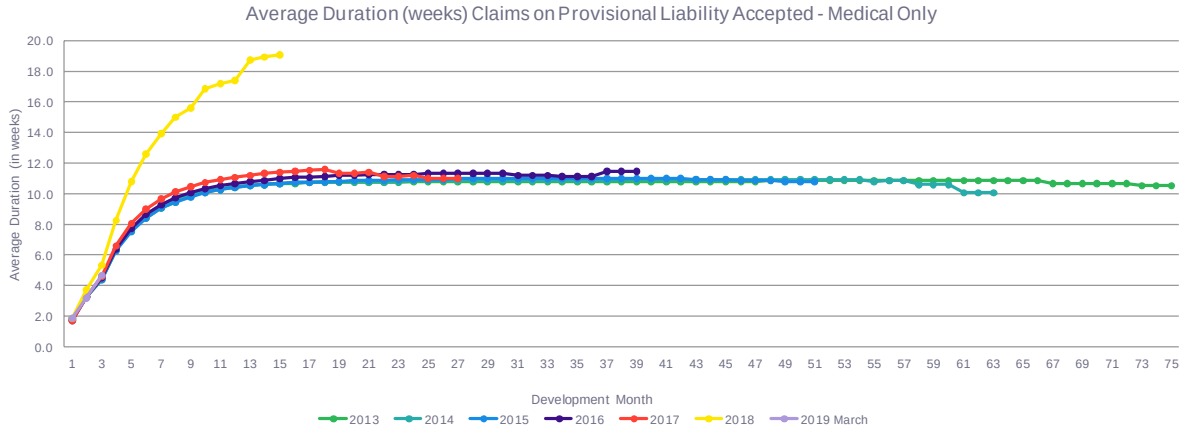


Figure C.5: Duration in provisional liability – medical only



Appendix D Claims incidence rates

Key Findings / Conclusion

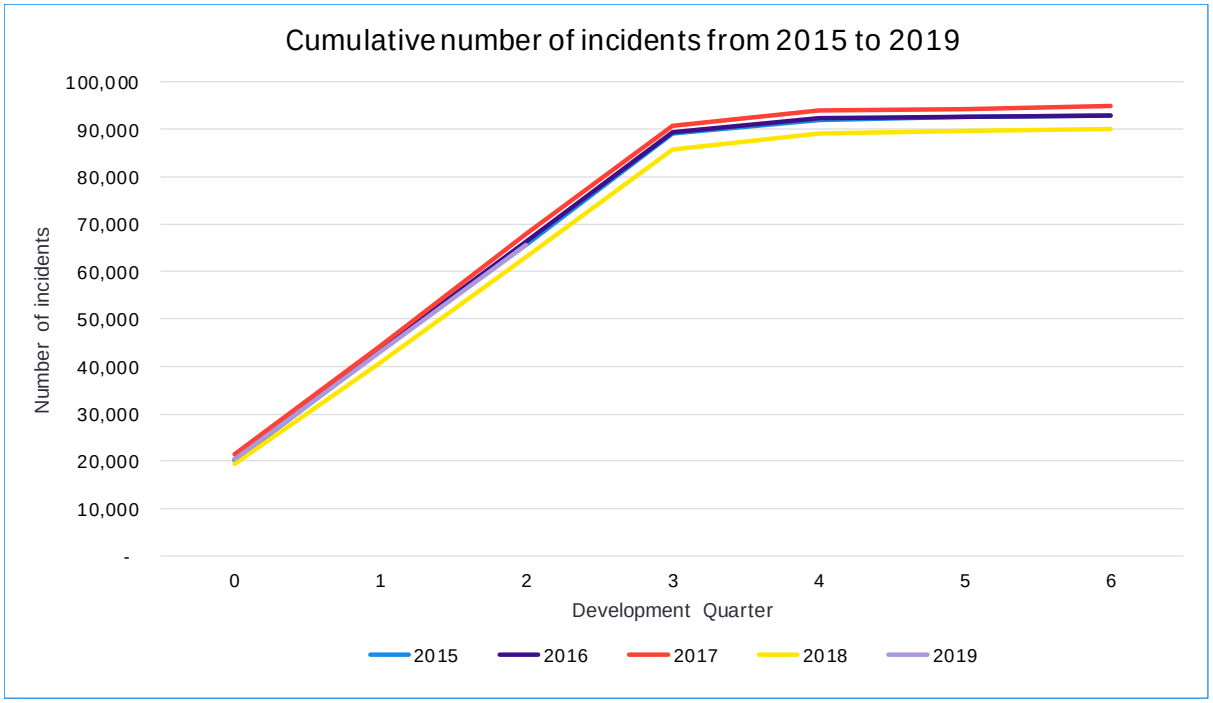
- The number of incidents reported to the Nominal Insurer, including non-reportable claims, has been relatively stable over the last 5 years. This suggests a relatively stable risk exposure.
- The number of reportable claims has increased for the 2018 accident year and further still for the 2019 accident year
- There has been an increase in the number and proportion of "provisional liability" claims. Further, there has been an increase in the number of claims remaining in the "provisional liability" status over the first year since date of injury

Number of incidents

An incident is any event which has been reported to the Nominal Insurer which may give rise to a claim or has resulted in a claim. Incidents comprise notifications, provisionally accepted claims, liability accepted claims and denied claims. In addition, incidents are further categorised into "reportable" and "non-reportable" claims, where non-reportable are predominantly incidents/claims which have been closed with no payments made and reportable claims make up the remaining incidents.

The following chart shows the cumulative number of incidents for the last 5 accident financial years (AFY) by development quarter. The development quarter is determined from the date of the incident relative to the start of the associated financial year (i.e. 1 July). For example, incidents reported in August and December would appear under development quarters 0 and 1, respectively, for that accident financial year.

Figure D.1: Cumulative number of incidents for 2015 to 2019 accident years



Key trends

The occurrence pattern for incidents has remained relatively stable over time. For the last 5 years, there have been approximately 95,000 incidents reported by the sixth development quarter.

There have been fewer reported incidents for injuries occurring in the 2018 AFY. For this AFY, there were approximately 90,000 incidents reported by the sixth development period, which is slightly below reported levels when compared to the prior 3 AFYs. The experience for the 2019 AFY appears to be in line with historical years and slightly above 2018.

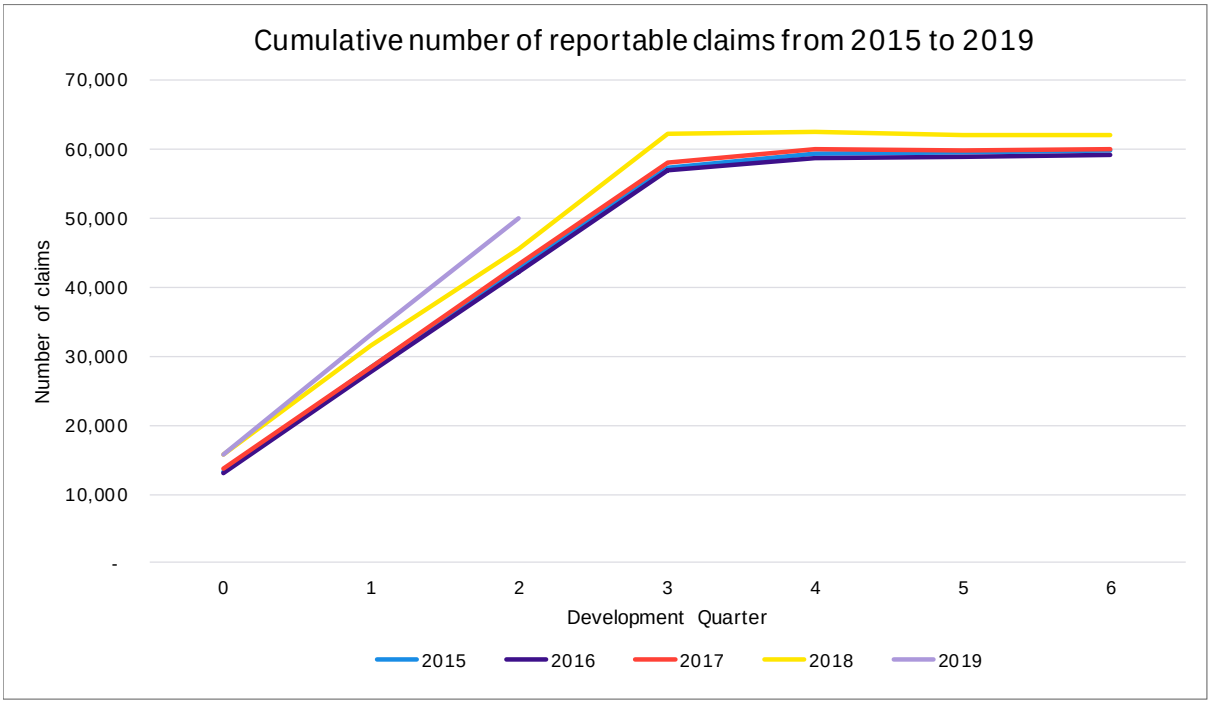
The relative stability in the number of incidents suggests that there has been no material change in the risk exposure for the Nominal Insurer.

Number of reportable claims

A reportable claim is an incident which has been reported to the Nominal Insurer and which either remains open or is closed with payments made to the claim.

The following chart shows the cumulative number of reportable claims for the last 5 AFY by development quarter.

Figure D.2: Cumulative number of reportable claims from 2015 to 2019



Key trends

The number of reportable claims for the 2018 and 2019 AFY is higher compared to prior AFYs. Further, the increase in the number of reportable claims for 2018 is generally consistent across all development periods shown. This indicates a real increase in the number of reportable claims rather than a speed up in the claims reporting pattern.

We do note that total premium collected by icare has increased over the last three years, indicating some portfolio growth which would result in an increase in the number of claims reported. However, figure D.1 does not indicate an increase in the number of notifications.

Claim liability status

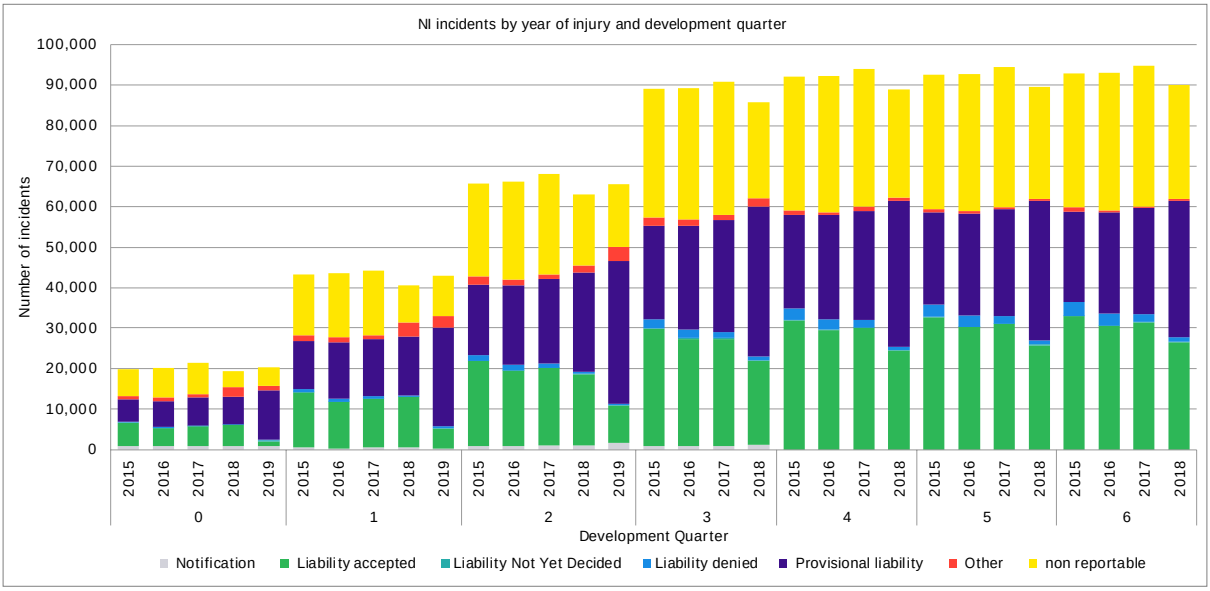
Any claim reported is initially assigned a “Notification” status. In accordance with the workers compensation legislation, claims managers are required to act on the claim within 7 days of it being reported to the insurer. These actions include:

- Accepting the claim with full liability
- Disputing the claim
- Providing reasonable excuse as to why weekly payments will not commence
- Assigning “provisional liability” status to the claim

Typically, “provisional liability” status may have been utilised when additional information was required for the claims manager to decide on whether to accept the claim. Assigning “provisional liability” status allows the claims manager to make up to 12 weeks of provisional weekly payments and up to $10,000 worth of provisional medical payments to the claimant. However, we understand that there has been a shift in process by EML to predominantly accept claims provisionally. This is a feature of the new model and is discussed in detail in Appendix I.

The following chart shows the number of incidents and the mix of claims by liability status for the last 5 AFY by development quarter. Note that for non-reportable incidents, the liability status is shown as “non-reportable” (yellow bar). As note, incidents with a liability status other than “non-reportable” are considered reportable claims.

Figure D.3: Number of NI incidents by year of injury and development quarter



Key trends

There has been an increase in the proportion of “provisional liability” claims in the 2018 AFY. For this year, this trend is evident from development quarter 2 onwards. For the 2019 AFY, this trend is evident from development quarter 0.

There has also been an increase in the proportion of claims remaining in the provisional liability status in the sixth development quarter. This is consistent with observations from the claim file review.

Conversely, there has been a reduction in the proportion of accepted and denied claims by the sixth development quarter. This indicates that claims managers are taking longer to make final decisions on claims and hence claims are remaining in the provisional liability status for longer (discussed further in Appendix I).

Appendix E Incidence of psychological injury

Key Findings / Conclusion

- There has been a significant increase in the number of primary psychological injury claims reported for the 2018 accident year
- The proportion of these claims has increased to over 4.5% of the total number reported (up from 3.5% on average) and 10% of total weekly and medical payments (up from less than 6% for 2016 and earlier periods)
- The medical and weekly average costs of these claims have been increasing year on year
- The number of claims with indications of secondary psychological injury for the 2018 accident year has increased significantly over previous years
- This experience coincides with icare's less adversarial approach to claims management

Key trends in numbers and cost

Primary and secondary psychological injury claims cause significant damage to injured workers, their families and potentially their communities. They are also the most difficult claims to manage and are a key cost driver of the workers compensation scheme. Claimants with psychological injuries often have difficulty returning to work and remain on benefits for longer. These claimants are at risk of a lower quality of life. This section will outline key trends in primary and secondary psychological injury claims.

Primary psychological injury claims are claims which have been identified as psychological immediately upon being reported. They range from workplace harassment claims through to PTSD claims.

Figure E.1 illustrates the trends in the cumulative number of primary psychological injury claims reported over the last 6 accident years. Each line on the chart below represents claims occurring in the same year. The horizontal axis represents the delay between the occurrence date and report date of a claim. Presenting the data in this manner allows us to easily observe changes in occurrence and reporting patterns over time.

