August 2022

Treatment and care decisions

Insurer claims and conduct assurance program

State Insurance
Regulatory Authority

NSW GOVERNMENT

Contents

1. Introduction

The *Motor Accidents Injuries Act* 2017 (the Act) establishes the NSW Compulsory Third Party (CTP) insurance scheme. The Act sets out the entitlement to reasonable and necessary treatment and care for persons injured as a result of a motor accident in NSW.

The State Insurance Regulatory Authority (SIRA) is the independent regulator of statutory schemes in NSW, including CTP. In line with Division 9.1 of the Act, SIRA has issued licenses to six insurers who operate within the scheme. These licenced insurers are required to adhere to the obligations placed on them under the Act, Motor Accident Guidelines (MAGs) and the conditions of their licence. SIRA has a statutory function to monitor the compliance of the licensed insurers and authority to publish information about their level of compliance with requirements and duties imposed.

In accordance with its statutory functions and pursuant to Section 10.24 of the Act, SIRA undertook supervisory activity to ensure that licensed insurers were meeting their obligations as it relates to treatment and care decisions and related internal reviews. The activity was conducted in two phases:

1. Desktop review
2. Claims file review

This report outlines the findings of the supervisory activity on the information provided by insurers and access to their claims management platform.

SIRA notes and appreciates the licensed insurer's engagement and transparency throughout this supervision activity.

2. Treatment and care

The Act sets out the entitlement to reasonable and necessary treatment and care for persons injured as a result of a motor accident in NSW. Insurers have obligations to ensure injured persons receive treatment and care in line with their statutory entitlements. These obligations ensure fairness, timeliness and transparency in treatment and care decision making and payments.

Information received by SIRA in relation to treatment and care indicates:

- As at 28 February 2022, the most common issue resulting in complaints is timeliness and decisions, with the most common subject being treatment and care. This makes up 25% of complaints received by the Independent Review Office (IRO).
- Treatment and care obligation self-assessment results reported by insurers are below SIRA's compliance expectations.
- Treatment and care related remediation plans are the most common type required by insurers.

The Insurer Claims and Conduct Assurance Program (ICCAP) for treatment and care was commenced in response to the above data points, SIRA's functions and it's SIRA2025 strategy to improve the outcomes and experience for injured persons within the scheme.

3. Desktop review

A desktop review was conducted to ensure insurers had a systematic approach to ensuring compliance with their treatment and care decision obligations. Insurers were requested to provide information demonstrating how they implement systematic compliance with the Act and MAGs in relation to treatment and care decisions and related internal reviews. This included the provision of:

- Policies, procedures and processes
- Training and support provided to staff
- Compliance measures and assurance activities
- A copy of any decision notice templates

Key themes from the desktop review included:

- Procedures and training materials did not include information relating to all requirements established by the MAGs, with no information provided as to how the insurer operationalised requirements.
- Compliance measures presented seemed insufficient to ensure compliance with licence condition 10 which states:

  "(Compliance with laws) The Licensee must establish and maintain compliance measures to ensure that it complies at all times with its obligations under the Act and the regulations and guidelines made under it."
- Templates provided did not include the information required in line with the MAGs.

As a result of the desktop review, all insurers were directed to undertake activity to strengthen the systems in place to ensure compliance with their treatment and care obligations. SIRA was able to evidence some key changes insurers had made to their systems as part of the claims file review.

4. Claims file review

4.1. Scope

Insurers	Allianz Australia Insurance Limited trading as Allianz (Allianz) AAI Limited trading as AAMI (Suncorp) AAI Limited trading as GIO (Suncorp) Insurance Australia Limited trading as NRMA Insurance (NRMA) QBE Insurance (Australia) Limited trading as QBE (QBE) Youi Pty Ltd (Youi)
File review date	File reviews were conducted in July 2022.
Scope	The claims file review assessed the insurer's systems to comply with 14 criteria including: • treatment and care decision and related internal review requirements as defined in the MAGs (4.6, 4.94 – 4.99, 7.9-7.13 & 7.24-7.28). • SIRA's Customer Service Conduct Principles in line with the insurer's licence condition 2.
Criteria	See appendix 1
Review period	Claim management related activities from 30 June 2021
Access to information	Insurers provided SIRA with unrestricted access to their claims records and claims representatives to assist in the completion of the review. The SIRA reviewers engaged with insurer claims representatives throughout the review to highlight potential non-compliances and gather further information in order to assess and determine compliance.