Figure E.1: Primary psychological injury claims

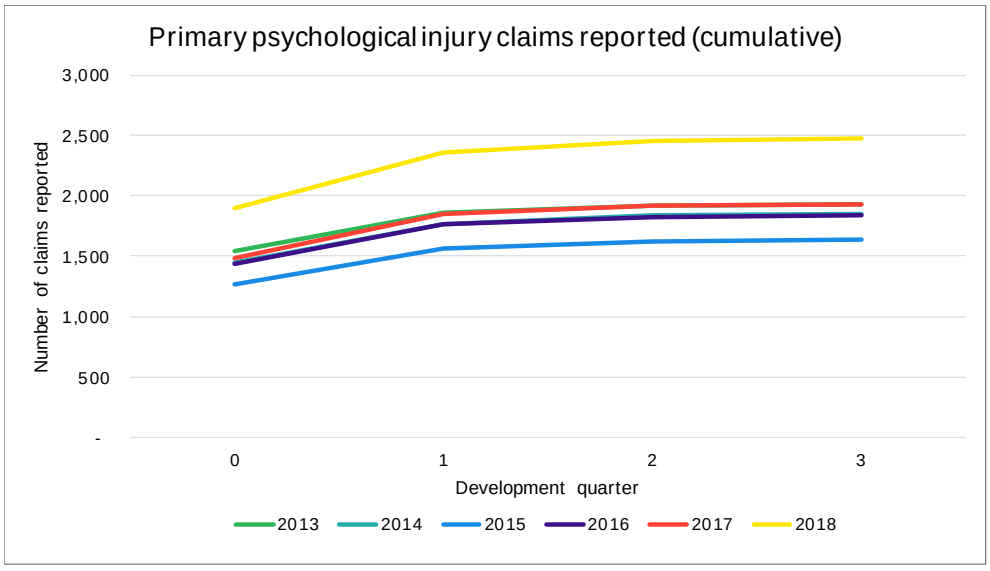
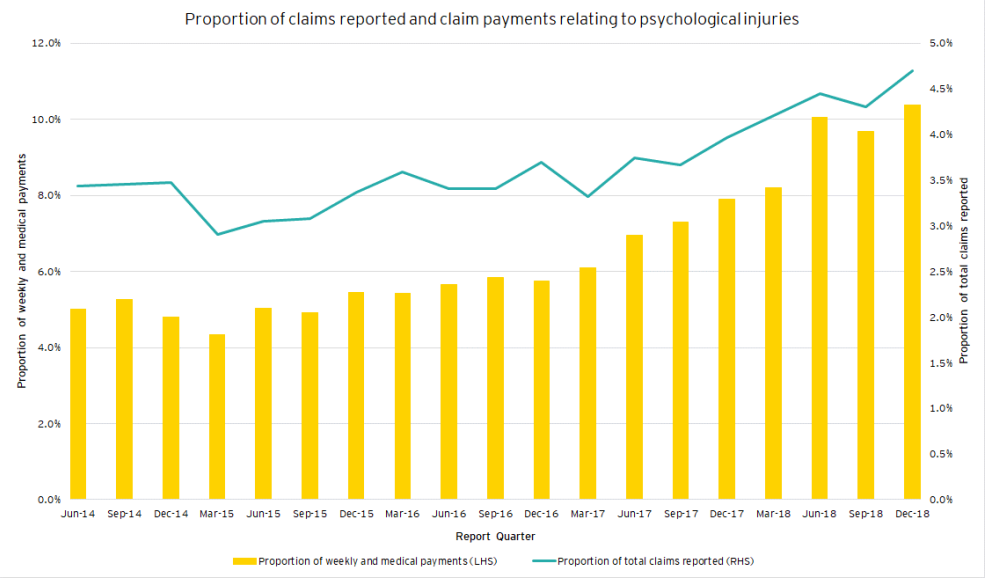


Figure E.2 illustrates the number of psychological injury claims as a percentage of all claims and the payments related to psychological injury claims as a percentage of all weekly and medical payments. Both analyses show a strong upward trend which began in 2016.

Figure E.2: Percentage of psychological injury claims



The number of psychological injury claims reported has been increasing since 2016. There has also been an acceleration in the number of these claims reported since 2017.

Psychological injury claims have also been making up an increasing proportion of total claim payments in the scheme. There has been an increasing trend since 2015. The proportion of claim payments relating to psychological injury is increasing at a faster rate relative to claim numbers, particularly since 2017. This presents a material risk to the overall cost of the scheme.

Average cost of psychological injury claims

Figures E.3 and E.4 illustrate the trend in average claim sizes for medical and weekly payments of primary psychological injury claims.

Figure E.3: Average medical payments of psychological injury claims

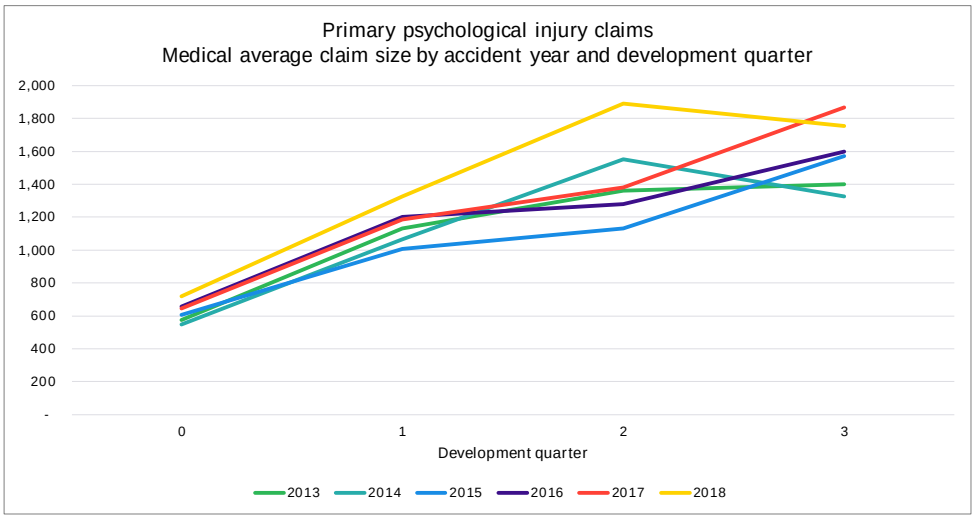
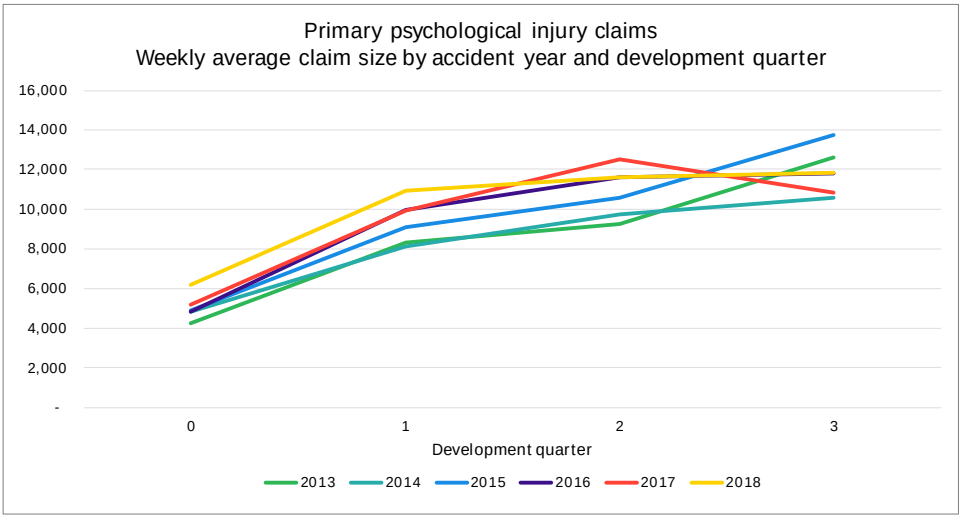


Figure E.4: Average weekly payments of psychological injury claims



There is evidence of an increasing trend in average medical claim sizes for psychological injury claims since 2015.

Weekly average claim sizes for psychological injury claims are slightly higher in 2018 compared to previous years. Due to the severity of psychological injury claims, average weekly payments for these claimants are approximately twice the size of average weekly payments for other claimants.

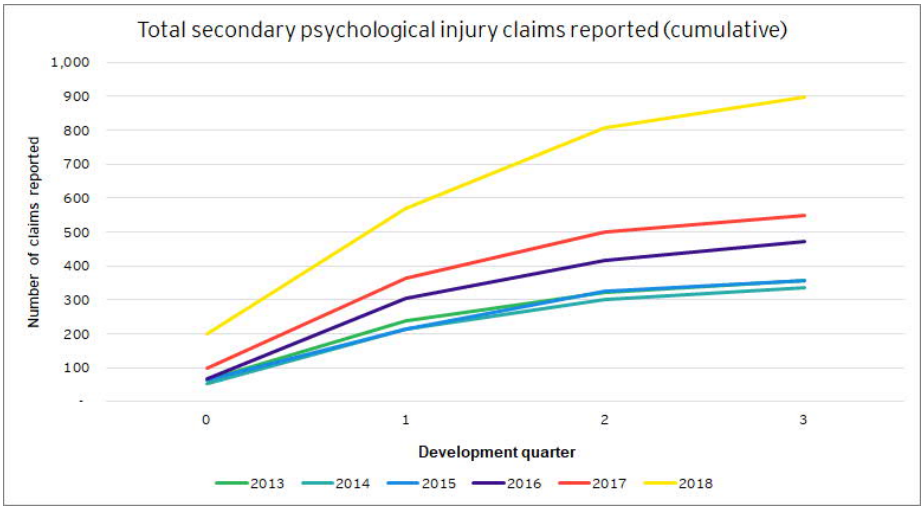
Secondary psychological injury claims

A secondary psychological injury claim is a claim which was not identified as a psychological injury when it was reported, but has subsequently received payments related to psychological services.

Secondary psychological injury claims can occur for any number of reasons including the impact of the primary physical injury on an injured worker's wellbeing and family, behaviour of an employer due to the primary physical injury or the impact of being within the workers compensation system.

Figure E.5 illustrates the number of physical injury claims that have had one or more payments for psychological services. These claims are indicative of secondary psychological injury claims. The analysis has been split by accident year and development quarter.

Figure E.5: Number of indicative secondary psychological injury claims reported



Since 2015, there has been an increasing trend in the number of claims developing secondary psychological injury claims, however the 2018 year is significantly higher than previous years.

Appendix F RTW Rates

Key Findings / Conclusion

- The overall 13 week RTW rate measured by SIRA reduced significantly from 85% at March 2018 to 75% at December 2018 on a 12 month rolling basis; on a 3 month rolling basis, RTW rates reduced to 75% at June 2018 and have shown no increase since then
- 4 week RTW rates assessed by SIRA have also shown a deterioration, from January 2018
- We understand that data issues have had a significant impact on measured RTW rates, however, SIRA's approach reflects the latest data available, including any adjustments to claim records following data quality improvements – it is unlikely that any ongoing data issues account for the entirety of the reduction in RTW rates
- RTW rates assessed by EY on icare's calculation basis for lost time claims only appear to indicate a similar pattern
- A deterioration in return to work experience is also commented on in Finity's December 2018 valuation report of the Nominal Insurer's claims liabilities, which indicates that average days paid to weekly benefit claims have increased over the last year
- We would highlight that the issues around data quality since the implementation of the new model appear to have significantly impacted the quality of monitoring and that, at the time of the review, icare either did not have effective monitoring of EML's performance in place or if it did, there is no evidence of effective action being taken to improve EML's performance

RTW review

Return to work rates are a key measure of the effectiveness of the scheme. SIRA monitors 4 and 13 week RTW rates and observed a steady reduction in RTW experience since the implementation of icare's new model. EY was asked to conduct a review of the RTW rates assessed by SIRA and icare. This is documented in a report presented to SIRA dated 29 May 2019.

Key issues identified in that review included:

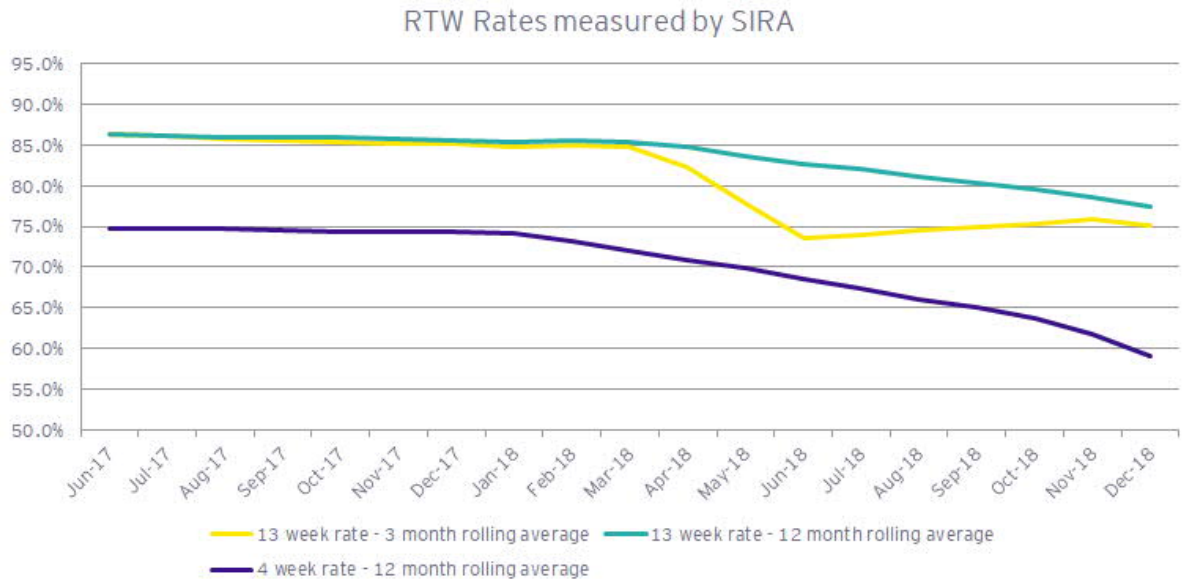
- There are a number of differences in the approaches to measuring RTW rates between SIRA and icare, including the way claims are collated, the types of claims included in the measure, and the basis for inclusion
    - SIRA's measure is based on the date a claim is entered, whereas icare's measure is based on date of injury
    - SIRA's measure considers only lost time claims where date ceased work and total days off are recorded, whereas icare's measure includes all claims including medical only claims (with a handful of exceptions)
    - SIRA's measure captures the latest data available including any adjustments to claim records, whereas icare's measure incorporates snapshot data with no adjustment
- There have been a range of data issues noted by icare, including work status codes not being entered into EML's system for claims reported after 1 January 2018, and potentially issues with date ceased work; we understand that icare and EML addressed the work status coding issues, however it is unclear to what extent date ceased work is not being correctly captured
- The overall 13 week RTW rate measured by SIRA reduced significantly from 85% at Mar 18 to 75% at Dec 18 on a 12 month rolling basis; on a 3 month rolling basis, RTW rates reduced to 75% at Jun 18 and have shown no increase since then. As noted, SIRA's measure incorporates the latest data, therefore reflects any data adjustments to date
- The results of icare's measure demonstrated a reduction in RTW rates between Mar 18 and Jun 18, which was attributed to data coding issues, and a subsequent increase back to Mar 18 levels by Dec 18

- Our findings indicated that the increase in the RTW rates measured by icare was impacted by a large increase in the proportion of medical only claims
- icare maintained that there was no significant underlying issue with lost time RTW rates, and that current RTW levels for lost time claims were not far below previous levels (notwithstanding any remaining data issues)

Key trends

SIRA's assessment of RTW rates is shown in the figure below.

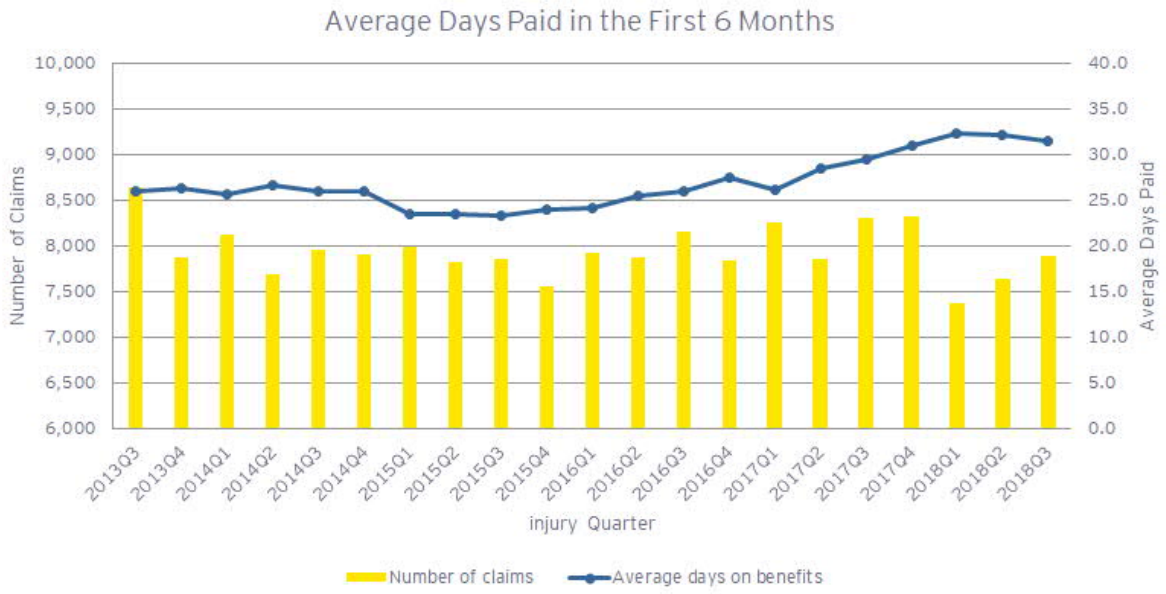
Figure F.1: RTW rates assessed by SIRA



The deterioration in RTW rates is evident in this graph. Both 4 week and 13 week RTW rates appear to have started decreasing from the commencement of the new model.

We have also examined the trends in average days paid for claims in their first 6 months receiving weekly benefits (based on hours recorded for each claimant).

Figure F.2: Average days paid for claims in their first 6 months of benefits



The graph indicates that the average days paid has increased significantly from 25 days on average to over 30 days on average. The drop in numbers of claims in the first part of 2018 is related to processing delays during the implementation of the new claims operating model.

There have been a number of data issues impacting key variables that have arisen since the implementation of the new operating model and this has impacted the quality of the monitoring that has been in place. Due to the data quality issues, particularly related to work status code, icare appears to have been reluctant to measure RTW at early durations.

Appendix G Increasing weekly payments

Key findings / conclusions

- There appears to be an increasing number of weekly claimants since the 2017 payment year
- There appears to be an increasing level of weekly claim payments – payments are increasing at a faster rate than claimant numbers
- Consequently, we have observed an increase in the average weekly payment in 2018 in particular– given that payments are rising faster than claim numbers, this is indicative of an increase in the duration of claims and deterioration in return to work experience.

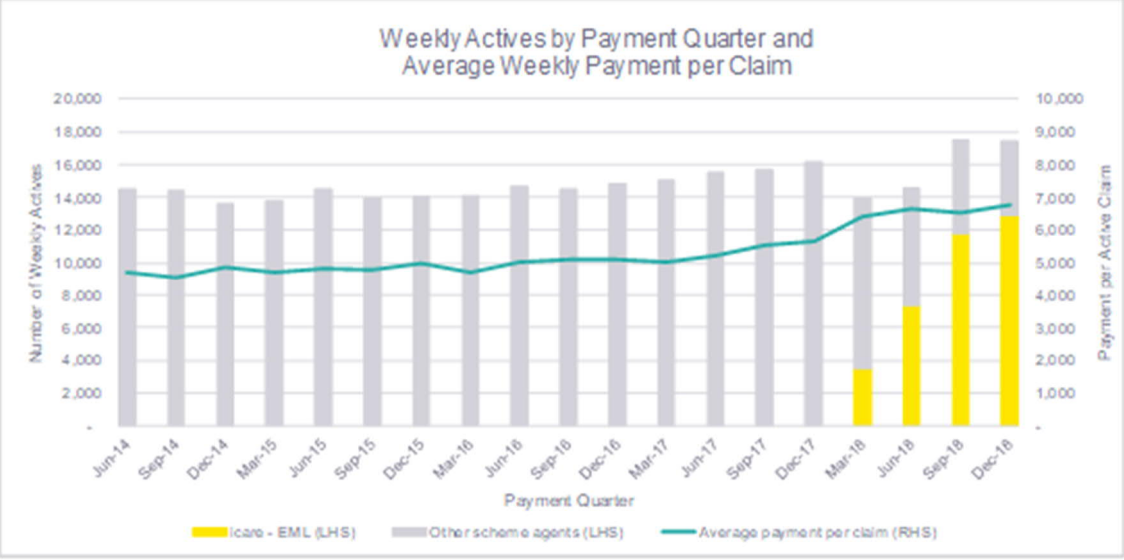
Factors around the design and implementation of the new claims management model noted throughout this report, including the increased use of provisional liability and the payment of weekly benefits without due scrutiny of reimbursement schedules and certificates of capacity, appear to have had an impact on weekly benefits experience.

The experience and potential drivers are discussed below.

Recent weekly payment experience

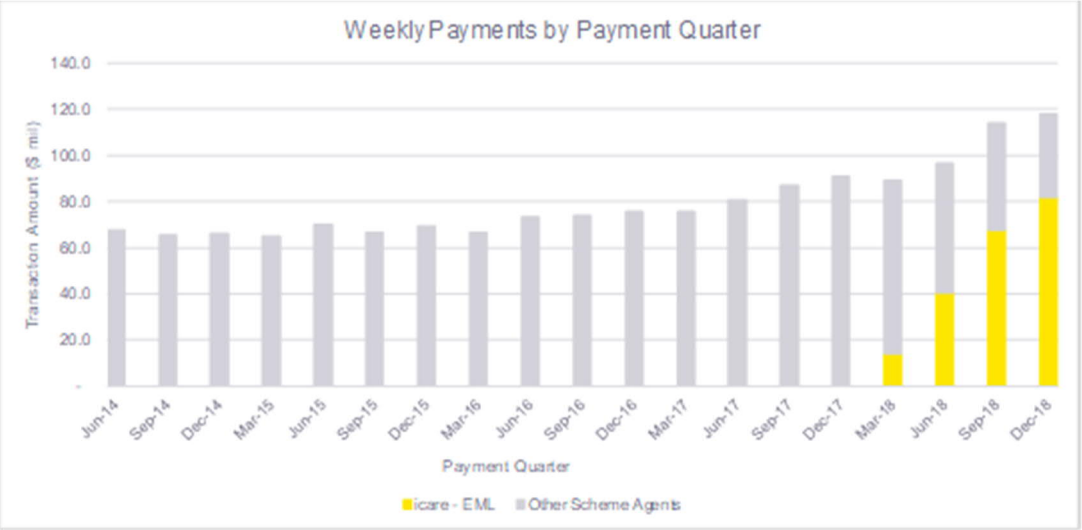
Both the number of active weekly claims (claims which have received a weekly payment in the quarter) and the average cost per claim have been increasing in the last 2 years, leading to an increase in total weekly expenditure by the NI. This is demonstrated in the following two figures, which examine the experience by payment quarter for the last 8 development quarters only (i.e. claims of less than 2 years' duration).

Figure G.1: Number of weekly active claims and average payment per claim by quarter



Note: Weekly actives and average weekly payment per claim only include the lates 8 accident quarters for the corresponding payment quarter, for example, Dec-18 payment quarter includes payments from accident quarters Mar-17 to Dec-18. The Sep-18 payment quarter includes payments from accident quarter Dec-16 to Sep-18, etc

Figure G.2: Weekly payments per quarter



Note: Payments only include the latest 8 accident quarters for the corresponding payment quarter. For example, the Dec-18 payment quarter includes payments from accident quarters Mar-17 to Dec-18. The Sep-18 payment quarter includes payments from accident quarter Dec-16 to Sep-18 and etc

As noted above, there is an increasing trend in active weekly claim numbers from the 2017 year. The 2018 year (September and December quarters) appears to be significantly higher. The first 2 quarters of 2018 show a decrease in numbers; we understand this is due to data and processing issues in the early stages of implementation of the new model.

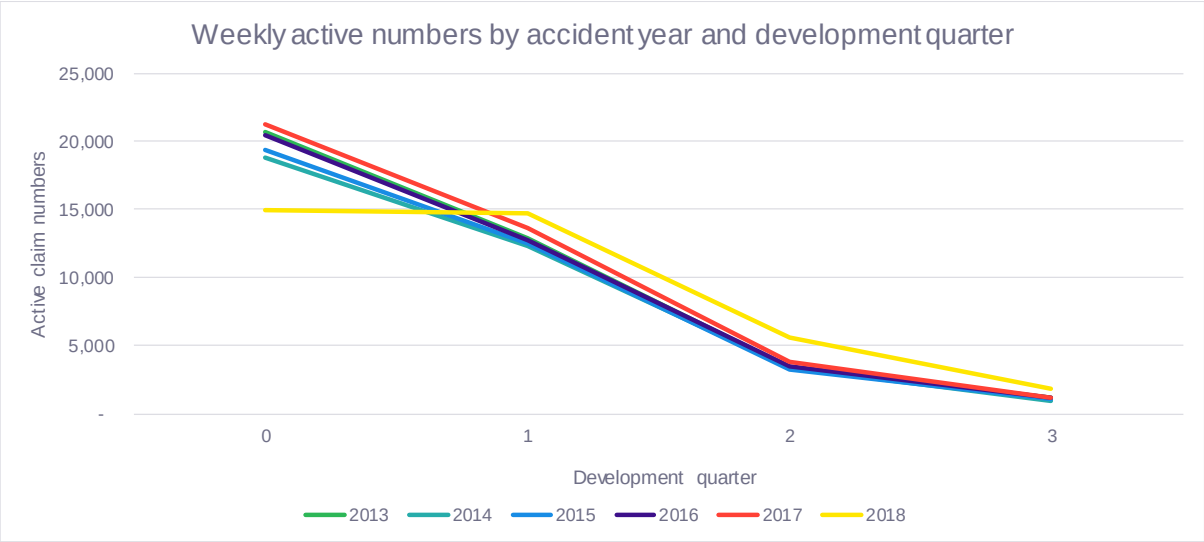
As similar pattern is observed for weekly claim payments (for claims of less than 2 years duration) from the 2017 year. The first 2 quarters of 2018 also appear to be impacted by the data and processing issues noted above. The September 2018 and December 2018 quarters may include some catch up.

We observe that total payments in 2018 are 25% higher than for 2017, which is a higher growth rate than observed for the number of active claims.

The total average claim size has also shown a significant increase from the Dec 17 payment quarter. Given that payments appear to have grown at a faster rate than numbers of claims, this suggests that there has been an increase in duration of claims. That is. individual claimants are receiving payments for a higher number of weeks than before, supporting the view that there has been an increase in duration and a deterioration in return to work experience.

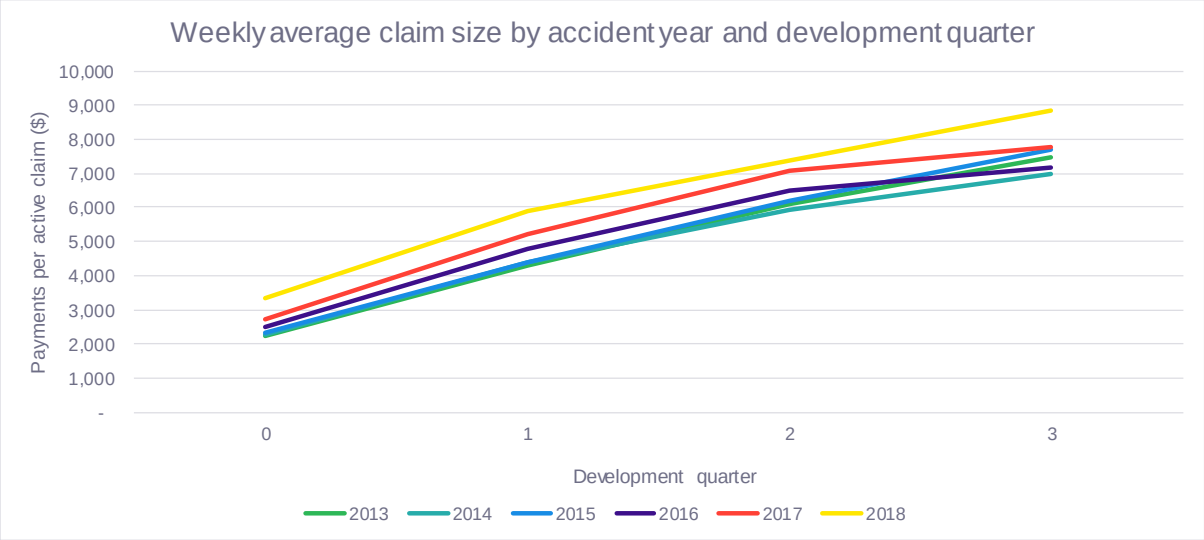
We have examined the experience of 2018 further below, to understand the potential impacts of the implementation of the new model and the introduction of EML as the sole scheme agent. The following graphs compare the experience of the 2018 accident year to previous accident years at the same stage of development.

Figure G.3: Number of weekly active claim numbers by accident year and development quarter



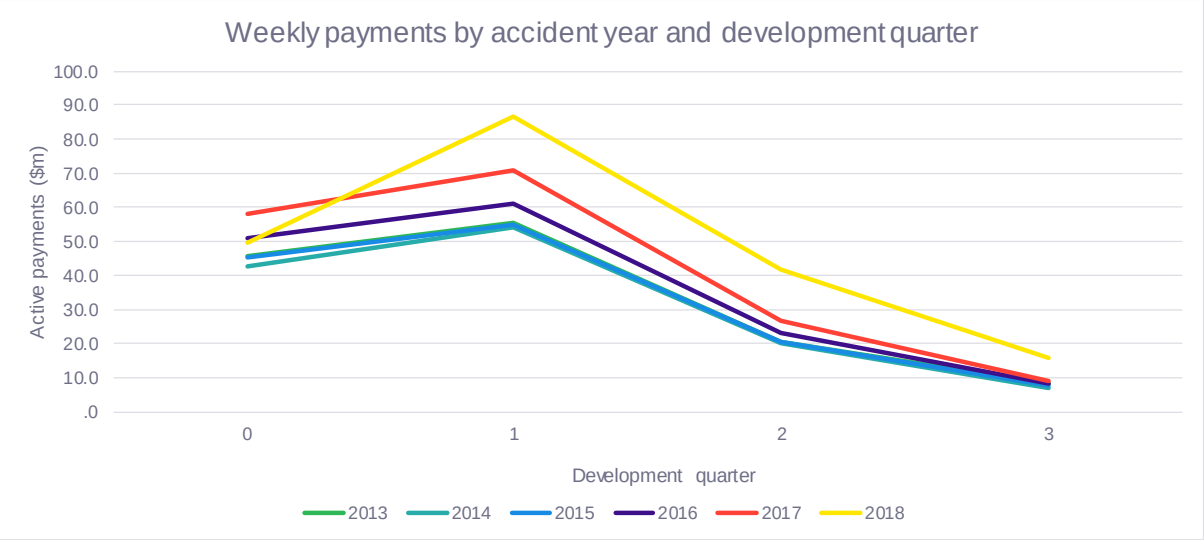
On a like with like basis, the 2018 accident year is showing a significant increase in active weekly claimants at the same point in time relative to previous accident years. The first point should be ignored due to known EML data recording issues.

Figure G.4: Weekly average claim size by accident year and development quarter



On a like with like basis, the 2018 accident year is showing a higher average size at the same point in time relative to previous accident years. This is consistent with our observations on a payment quarter basis.

Figure G.5: Weekly payments by accident year and development quarter



This graph demonstrates the significant increase in weekly payments in the 2018 accident year relative to previous years at the same point of development (ignoring the first point which is likely impacted by data issues). This is similar to the experience observed for the 2018 payment year.

As discussed throughout this report, the design of the new model and factors around implementation, including the increased use of provisional liability, are likely factors leading to higher active numbers, increased duration of claims, deteriorating return to work rates and lack of governance around weekly payments.

Appendix H Increasing medical spend

Key findings / conclusions

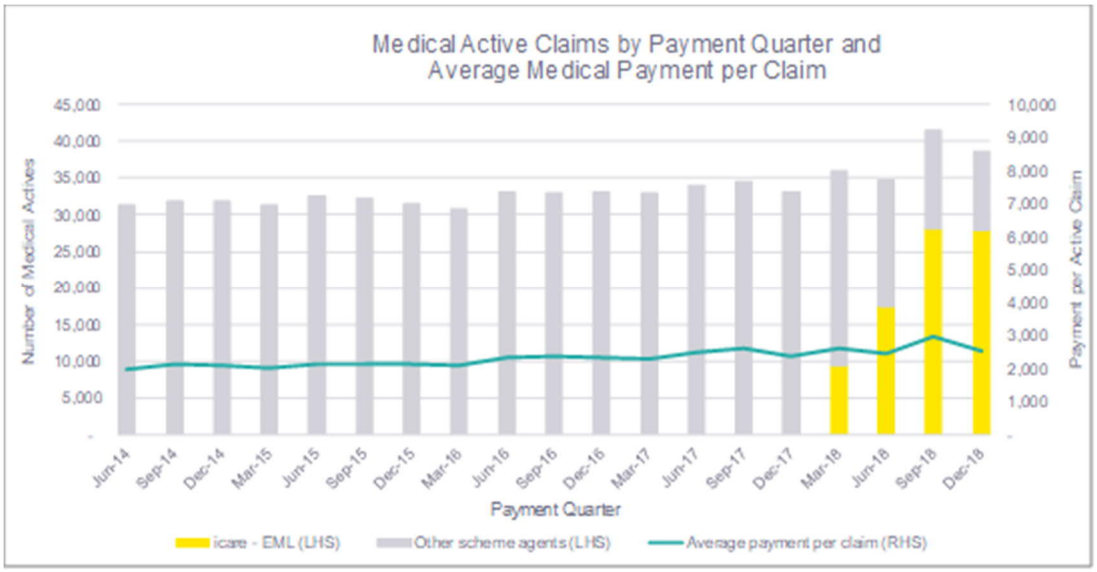
- There have been steady increases in medical spend on claims over the last four years, at a rate of around 10% per annum in excess of wage inflation
- There have been comparatively stable movements in active claim numbers since 2014, however the 2018 year is exhibiting a higher level of active claim numbers, particular the September and December 2018 payment quarters
- Increased utilisation of high cost services such as surgery has had a significant effect on medical costs, including a flow on effect to hospital costs
- The claims file review identified instances where there is a lack of scrutiny or challenge to proposed medical treatments and the associated costs.