4.2. Results

The insurers demonstrated an overall average file review result of 76%. The review criteria could be separated into three main components. Treatment and care, internal review and Customer Service Conduct Principles. As a collective, the insurers scored 68%, 91% and 85% respectively in these areas.

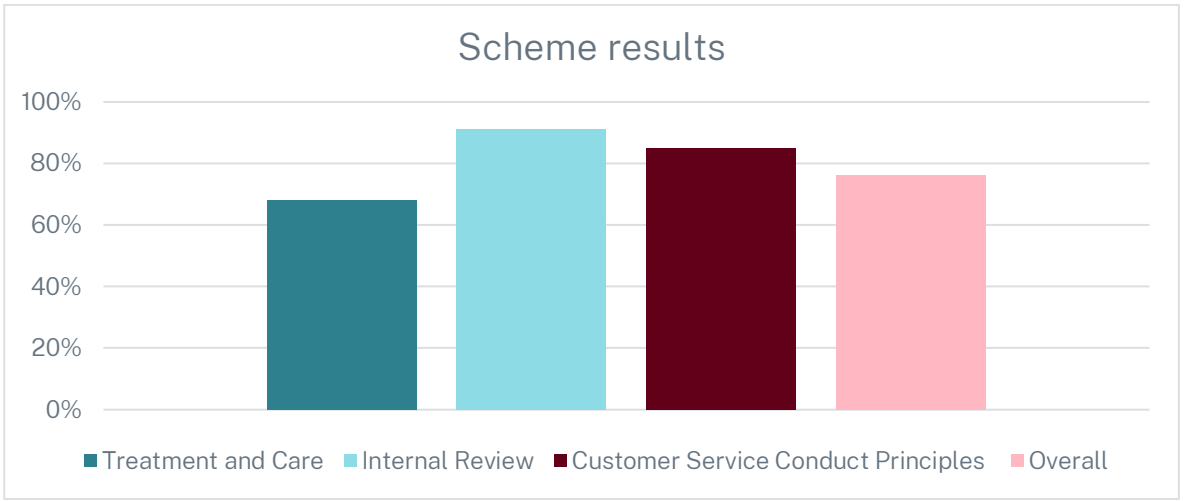

Chart 1: Scheme results of the file review

At an insurer level, Suncorp received the highest overall score of 86%. Suncorp also scored the highest result in relation to treatment and care (81%) and internal review (96%). Allianz scored the highest score (100%) in relation to the Customer Service Conduct Principles.

Youi had the lowest score overall. As a new entrant to the scheme Youi has been operationalising claims management in the scheme for 18 months, compared to the other insurers who have been operating in the current scheme since 2017. Youi continues to have a relatively small cohort of claims, noting that the internal review cohort for Youi was small (n=13) compared to other insurers (av. n=79).

It should further be noted that both QBE and NRMA have current remediation plans in place for treatment and care obligations.