The experience and potential drivers are discussed below.

Recent medical payment experience

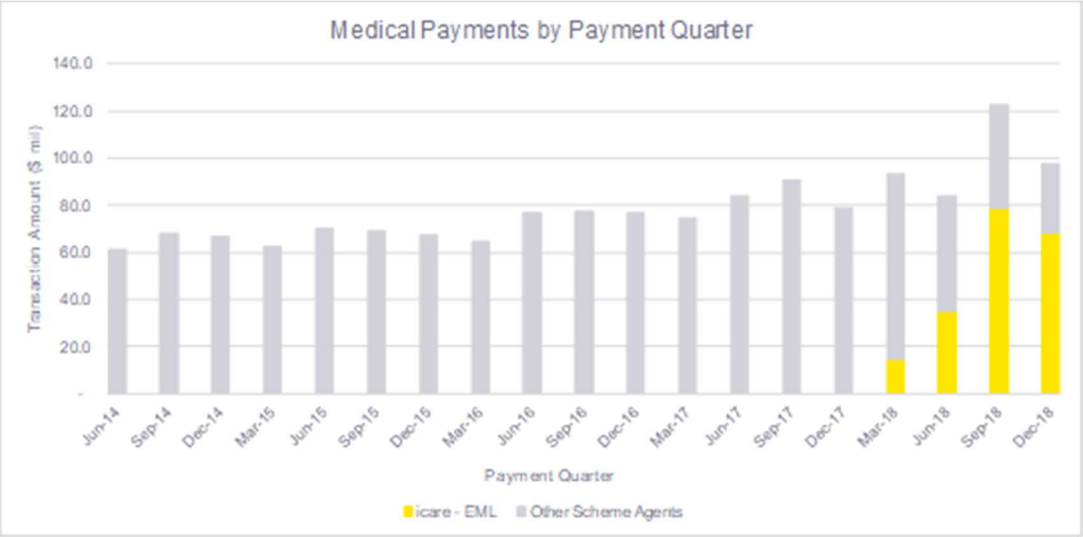
Both the number of active medical claims (claims which have received a medical payment in the quarter) and the average cost per claim have been increasing in the last 4 years, leading to an increase in total medical expenditure by the NI.

Figure H.1: Number of medical active claims and average payment per claim



Note: Payments only include the latest 8 accident quarters for the corresponding payment quarter. For example, Dec-18 payment quarter only includes payments from accident quarter Mar-17 to Dec-18. The Sep-18 payment quarter includes payments from accident quarter Dec-16 to Sep-18 and etc.

Figure H.2: Medical payments per quarter



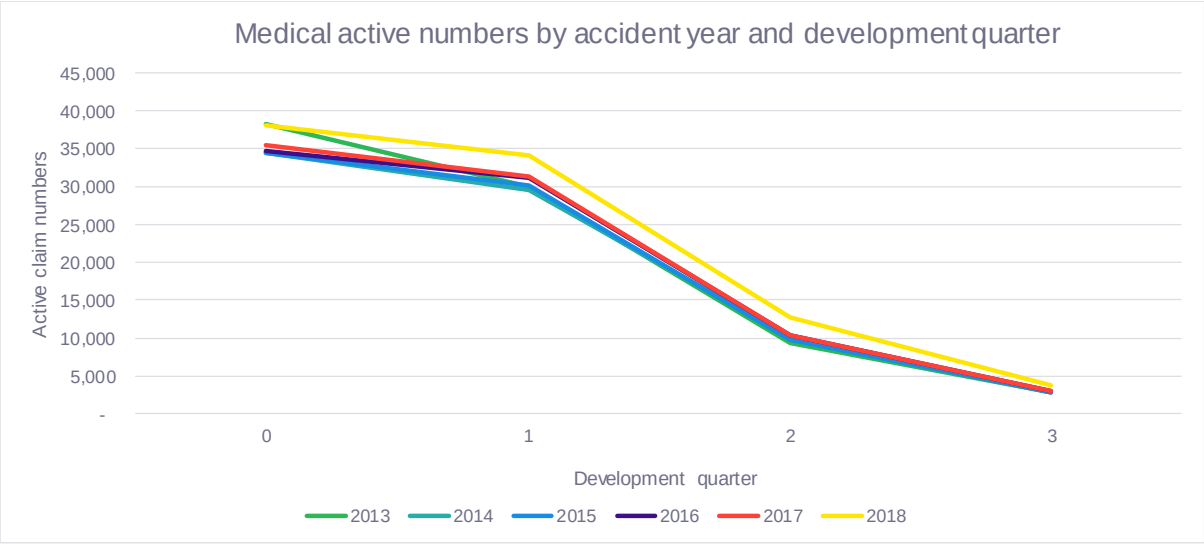
Note: Payments only include the latest 8 accident quarters for the corresponding payment quarter, eg. Dec-18 payment quarter only includes payments from accident quarter Mar-17 to Dec-18. The Sep-18 payment quarter includes payments from accident quarter Dec-16 to Sep-18 and etc

The average medical payment made to claimants has been steadily increasing since 2013. The annual growth has been around 10% per annum above inflation for the last 4 years.

We observed a change in experience in the 2018 year, with active medical claim numbers increasing by around 15% over the previous year, compared with less than 5% per annum increases in previous years. The September and December 2018 payment quarters are particularly high.

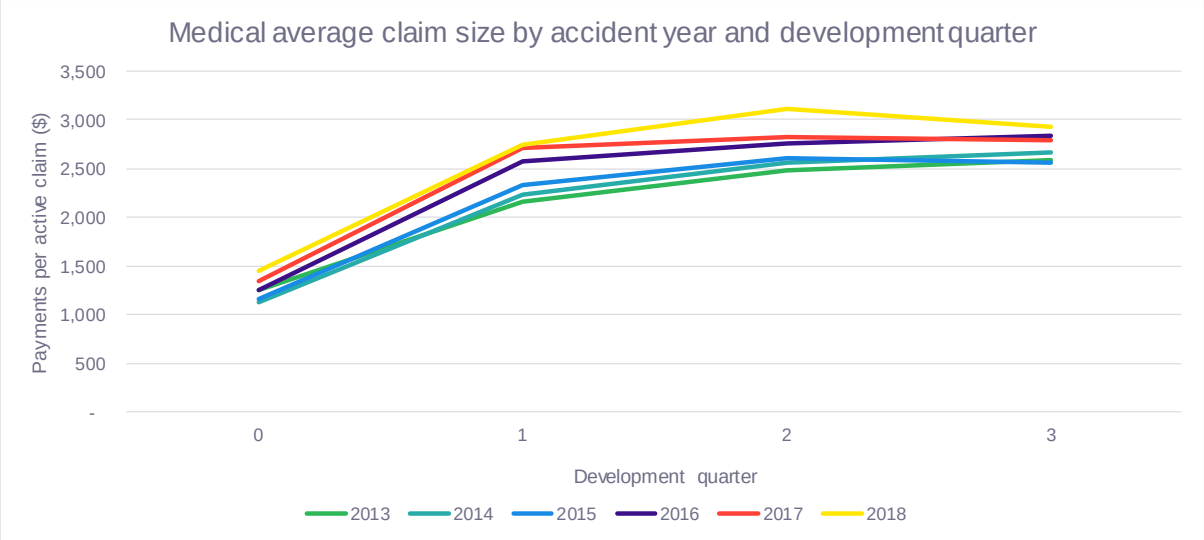
We have examined the experience of 2018 further below, to understand the potential impacts of the implementation of the new claims operating model. The following graphs compare the experience of the 2018 accident year to previous accident years at the same stage of development.

Figure H.3: Number of medical active claims by accident year and development quarter



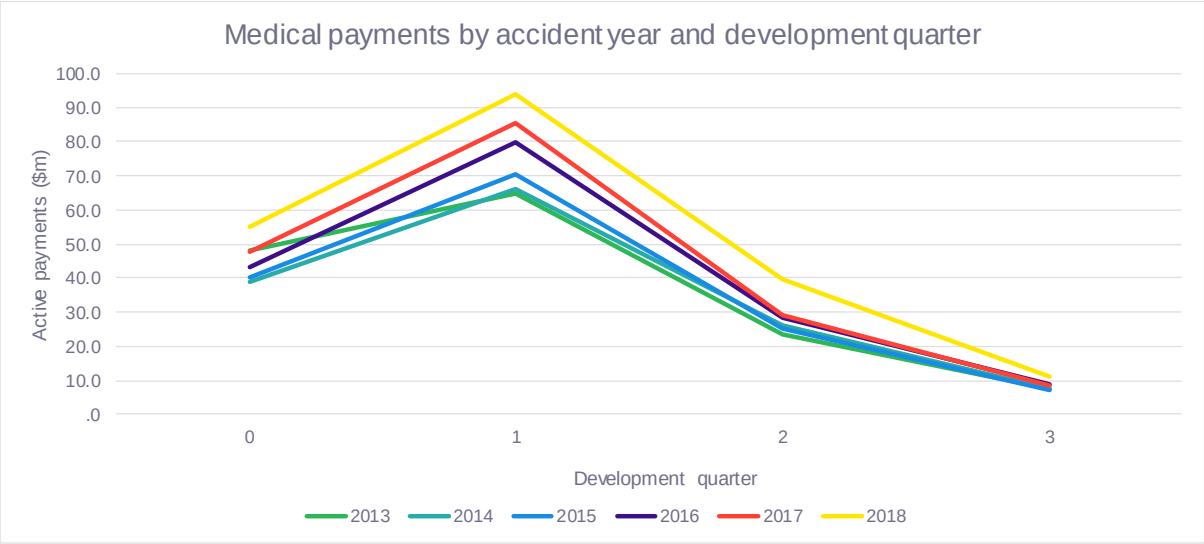
It is evident that there is an increase in active medical claimants for the 2018 accident year (as well as for the 2018 payment year) when compared with other accident years at the same stage of development.

Figure H.4: Medical average claim size by accident year and development quarter



The graph above clearly demonstrates the trend of successive increases in average cost per medical claim.

Figure H.5: Medical payments by accident year and development quarter



The consequence of these two scheme features is an increase in total medical costs Over the last three years

Despite the implementation of the new model, there has been no slowing in medical cost increase. The experience in fact appears to have worsened. The potential causes of the increasing trend are a lack of scrutiny of medical approvals and expenditure and an increased willingness to pay in the less adversarial approach to claims management, and possibly a more generous interpretation of "reasonably necessary".

Appendix I Results of Claim File Review

This appendix sets out the detailed results of the claim file review.

Claim file review process

The results of the experience analyses and desktop review described in this report and in appendices C through H were used to develop criteria to select a stratified random sample of files to review. The claims selected were notified on or after 1 January 2018, representing a cross-section of EML's claims across the first year of the new model (and a smaller number of Allianz and GIO claims were also selected).

The review was conducted by three experienced claim file reviewers (including one reviewer from SIRA). The review involved:

- Developing a consistent set of evaluation criteria to assess claims / files – these included both objective criteria as well as judgmental criteria
- Reviewing the sample of claims / files based on the evaluation criteria and recording the findings
- Consulting with an assigned icare contact person as needed to clarify relevant matters with respect to each claim
- Consolidating the individual review findings and identifying key themes
- Documenting the detailed review for each claim / file

The review encompassed 122 claim files including 92 from EML, 15 from Allianz and 15 from GIO. The majority of claims were lost time injuries with varying durations. Claim files were selected randomly across the following categories:

- Duration on benefits (<1 week, 1-4 weeks, 4-13 weeks, 13-26 weeks, 26+ weeks)
- Claimant age (18-30, 30-40, 40-50, 50-65, 65+)
- Injury type (fractures, sprains, psychological, other injury types)
- Liability status (accepted, provisionally accepted, denied)

This review has focused on key processes within the claims management life cycle, including areas that are specific to icare's model:

- Claim acceptance and triage
- Use of provisional liability
- Liability decisions
- Ongoing liability and work capacity assessment
- Injury management and return to work
- Medical treatment and costs
- Weekly benefit assessment and payments

While not specifically in scope, during the process of the claims file review, the effectiveness of EML's IT system and capability of case management staff were also considered.

The audit tool used for the review consisted of a series of "yes"/"no" questions. These questions also had an option to answer unknown where evidence for the question could not be found on the file to support either a definitive "yes" or a definitive "no". The detailed claims file review results are discussed below.

Summary of results

The following table summarises the key findings of the claims file review.

Summary of results	
Claim acceptance and triage	• For the majority of claims reviewed, the initial claims acceptance process was done in a timely manner and in compliance with the legislation • With regard to the initial triage of claims, it was identified that approximately 40% of claims were triaged into the wrong level of support and were subsequently moved to a higher level of support • Compounding the initial triage misclassification, it was identified that there was a substantial delay in rectifying the triage category, thus delaying the necessary treatment and support that injured workers required
Use of provisional liability	• The majority of claims reviewed had been accepted provisionally, even those where it was obvious that liability would ultimately be accepted. This approach causes unnecessary extra work for the case managers and creates uncertainty for injured workers • A number of examples were identified where the acceptance of the liability decision was subsequently made outside of the legislated timeframes or medical payment limits • Although provisional liability was used, this did not seemingly always translate into thorough liability investigations being subsequently carried out. This was one of the key findings of the review and is elaborated upon under the next section “Liability Decisions” • It is our view that provisional liability is being used beyond its intended purpose and is likely to be having an adverse impact on claimant outcomes. In summary: o There is a requirement to decide liability on a claim within 7 calendar days. If an outright decision cannot be made, a provisional liability decision can be made so that the necessary payments and treatments can begin o It is clear that reliance on provisional liability has become excessive. In the majority of cases, there was evidence supporting a decision to accept liability on a claim outright o Failure to accept liability and the use of provisional liability leads to a requirement to send correspondence advising all parties the matter is subject to further enquiry o This approach can lead to unnecessary fomentation of distrust and an adversarial atmosphere when no form of distrust truly exists. This level of distrust is likely to have a negative effect on treatment, rehabilitation and attempts at return to work

Summary of results	
Liability decisions	• In approximately 65% of cases reviewed, the investigation carried out to determine liability was adequate • In a number of instances, claims were being accepted and paid without the appropriate due diligence or investigation. One possible explanation for this is that EML is not encouraged or incentivised to apply the requisite challenge to the initial investigation and ongoing liability determination • In 31 of the 122 claims reviewed (25%), the employer raised concerns with the claim that had been lodged. Many of the concerns of the employer were in relation to reasonable management actions and the use of section 11A of the Act. Of these 31, there were 17 claims where the employers' concerns had not been thoroughly investigated but liability had been accepted • Alleged work-related stress was prevalent in a number of claims reviewed. In a high proportion of these claims, the relationship between a claimant's alleged psychological injury and any events which arose out of, or in the course of, the claimant's employment appeared to be questionable, and there appeared to be grounds to at least consider disputing the claim on the basis of section 11A • The overall view of the reviewers is that there was a failure to properly assess liability in the first instance and to conduct the necessary due diligence into the circumstances of an injury. This is a key issue that needs to be addressed
Ongoing liability assessment	• For 45% of the claims reviewed, there was no evidence found on the file that the injured worker had been advised of changes in their liability status. These were primarily claims that had been accepted provisionally and subsequently had liability accepted • In 26% of the claims reviewed, issues with the ongoing assessment of liability were identified o These issues were either that claims were accepted provisionally and then no further investigation was carried out between provisional acceptance and full liability acceptance; or o Issues identified with causation (and clearly apparent on the file) were not followed up and acted upon
Injury management and return to work	• Injury management plans (IMP) were primarily generic and not tailored to the individual needs of the injured worker, and the plans did not evolve as the injury and subsequent injury management evolved • In regard to rehabilitation providers: o In most cases, the appointment of a rehabilitation provider was appropriate given the circumstances of the injured worker o Even though some rehabilitation providers were considered to have shortcomings, overall, they appeared to have a positive influence in respect of the injured party's attempts to return to work o In the cases where the rehabilitation provider was not being effective, there was a lack of pro-activity on the part of EML to rectify the situation. It appeared in many cases that once a rehabilitation provider was appointed then EML also ceded the case management to the provider • The most positive contributors to the rehabilitation process were considered to be the employers. Employers appeared to show the most enthusiasm in accommodating their injured employees. The reviewers also noted that employers persevered despite an apparent lack of engagement with them by EML and were enthusiastic in attempting to participate within the strictures of the system • The reviewers considered that EML was not active within the rehabilitation process. It was their view that in many cases, injured workers, employers, Nominated Treating Doctors (NTDs) and the rehabilitation providers were largely left to attend to matters as they saw fit

Summary of results	
Medical treatment and costs	• In approximately 40% of claims reviewed, the medical treatment plan was either non-existent or had not been reviewed on an ongoing basis as the circumstances of the injury evolved • In cases where the NTD was coordinating treatment in the absence of a treatment plan, there was no obvious no scrutiny as to the appropriateness of the treatment being carried out • Frequently allied health services were being funded with no Allied Health Recovery Request (AHRR) or were in excess of the treatment requested through the AHRR • Expenditure on prescription drugs, diagnostic tests, hospital fees, surgical costs, physiotherapy and travelling expenses in many cases did not appear to undergo proper scrutiny. In many cases there was evidence on file that much of this expenditure was either not warranted, excessive, or at the least, enquiries should have been made about the invoices submitted
Weekly payments	• In 20% of cases reviewed, there considered to be insufficient information gathered to accurately calculate PIAWE • In approximately 30% of cases reviewed, either it could not be determined that weekly benefits were paid at the appropriate rate or it was evident that the calculation was incorrect • The general themes from these cases included o Actual weekly payments being reimbursed to the employer that were not consistent with the PIAWE calculation on file o No reimbursement schedules on file from the employer o PIAWE calculation errors, for example, a lack of PIAWE indexation or not adjusting PIAWE at 52 weeks

Initial claim acceptance and triage

This section focuses on the initial triage of the claims reviewed and the subsequent claims acceptance process.

Key Findings

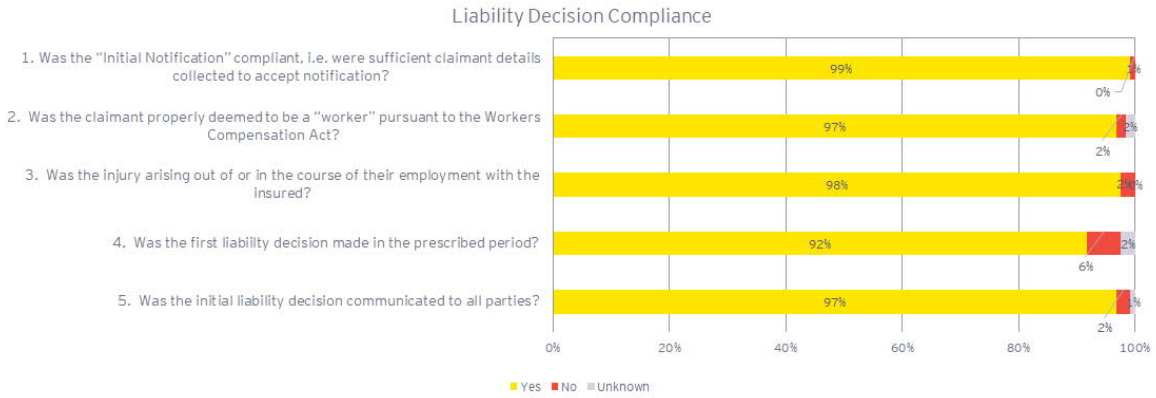
The key findings in regard to the initial triage of claims and the subsequent claims acceptance process are:

- For the majority of claims reviewed, the initial claims notification process was done in a timely manner and in compliance with the legislation
- The claims review identified that approximately 40% of claims were being triaged into the wrong level of support and were subsequently moved to a higher level of support
- Compounding the initial triage misclassification, it was identified that there was a substantial delay in rectifying the triage category, thus delaying the necessary treatment and support that injured workers require

Detailed results – claim acceptance

The following figure sets out the results of our review into claim notification processes, overall and by triage category, with respect to first liability decision compliance.

Figure I.1: Liability decision compliance of claims reviewed



The majority of claim files reviewed met the compliance and timeliness requirements for liability decisions and claim acceptance, i.e. claims were properly assessed for eligibility pursuant to the Workers Compensation Act 1987. This was consistent across all triage categories. The majority of claims were accepted provisionally (see section 3) within the prescribed timeframes.

Detailed results – claims triage

The following tables summarise the initial triage decisions made on the 122 claims reviewed and the subsequent movement of these claims to other levels of support (no claims from the "care" category were reviewed). The triage decision was not available for 17 claims reviewed.

Table I.1: Numbers of claims reviewed transitioning from one category to another

Transition:	EMPOWER	GUIDE	SUPPORT	SPECIALISED	UNKNOWN	Total
EMPOWER	14	1	33	0	0	48
GUIDE	0	8	12	1	0	21
SUPPORT	1	0	15	1	0	17
SPECIALISED	0	0	0	19	0	19
UNKNOWN	0	0	0	0	17	17
Total	15	9	60	21	17	122

Table I.2: Percentage of claims reviewed transitioning from one category to another

Transition:

	EMPOWER	GUIDE	SUPPORT	SPECIALISED	UNKNOWN
EMPOWER	29.2%	2.1%	68.8%	0.0%	0.0%
GUIDE	0.0%	38.1%	57.1%	4.8%	0.0%
SUPPORT	5.9%	0.0%	88.2%	5.9%	0.0%
SPECIALISED	0.0%	0.0%	0.0%	100.0%	0.0%
UNKNOWN	0.0%	0.0%	0.0%	0.0%	100.0%

Table I.3: Change of triage category of claims reviewed

	Remains in initial triage bucket	Moves to higher triage bucket	Proportion automatically triaged
EMPOWER	29.2%	70.8%	77.1%
GUIDE	38.1%	61.9%	95.2%
SUPPORT	88.2%	11.8%	64.7%
SPECIALISED	100.0%	0.0%	78.9%
UNKNOWN	100.0%	0.0%	
Total	59.8%	40.2%	68.0%

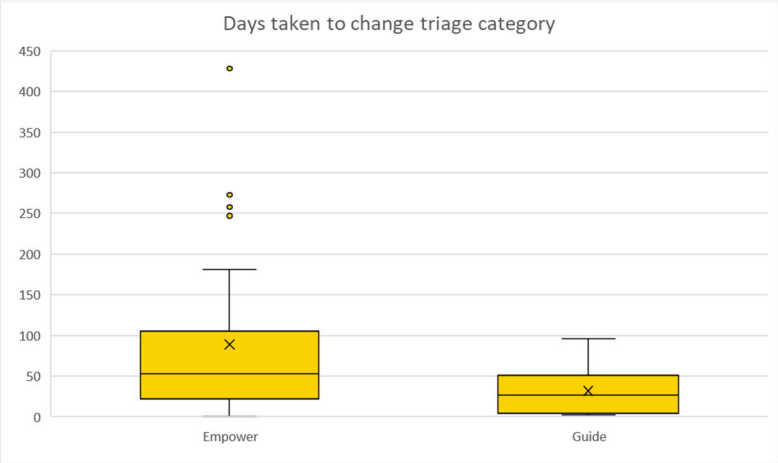
We note the following:

- Nearly 70% of the claims in the audit sample were automatically triaged to the 4 support categories.
- However, as shown in tables I.1 and I.3, approximately 40% claims were moved from their initial triage category into a higher level of support
  - As an example, 48 claims reviewed were initially triaged into the Empower category (expected to resolve within 2 weeks).
  - Of these only 14 or 29% remained in the Empower category
  - The remainder were moved to a higher level of support and the majority (33 claims or 69%) moved to the Support category (which are not expected to resolve within 6 weeks)
- We note that of the 20 psychological injury claims reviewed, the majority were triaged into the correct category (18 went to Specialised, 1 went to Support and 1 we could not identify).

The evidence above suggests that the current triage process is ineffective in allocating claims to the correct level of support. This is particularly so for claims that were initially allocated to Empower and Guide.

The file review also identified that it has taken an excessive amount of time to identify that claims have been in the wrong triage category and to subsequently move them. This is leading to a delay in the treatment and support that these claims require. The following graph shows the time taken for claims in the Empower and Guide segments to move to a higher support level.

Figure I.2: Days taken for claims reviewed to change triage category



- The time taken to move claims to the required level of support is substantial, compounding the impact of the initial misclassification
  - For the Empower claims, it took on average 90 calendar days to move claims, with more than 25% of the sample taking more than 105 days
  - For the Guide claims, the movement happened faster. On average 32 days, with more than 25% of the sample taking more than 50 days.
- The consequences of incorrect triage are that claims are not given the optimal level of case management. In the case of the Empower and Guide categories, the design of the system is such that minimal support is given by the case managers (as these claims are expected to resolve quickly and with minimal intervention), however when claims are wrongly triaged into these categories then there is a substantial delay in claims receiving the treatment and support they require.

Use of provisional liability

Key Findings

The key findings in regard to the use of provisional liability include:

- The majority of claims reviewed had been accepted provisionally, even those where it was obvious that liability would be accepted. This appears to make extra work for the case managers and creates uncertainty for injured workers
- A number of examples were found where the acceptance of the liability decision was subsequently made outside of the legislated timeframe or after medical payments had breached limits. The acceptance of provisional liability places further obligation on the insurer to make a full determination of liability within certain boundaries. The boundaries are:
    i. Costs for medical treatment while in provisional liability cannot exceed a maximum of $7,500 for claims pre 1/1/2019 or $10,000 for claims post 1/1/2019; or
    ii. The payment of weekly benefits cannot exceed the maximum of 12 weeks.

  The file review identified a number of cases that were outside these requirements
- Although provisional liability was used, this did not seemingly always translate into thorough liability investigations being carried out (refer to section 5 for more detail)
- It is our view that provisional liability is being used beyond its intended purpose and is likely having an adverse impact on claimant outcomes
    - There is a requirement to decide liability on a claim within 7 calendar days. If an outright decision cannot be made, a provisional liability decision can be made
    - It is clear that reliance on provisional liability has become excessive. In the majority of cases, there was evidence supporting a decision to accept a claim outright. It is not clear what is driving the excessive use of provisional liability; it is possibly related to the capacity and capability gaps within EML that are discussed in the main body of the report
    - Failure to accept claims leads to a requirement to send correspondence advising all parties that the matter is subject to further enquiry.
    - This approach can lead to unnecessary fomentation of distrust and an adversarial atmosphere when no form of distrust truly exists. This level of distrust is likely to have a negative effect on treatment, rehabilitation and attempts at return to work.

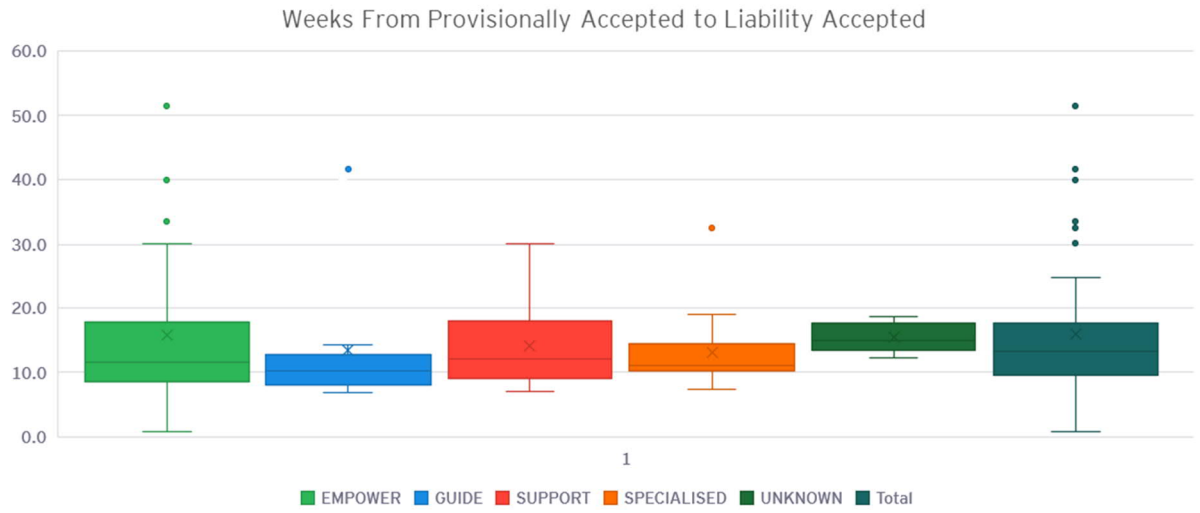
Detailed results – provisional liability

The following table and graph set out the acceptance profile and experience of the claims reviewed.

Table I.4: Acceptance profile of claims reviewed

Initial Triage	Total Number of Claims	Number of PL claims	Proportion of files reviewed with PL	Liability subsequently accepted	Proportion of Acceptance
EMPOWER	48	48	100.0%	36	75.0%
- EMPOWER TO SUPPORT	33	33	100.0%	27	81.8%
GUIDE	21	18	85.7%	12	66.7%
- GUIDE TO SUPPORT	12	10	83.3%	9	90.0%
SUPPORT	17	12	70.6%	9	75.0%
SPECIALISED	19	19	100.0%	19	100.0%
UNKNOWN	17	16	94.1%	5	31.3%
Total	122	113	92.6%	81	71.7%

Figure I.3: Median weeks from provisional acceptance to full claim acceptance of claims reviewed (by triage category)



The majority of the claims in the file review were initially provisionally accepted. Of these claims, almost 72% were subsequently accepted (the remainder were either closed while still under provisional liability or are still under provisional liability).

The file review determined that the time taken to make a subsequent decision to accept the 81 claims was approximately 15 weeks on average. The data indicated that there were some cases where the time to accept a claim fully was well over 30 weeks (6 cases), and these were predominantly in the lower support triage categories.

We utilised data from the SIRA data warehouse (CDR) to perform additional analysis on the reviewed claim files. Figure I.4 shows medical payments made on the 113 provisionally accepted claims while on provisional liability. There are a number of examples where the amount paid exceeds the statutory maximum amount of $10,000.