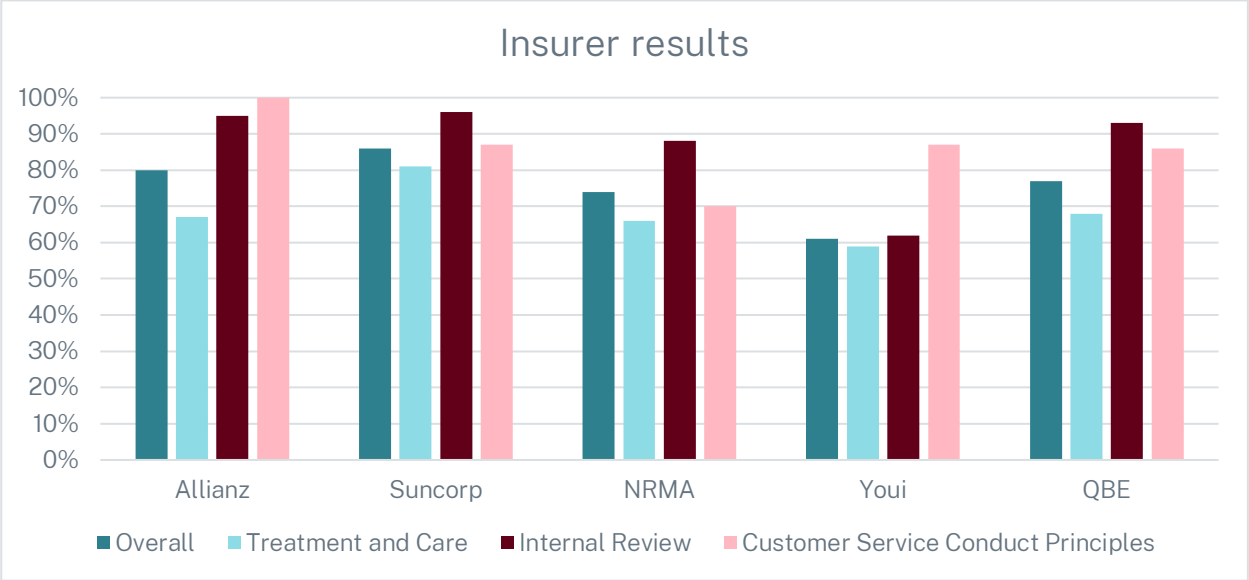

Chart 2: Individual insurer results

In relation to individual obligations, insurers demonstrated poorer levels of compliance in relation to:

- Criteria 3: Communicating a treatment and care decision to the claimant and service provider within 10 days (MAGs requirement 4.98a)
- Criteria 4: Ensuring that the treatment and care decision communication included all the information required (criteria 4: MAGs requirement 4.98 (a) & (b))
- Criteria 2: Referring the injured person to treatment, rehabilitation or attendant care service within 10 days of identifying the requirement (criteria 2: MAGs requirement 4.95).
- Criteria 13: Notification requirements in relation to the result of the internal review (MAGS requirement 7.28).

The review found minimal applicability (n=1) in relation to:

- Criteria 6: Requirement to copy the nominated treating doctor into all correspondence if requested by the claimant or NTD (MAGs requirement 4.99).
- Criteria 10: Notice requirements if the insurer does not accept an internal review (MAGs requirement 7.13). This was due to insurers in all other instances accepting jurisdiction to accept the internal review.