Figure I.4: Medical payments while on provisional liability for claims reviewed (by triage category)

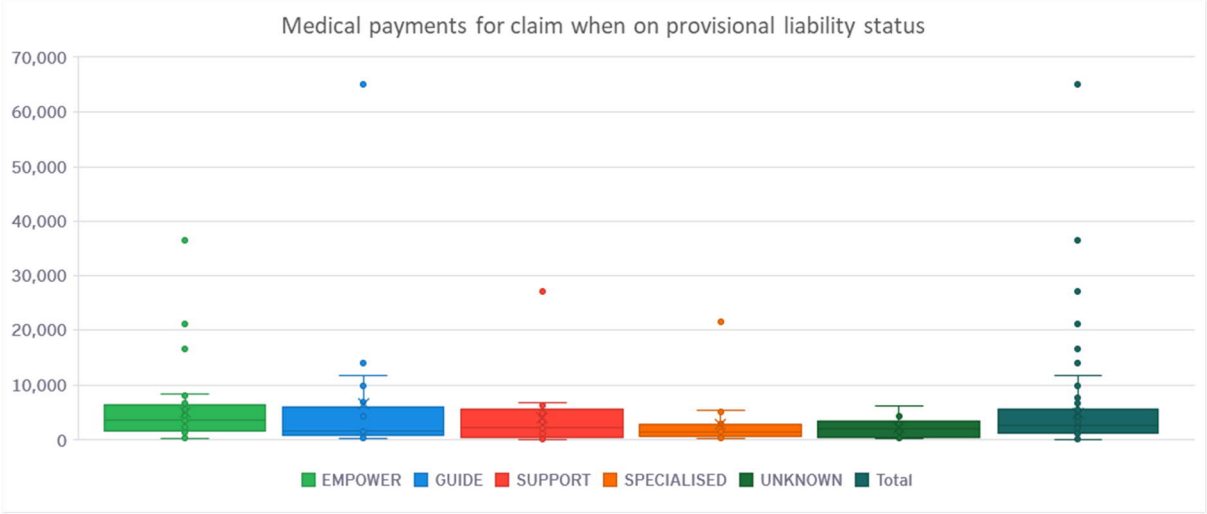
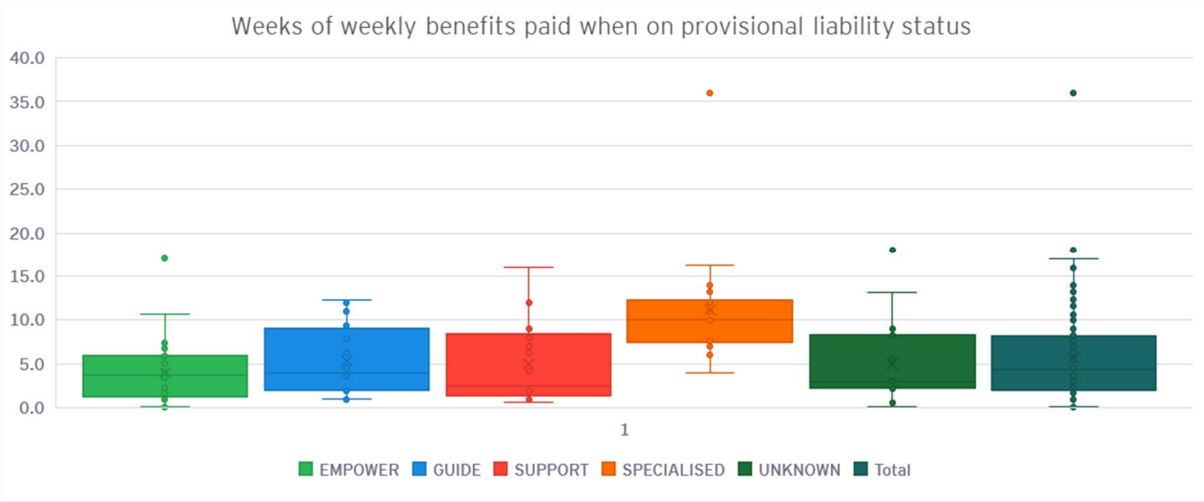


Figure I.5 shows the number of weeks of weekly benefits paid to claims while on provisional liability. It highlights the incidence of claims reviewed that have received more than the 12 weeks maximum statutory limit (7 files). Note, the number of weeks was derived by taking the total payments made when in provisional liability and dividing by the PIAWE amount recorded for the claim.

Figure I.5: Number of weeks of weekly benefits paid on provisional liability for claims reviewed (by triage category)



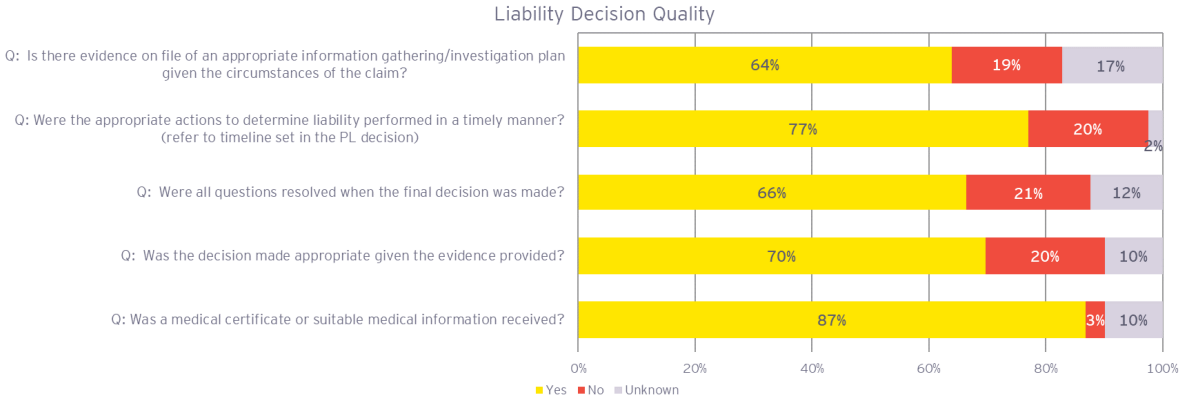
Quality of liability decisions and stakeholder engagement

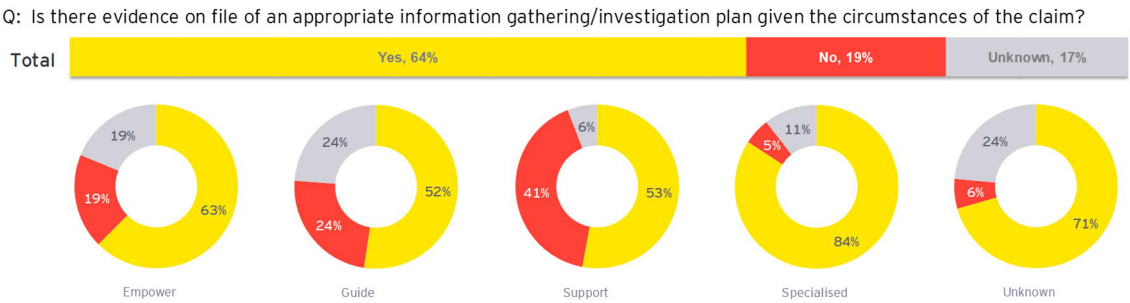
Key findings

- In only approximately 65% of files reviewed was the investigation carried out to determine liability considered to be adequate
- In a number of instances, claims were being paid without the appropriate due diligence or investigation. One possible explanation for this is that EML is not encouraged or incentivised to apply the requisite challenge to the initial investigation and ongoing liability determination
- In 31 of the 122 claims reviewed (25%), the employer raised concerns with the claim that had been lodged. Many of the concerns of the employer were in relation to reasonable management actions and the use of section 11A of the Act. Of these 31, there were 17 claims where the employer's concerns had not been thoroughly investigated and liability had been accepted
- Alleged work-related stress was prevalent in a number of claims reviewed. In a high proportion of these claims, the relationship between a claimant's alleged psychological condition and any events which arose out of, or in the course of, the claimant's employment appeared to be questionable. There were a number of matters in which an allegation of misconduct on the part of the employer was not subject to thorough investigation. This was particularly the case in relation to Section 11(A) of the Workers Compensation Act 1987. There were a number of instances in which reliance on this section was not considered by the case managers, although there appeared to be grounds to at least consider disputing the claim on this basis
- The overall view of the reviewers is that a failure to properly assess liability in the first instance is an issue which needs to be addressed. The method of triaging new claims has an inherent fault if it does not allow a proper assessment of the liability of new claims in the first instance

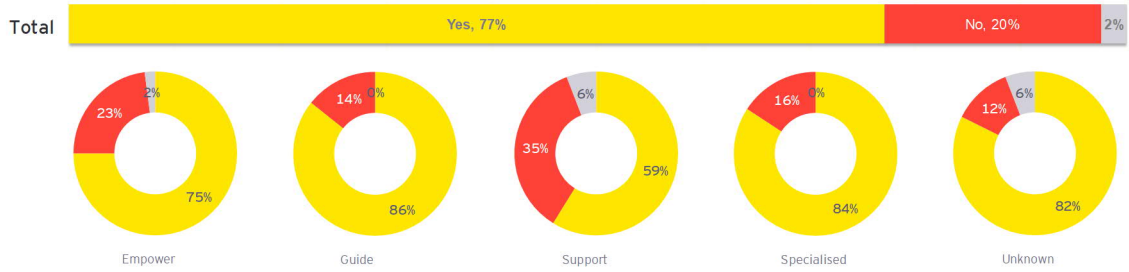
Detailed results – quality of liability decisions

Figure I.6: Liability decision quality of claims reviewed

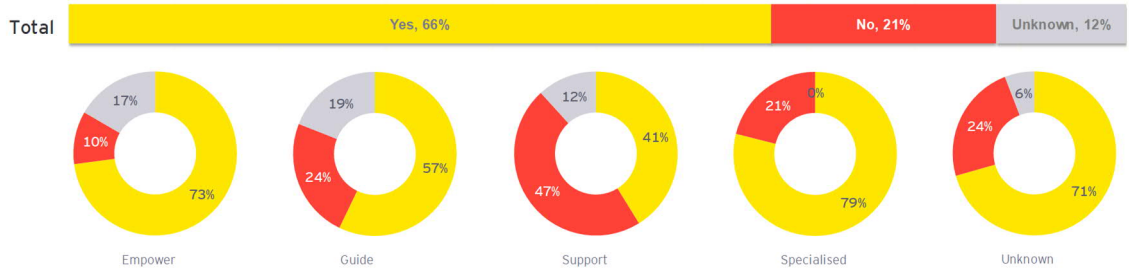




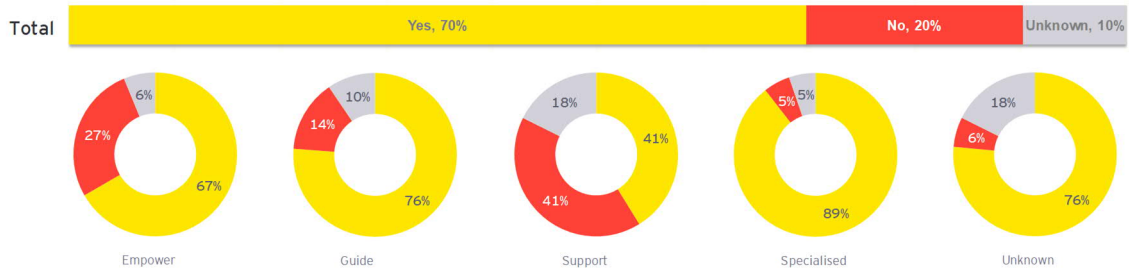
Q: Were the appropriate actions to determine liability performed in a timely manner? (refer to timeline set in the PL decision)



Q: Were all questions resolved when the final decision was made?



Q: Was the decision made appropriate given the evidence provided?



We note the following on the results above:

- It appeared that only approximately 65% of cases was the investigation carried out to determine liability thorough. In particular:
  - In only 64% of cases was the information gathering and investigation sufficiently thorough
  - In only 66% of cases was it considered that there were no unanswered questions when the liability decision was made
  - In only 70% of cases was it considered that the correct decision was made given the evidence provided
- In the majority of cases, suitable medical information was received
- In 31 of the 122 claims reviewed (25%), the employer raised concerns with the claim that had been lodged. Many of the concerns of the employer were in relation to reasonable management actions and the use of section 11A of the Act. Of these 31, there were 17 claims where the employer's concerns had not been thoroughly investigated and liability had been accepted.

The following detailed comments were raised by the file reviewers in relation to claim reporting and acceptance:

- When considering the details within the files, a number of claims were considered to have been assessed without taking due consideration for the existence of conditions which were unrelated to the claimant's employment
- In some cases, a claimant's past medical history was acquired but in the reviewer's view, either not relied upon or not properly assessed when considering issues of causation
- Effectiveness in assessing new claims appeared to be hampered by a frequent absence of claim forms completed by both the employer and employee. The absence of claim forms is considered to be an impediment to the appropriate accumulation of information such as a claimant's occupation, period of employment, existence of witnesses, claims histories and suspicious items

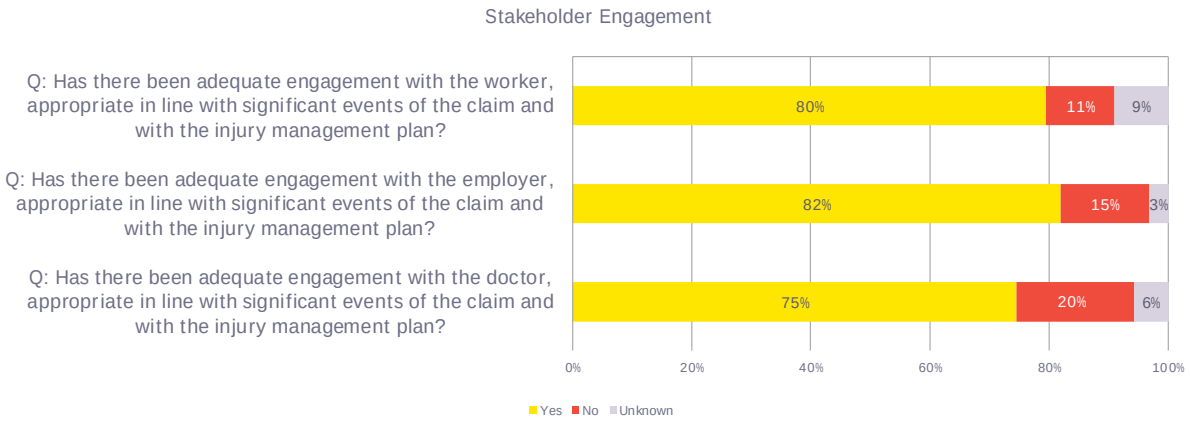
(The reviewers also observed that Allianz and GIO adhered to the use of claim forms whereas EML did not)

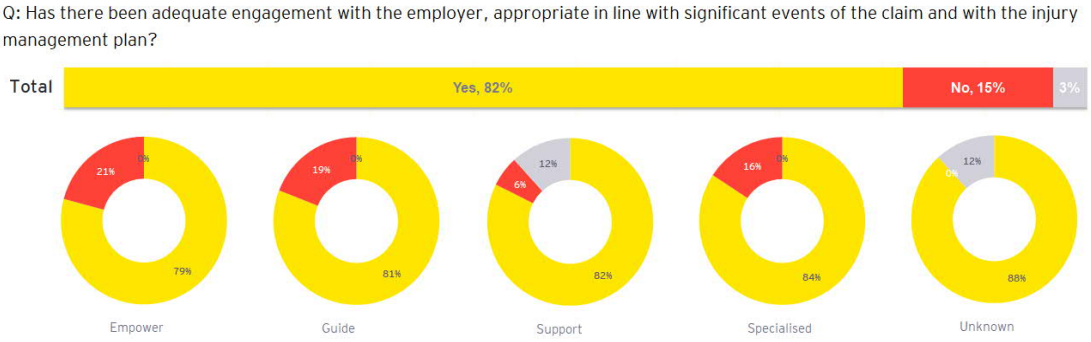
- Alleged work related stress was prevalent in a number of claims reviewed. In a high proportion of these claims, the relationship between a claimant's alleged psychological condition and any events which arose out of, or in the course of, the claimant's employment appeared to be questionable
- On occasion, this relationship was subject to challenge and these challenges were successful. There were, however, a number of matters in which an allegation of misconduct on the part of the employer was not subject to challenge. This was particularly the case in relation to Section 11(A) of the Workers Compensation Act 1987. This section removes liability for an employer to compensate a worker for any psychological injury claims if the employer's actions are considered reasonable. There were a number of instances in which reliance on this section was not considered by the case managers, although there appeared to be grounds to at least consider disputing the claim on this basis
- It is possible that icare's "non-adversarial" approach may be encouraging more claims of a dubious nature.
- In a number of examples, there was evidence on file to suggest the claimant's entitlement should be challenged. Some examples are:
    - It was clear in one instance from the claim file notes that the worker was prolonging incapacity because that was essential for their associated life/TPD and mortgage insurance claims. Despite this, there was no evidence to gain an independent view on work capacity
    - There was evidence on another claim from an IME (psychiatrist) that the worker was not suffering from a diagnosable psychiatric or psychological condition and was fit to work full time hours. Despite this, EML continued to make weekly payments to the worker. It is the opinion of the reviewer that, on this claim, a liability dispute decision or a work capacity decision should have been made.

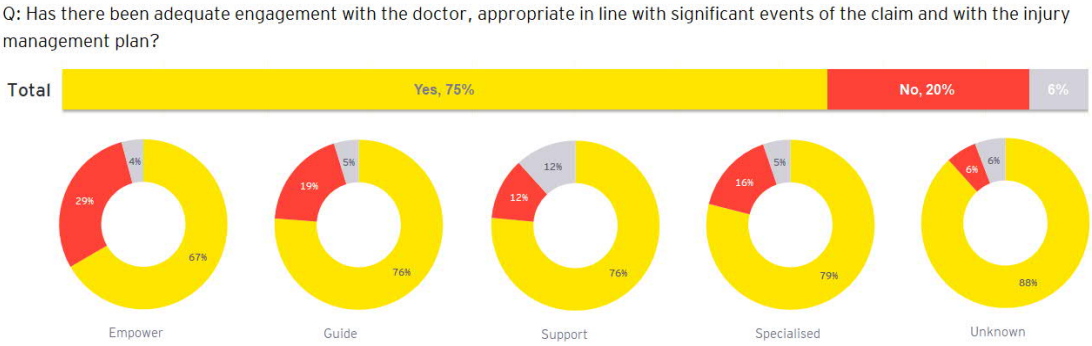
The overall view of the reviewers is that a failure to properly assess liability in the first instance is an issue which needs to be addressed. The method of triaging new claims has an inherent fault if it does not allow proper assessment of the liability of new claims in the first instance.

Detailed results – stakeholder engagement

Figure I.7: Stakeholder engagement for claims reviewed







The reviewers considered that between 10% and 20% of claim files reviewed did not demonstrate adequate engagement by EML with the worker, the employer or the treating doctor. This was particularly the case for the Empower and Guide segments. It was noted on a number of files that effort was made to engage with the treating doctor, however, this was difficult due to unresponsiveness of the doctor.

Ongoing liability and work capacity assessment

This section focuses on ongoing liability and work capacity, in particular processes around making changes to a claimant's liability status and work capacity assessments.

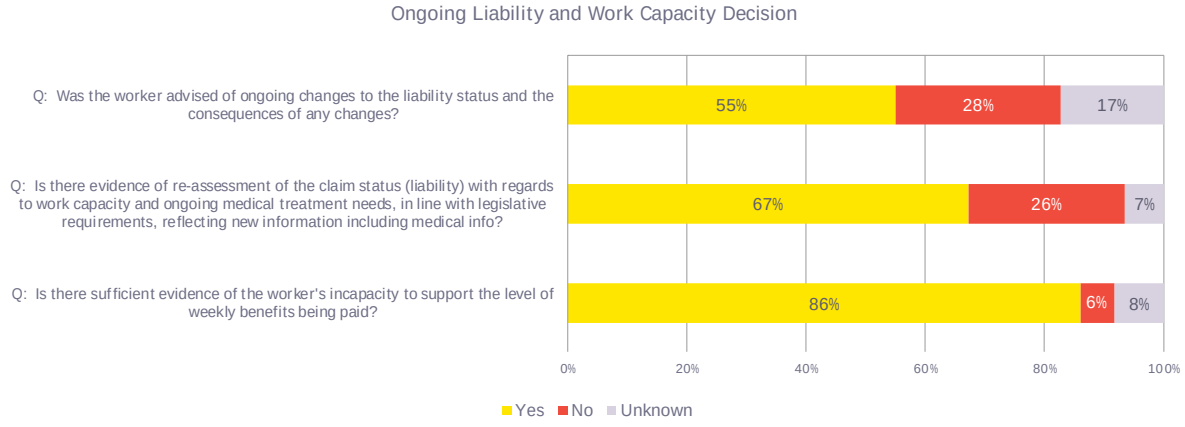
Key findings

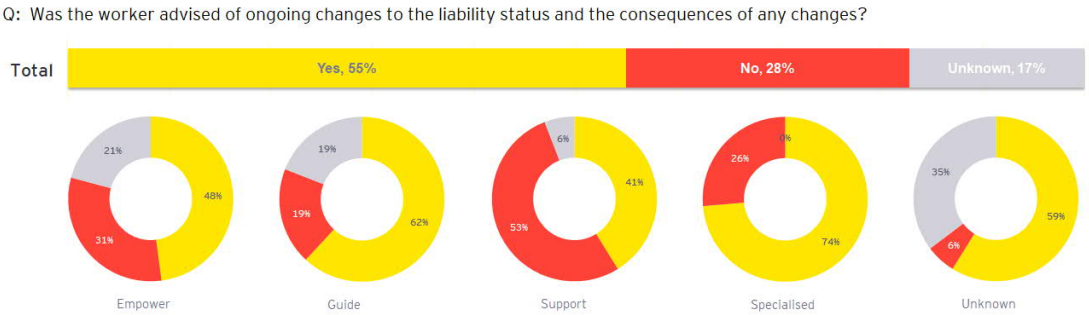
- On only 55% of claims reviewed was evidence identified that the injured worker had been advised of changes in their liability status. Primarily these were claims that had been accepted provisionally and subsequently had liability accepted in full
- In 26% of cases, issues with the re-assessment of liability status were identified. Generally, the issues were either no further investigation was carried out between provisional acceptance and full liability acceptance or issues identified with causation were not followed up and acted upon
- In the majority of cases, certificates of capacity on file supported the level of weekly benefits being paid

Detailed results – ongoing liability assessment

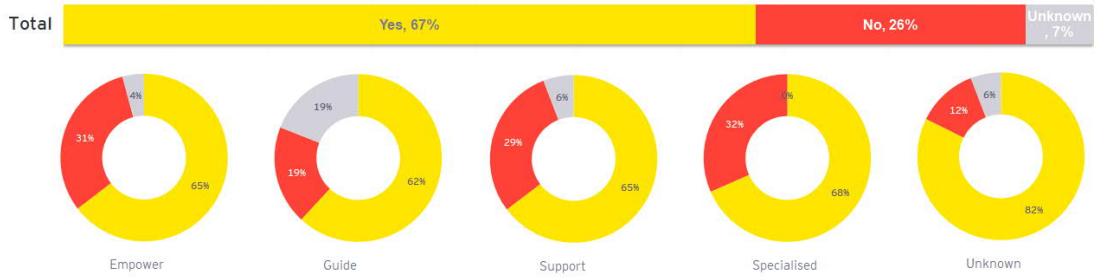
Figure I.8 shows the results of questions raised in relation to ongoing liability and capacity assessment.

Figure I.8: Ongoing liability and work capacity

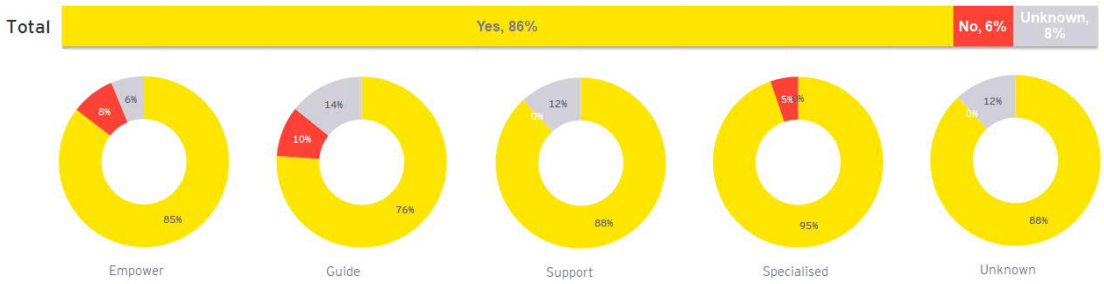




Q: Is there evidence of re-assessment of the claim status (liability) with regards to work capacity and ongoing medical treatment needs, in line with legislative requirements, reflecting new information including medical info?



Q: Is there sufficient evidence of the worker's incapacity to support the level of weekly benefits being paid?



We note the following:

- In over 28% of files reviewed, there did not appear to be evidence of the worker being advised of ongoing changes to their liability status and the consequences of any changes (particularly in the Empower, Support and Specialised triage categories). This was particularly the case where claims had been accepted provisionally and liability subsequently accepted. The absence of this additional advice likely resulted in the claimant being unaware of their changed liability status and their rights under the workers compensation act
- In 26% of cases, issues with the re-assessment of liability status were identified. Generally, the issues were either no further investigation was carried out between provisional acceptance and full liability acceptance or issues identified with causation were not followed up and acted upon
- In most cases there did appear to be sufficient evidence of the worker's incapacity to support the level of weekly benefits being paid

Injury management and return to work

This section focuses on injury management and return to work outcomes for claimants in the sample reviewed.

Key findings

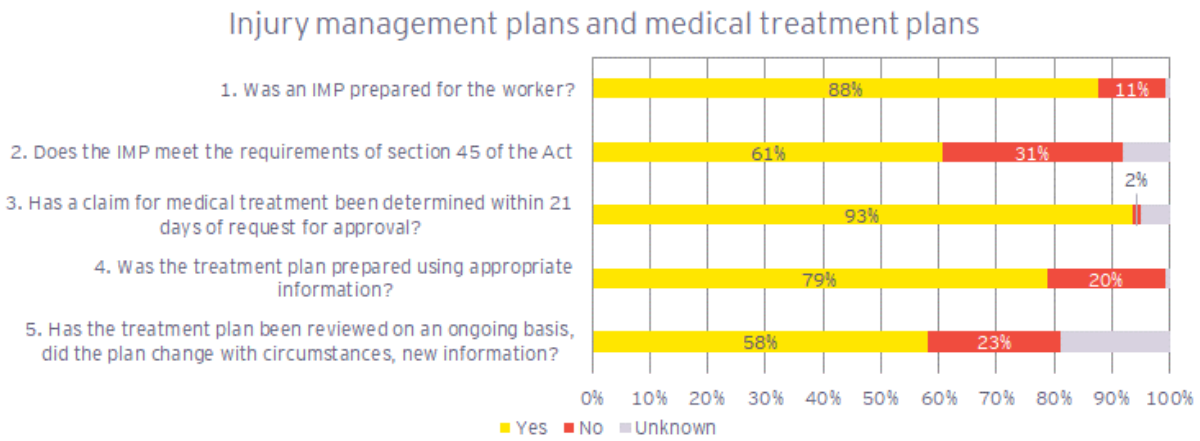
The key themes in relation to injury management and return to work from the claims file review are:

- Injury management plans (IMPs) were primarily generic and not tailored to the individual needs of the injured worker, and the plans did not evolve as the injury management evolved
- In regard to rehabilitation providers:
    - In most cases the appointment of a rehabilitation provider was appropriate given the circumstances of the injured worker
    - Even though some rehabilitation providers were considered to have some shortcomings, overall, they appeared to have a positive influence in respect of the injured party's attempts to return to work
    - In the majority of cases, providers appeared to have successfully liaised with the treating doctors, employers and the injured workers, often performing case management activities which should have been performed by EML
    - In the cases where the rehabilitation provider was not being effective, there was a lack of pro-activity on the part of EML to rectify the situation. It appeared in many cases that once a rehabilitation provider was appointed, then EML also ceded the case management to the provider, leading to a lack of oversight of costs
- The most positive contributors to the rehabilitation process were considered to be the employers
    - These organisations appeared to show the most enthusiasm in accommodating their injured employees
    - There was a willingness to amend workplace activities as well as the hours injured workers were expected to work
    - There was little evidence of a desire not to cooperate or an intent to terminate employment at the earliest opportunity
    - The reviewers also noted that employers persevered despite an apparent lack of engagement with them by EML and were enthusiastic in attempting to participate within the strictures of the system discussed above
- The reviewers considered that EML was not active within the rehabilitation process. It was their view that in many cases, injured workers, employers, NTDs and the rehabilitation providers were largely left to attend to matters as they saw fit

Detailed results – injury management plans

Figure I.9 shows the results of questions raised in relation to injury management plans.

Figure I.9: Injury management plans of claims reviewed



We note the following:

- A high proportion of files had a treatment and injury management plan prepared /applied for the worker, however just over 10% did not (across most triage categories excluding Support)
- The reviewers considered that the injury management plan (IMP) was developed in consultation with the employer /worker /treatment provider /treating doctor in 77% of cases
- The IMP did not appear to fulfill the requirements of Section 45 of the Act for a significant 30% of claims reviewed (see further discussion below)
- Appropriate communication appeared to have been provided to the injured worker / employer / treating doctor in over 80% of cases

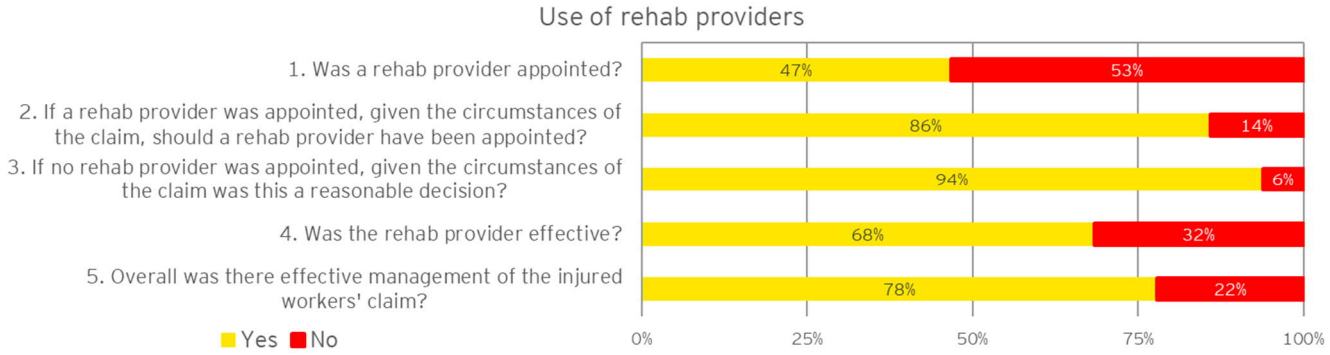
The following comments were raised by the file reviewers in relation to IMPs), which existed on all claims in which one was required (for 7 days continuous incapacity):

- Despite their existence, IMPs appeared to be extremely generic and often not suited to the unique circumstances of the claim
- Furthermore, there was ample evidence of the injury management plan not changing with circumstances
- The technical administration of the IMP appeared to be frequently assumed by the employers, rehabilitation counsellors and the treating doctors, rather than the insurer. The reviewers considered this to be an abrogation of responsibility and concluded that at times, this led to claims being misdirected.

Detailed results – use of rehabilitation and RTW

Figure I.10 shows the results of questions raised in relation to RTW and rehabilitation.

Figure I.10: RTW management and rehabilitation for claims reviewed



The comments in relation to the above graph include:

- Of the claims reviewed, 47% had a rehab provider appointed
- For this 47%, it was considered that in 86% of these cases, it was the correct decision to appoint the rehab provider
- For the 53% where no rehab provider was appointed, it was considered that this was the correct decision in 94% of cases
- In the cases where a rehab provider was appointed, it was considered that the rehab provider was effective in 68% of these cases
- Overall, across all claims reviewed, it was considered that the management of the claim was effective in 78% of cases

There were differing reasons why the rehab provider was considered ineffective in just over 20% of cases. The general themes included:

- There was often a delay in appointing the rehab provider, and by this time, the injured worker appeared disengaged
- In some cases, the rehab provider was ineffective, and the employer had requested a different provider, but this request was not actioned
- There were a number of cases where there was a question regarding whether ongoing incapacity was due to the workplace injury

In most cases where a rehab provider was appointed, it appeared that the management of the claim had been ceded to the rehab provider. The rehab provider appeared to become the major party handling coordination between the injured worker, the employer and other service providers. This was effective (although expensive) for the better rehab providers, however, the results for other rehab providers could have been improved through a more pro-active approach from EML.

This is a recurring theme and is the prominent reason why overall the management of claims was ineffective in approximately 20% of cases. EML appear to be reactive in their case management approach, and this misses an opportunity to achieve better results, both in terms of outcomes for injured workers and costs for the scheme.

Medical treatment and costs

This section focuses on medical treatment and costs for claimants in the sample.

Key findings

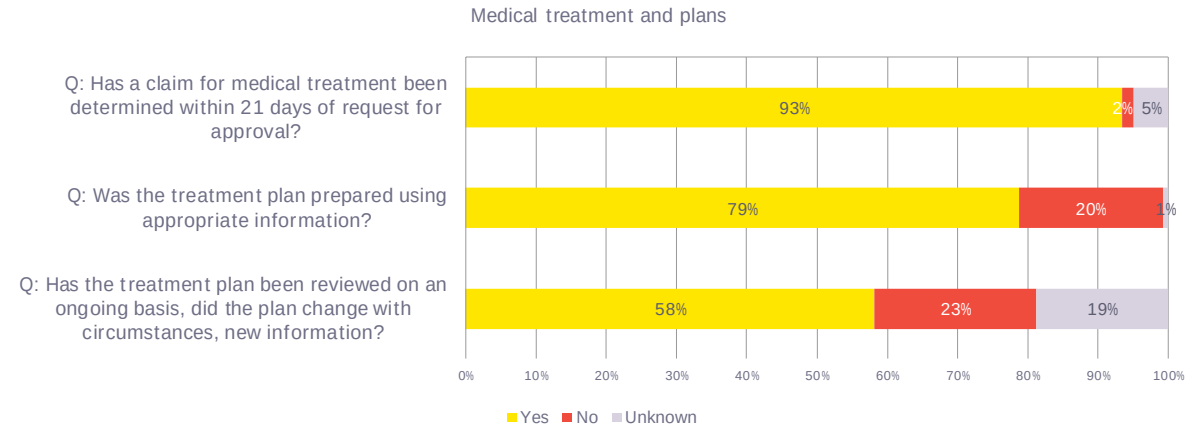
The key themes in relation to medical treatment and associated costs from the claims file review are:

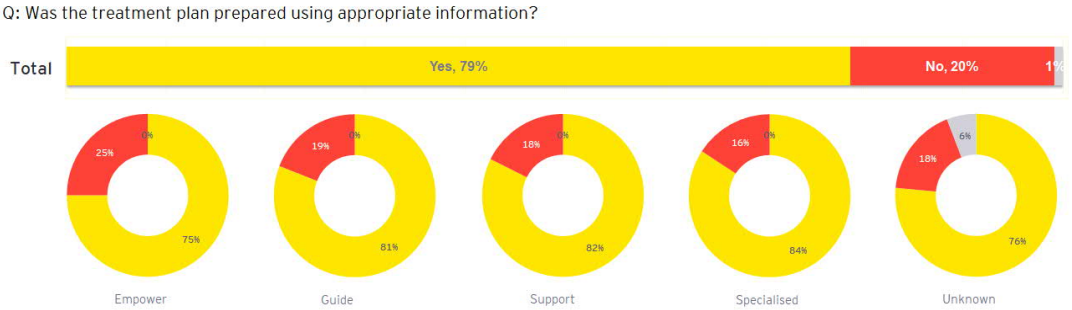
- In approximately 40% of claims reviewed, the medical treatment plan was either non-existent or had not been reviewed on an ongoing basis as the circumstances of the claim evolved
- In cases where the NTD was coordinating treatment in the absence of a treatment plan, there was no apparent scrutiny as to the appropriateness of the treatment being carried out
- Frequently allied health services were being funded with no AHRR or in excess of the treatment requested through the AHRR
- Expenditure on prescription drugs, diagnostic tests, hospital fees, surgical costs, physiotherapy and travelling expenses in many cases did not appear to undergo proper scrutiny. In many cases, there was evidence on file that much of this expenditure was either not warranted, excessive, or at the least, enquiries should have been made about the invoices submitted

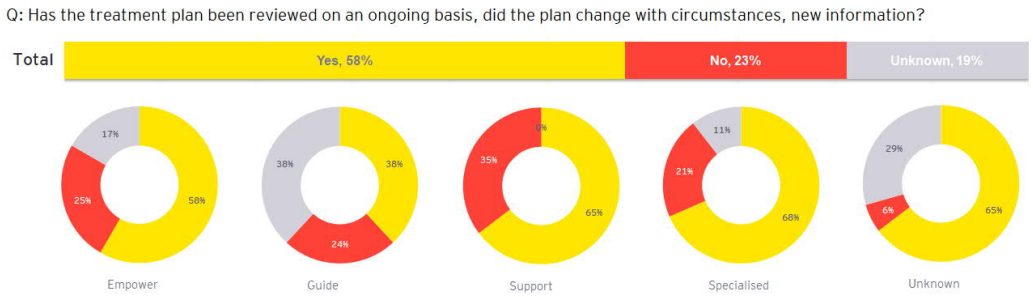
Detailed results – medical treatment and costs

Figure I.11 shows the results of questions raised in relation to medical treatment and plans.

Figure I.11: Medical treatment and plans





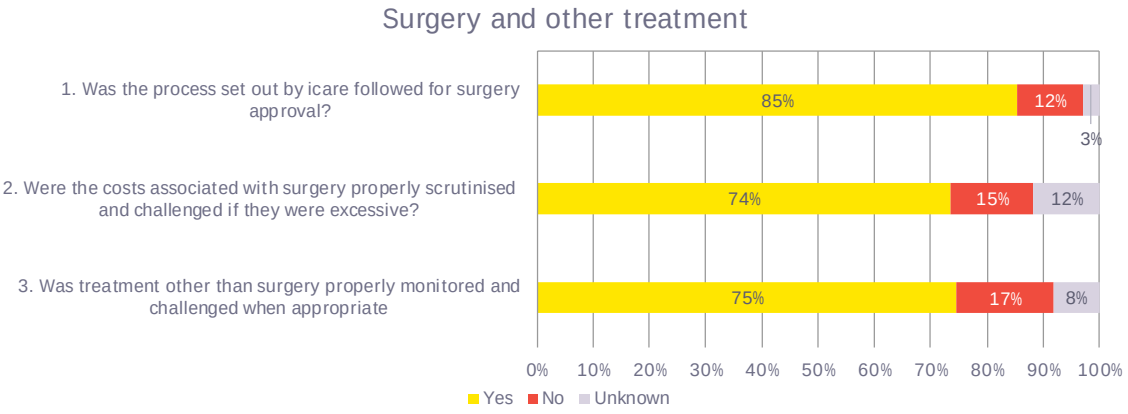


We note the following:

- The majority of files reviewed had claims for medical treatment determined within the required 21 days of request for approval
- 20% of files reviewed were considered not to have treatment plans prepared using appropriate information; this was across all triage categories. In the majority of these cases, there was evidence that the NTD was coordinating treatment; however, there was no plan on file and therefore no scrutiny or approval of the treatment
- Just over 20% of files were considered to not have a treatment plan that had been reviewed on an ongoing basis, or, that had changed with circumstances and/or new information (noting there were a number of files where the reviewers were not able to draw a conclusion based on the file details and this was primarily the case in the empower and guide segments).
- The concern with a number of these cases was that ongoing treatment was being provided with no scrutiny and no consideration of the outcomes being achieved.
- Some of the reviewer comments that capture this theme include:
  - "Initial IMP approved up to 8 sessions of Physio. 19 sessions provided to date with no AHRR or Physio report on file, no file notes"
  - "The treatment provided needed to be reviewed as it has proven ineffective for the last 16 months"

Figure I.12 shows the results of questions raised in relation to surgery and other treatment.

Figure I.12: Surgery and other treatment



- The process set out by icare for surgery approval was followed in the majority of cases, although the reviewers considered this was not the case for just over 10% of files
- The reviewers considered that the costs associated with surgery were not properly scrutinised and challenged in approximately 15% of cases. In a number of these cases, costs were paid with no prior approval of the surgery recorded on the file
- The treatment other than surgery was not considered to be properly monitored and challenged for just over 15% of cases. A number of these cases related to either seemingly excessive pharmacy use, excessive diagnostic tests or payment of allied health services with no AHHR
- There were a number of cases in which medical treatment appeared to be rendered and paid inappropriately, without prior approval or not properly challenged:

- This was best exemplified by what appeared to be a general overuse of diagnostic services, particularly so for magnetic resonance imaging ("MRIs")
- Accounts of this type were being paid generally without exception despite what the reviewers considered was limited or no justification for this treatment
- Expenditure on prescription drugs, hospital fees, surgical costs, physiotherapy and travelling expenses in many cases did not appear to undergo proper scrutiny
- Invoices for allied health services were observed to be paid for in the absence of the required Allied Health Recovery Request (AHRR), which provides prior approval for such services. Where an AHRR was provided, the number of treatment sessions regularly exceeded the number of sessions requested/approved.
- There were other examples of payments for other expenses being made when the treatment appeared to bear no relationship to any work injury

Weekly benefit payments

This section focuses on weekly benefit payments for claimants in the sample.

Key findings

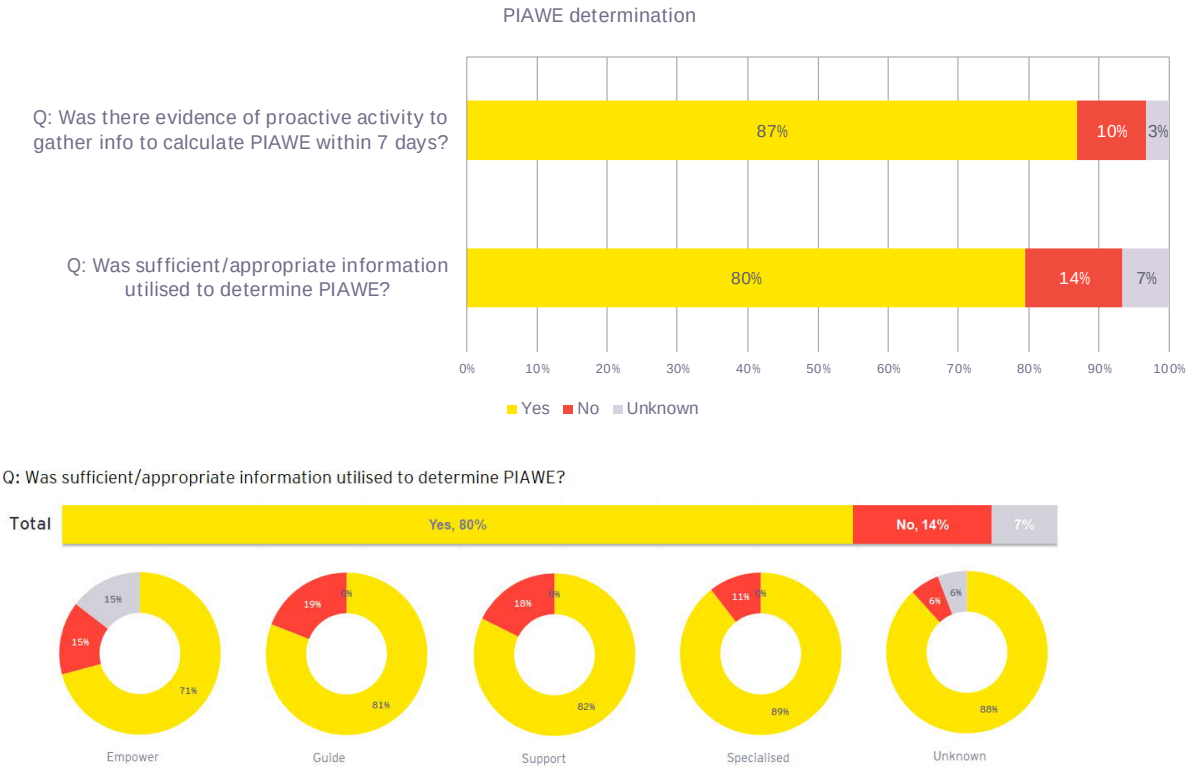
The key themes in relation to weekly benefit payments from the claims file review are:

- For most claims, the PIAWE decision was made within a week of the claim being reported.
- In 20% of cases reviewed, there was considered to be insufficient information gathered in order to accurately calculate PIAWE
- In approximately 30% of cases, either it could not be determined that weekly benefits were paid at the appropriate rate or it was evident that the calculation was incorrect
- The general themes from these cases included:
  - Actual weekly payments being reimbursed to the employer that were not consistent with the PIAWE calculation on file
  - No reimbursement schedules on file from the employer
  - PIAWE calculation errors, for example, a lack of PIAWE indexation or not adjusting PIAWE at 52 weeks

Detailed results – weekly payments

Figure I.13 shows the results of questions raised in relation to PIAWE determination.

Figure I.13: PIAWE determination

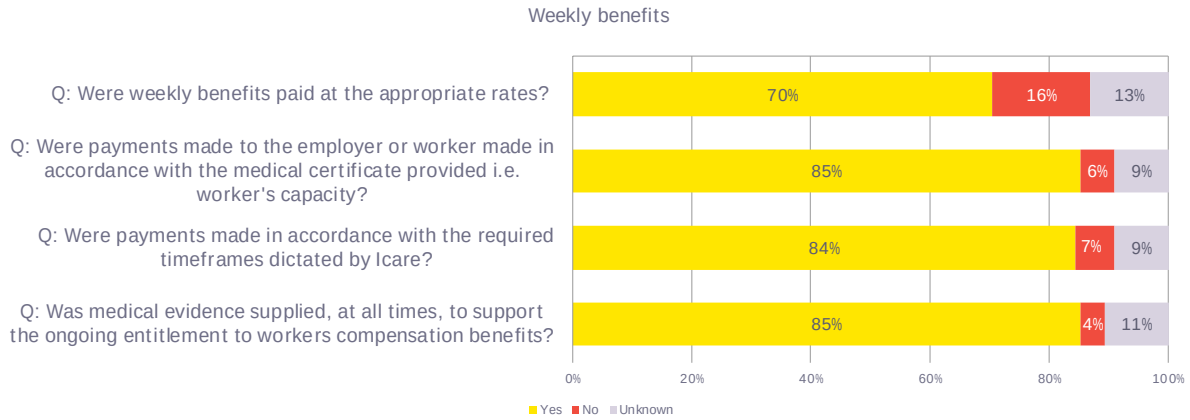


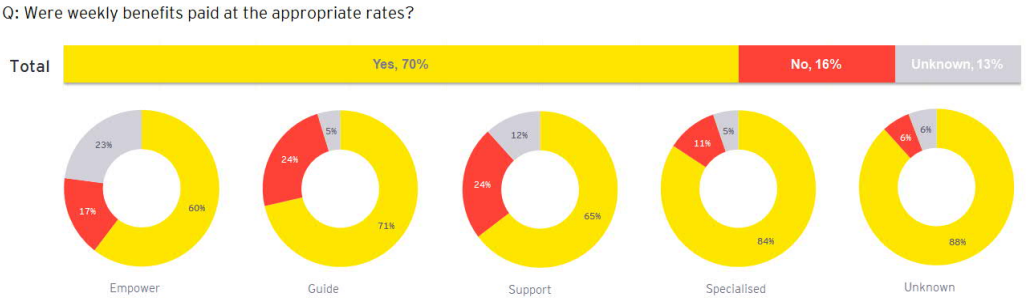
We note the following:

- Generally, there appeared to be evidence of proactive activity to gather info to calculate PIAWE within 7 days, with 10% not demonstrating this evidence
- There appeared to be sufficient/appropriate information utilised to determine PIAWE in 80% of cases reviewed, however for almost 15 % of claims, this was not the case. For this 15%, either an interim PIAWE amount was still being utilised or PIAWE amounts had not been corroborated with the employer

Figure I.14 shows the results of questions raised in relation to weekly benefits.

Figure I.14: Weekly benefits





In general, the reviewers concluded that the majority of claims reviewed were managed appropriately with respect to:

- Making payments to the employer or worker in accordance with the medical certificate provided i.e. worker's capacity
- Making payments in accordance with the required timeframes dictated by icare
- Acquiring medical evidence, at all times, to support the ongoing entitlement to workers compensation benefits

However, in only 70% of cases were the reviewers able to determine that weekly benefits were paid at the appropriate rate.

In 16% of cases the review revealed problems with the calculation of weekly benefits. The general themes from these cases included:

- The actual weekly payments being reimbursed to the employer were not consistent with the PIAWE calculation on file
- There were no reimbursement schedules on file from the employer
- PIAWE calculation errors, for example, a lack of PIAWE indexation or not adjusting PIAWE at 52 weeks

IT systems

While not in scope, the file reviewers noted the following key points with respect to EML's IT systems:

- The EMICS system utilised by EML was inconsistently populated in terms of filing of case notes and claims documentation
- The reviewers experienced difficulty in locating some information on the claim in EMICS, as this information appeared to be stored in several different places within the EMICS system
- The inability to quickly locate pertinent information on a file was a concern, and was considered a particular risk for claims triaged into "Guide" or "Empower" where there is no individual case manager assigned
- Difficulty in locating the correct information could lead to poor decision making on a claim and a focus on only managing the current issue, rather than a more proactive approach to managing the whole claim in context.

Case management expertise

While not in scope, the file reviewers noted the following key points with respect to the case management expertise observed during the file review:

- Discussions with icare management and a review of the documentation provided indicated that there was a recruiting emphasis on customer service skills
    - Whilst acknowledging the merits of having effective communication skills, the reviewers believe they are of relatively less importance compared to having a proper understanding of the relevant legislation, issues of causation, medical management and rehabilitation procedures
    - icare informed us that customer service skills were required for some roles; however, other roles had a focus on case management
    - During the transition of EML to the primary scheme agent, icare recognised that EML struggled to recruit sufficient experienced case management personnel, and this has had an adverse impact on the claims outcomes achieved. Additional training is now in place
- There appear to be a number of areas of inadequacy in the service provided by case managers to all key stakeholders, including a lack of continuity in claims service. This seemingly has led to a deterioration in technical case management standards

  This is best exemplified in the Empower and Guide segments where there were multiple numbers of case managers becoming involved in claims. A number of claims were observed to be managed by six or seven case managers within the life of a claim, which has led to frustration amongst claimants, employers, medical practitioners and other parties engaged in the claims process

- Inadequate capacity and high staff turnover are also factors causing issues with effective case management, in addition to the segmentation system (the Guide and Empower claims categories are managed by a team approach as opposed to individual claims managers)

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