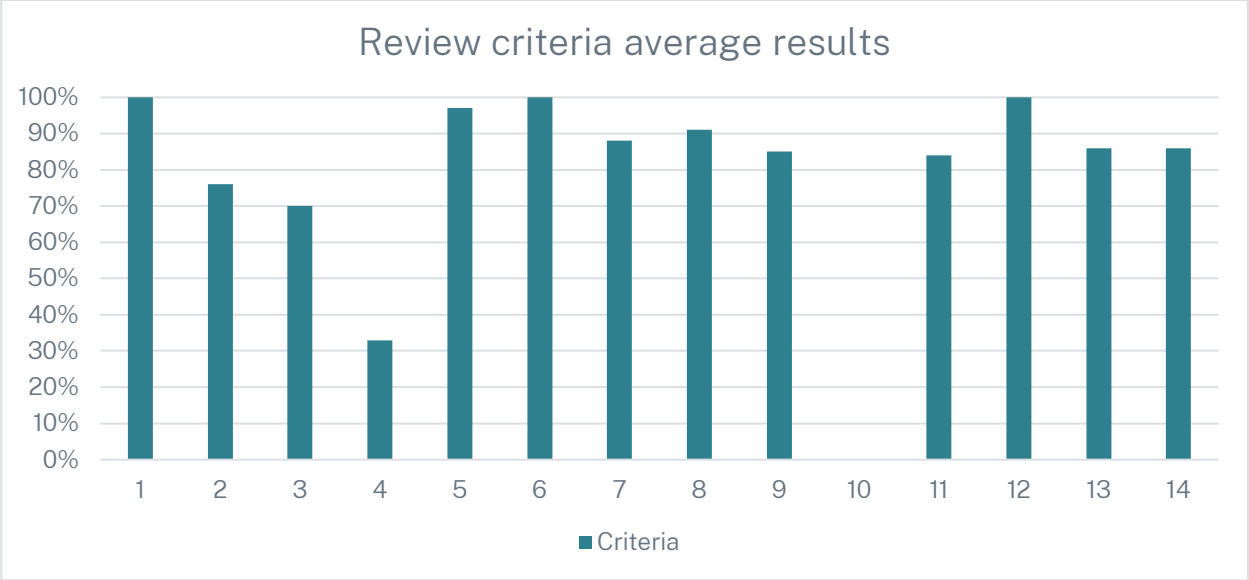

Chart 3: Individual criteria average results – refer to Appendix 1 for individual criteria detail.

4.3. Observations

- Insurers had varying compliance measures in place that had differing levels of effectiveness in achieving licence condition 10:

  "(Compliance with laws) The Licensee must establish and maintain compliance measures to ensure that it complies at all times with its obligations under the Act and the regulations and guidelines made under it."
- Records management requires improvement at varying degrees from all insurers, including how documents are labelled and stored. At times, documentation was missing from claim files and was later uploaded by the insurer during the file review.
- Whilst insurers had letter, email and notice templates available, these were operationalised to varying degrees leading to lower levels of compliance.
- Treatment approval notices sent to injured people often saw insurers referring to "AMA rates" rather than the actual cost for the treatment. SIRA has encouraged insurers to state specific costs to aid transparency for the injured person.

5. Regulatory response

All insurers were provided with an individual report from the ICCAP activity outlining their results, details of non-conformances and required actions.

Based on the findings of the treatment and care ICCAP, the following actions will be undertaken:

Action 1

All insurers to develop and implement a remediation plan to ensure systematic compliance is embedded across all areas where substantial compliance was not demonstrated. The development of the remediation plan and associated reporting requirements must be conducted in line with SIRA's remediation plan expectations.

Action 2

SIRA will monitor the implementation of the remediation plans on a monthly basis. Remediation plan requirements will be monitored until SIRA is satisfied that substantial compliance is being achieved.

Action 3

SIRA will conduct a further file review in January 2023 to ensure systematic compliance is embedded in each of the insurer's operations. SIRA will consider further regulatory action should substantial compliance not be demonstrated to the requirements at this time.

Action 4

SIRA will consider further regulatory action in relation to specific insurers who have demonstrated ongoing non-compliance to treatment and care obligations.

Appendix 1

Criterion number	Clause reference	Clause description
1	Motor Accident Injuries Act 2017 s6.3(3) Motor Accident Guidelines: 4.73	The insurer has acted in good faith and provided the claimant with information about statutory benefits in relation to entitlements that can be paid under 4.73 - The insurer may approve access to treatment before a claim is made but after notification of injury has been given. This may also apply where a notice of claim has not included all required information and documents and the insurer is waiting for further information from the claimant.
2	Motor Accident Guidelines: Treatment and care decisions - 4.95	An insurer who has identified a claimant requiring treatment, rehabilitation and attendant care services must facilitate referral to an appropriate treatment provider (including vocational provider, if appropriate) within 10 days, with the claimant's agreement.
3	Motor Accident Guidelines Treatment and care decisions - 4.98 (a)	Where the insurer receives the claimant's request for treatment, rehabilitation, vocational support and attendant care services, it must advise the claimant and service provider in writing of its decision as soon as possible but within 10 days of receipt of the request
4	Motor Accident Guidelines: Treatment and care decisions - 4.98 (a) & (b)	The advice issued under 4.98 meets the requirements: (a) if approved: - state the costs the insurer has agreed to meet - advise the claimant of the insurer's obligation to pay all reasonable and necessary costs and expenses – including travel expenses to attend approved treatment, rehabilitation services or assessments, including all services or assessments conducted by a medical assessor of the Personal Injury Commission – as soon as possible (no later than 20 days after receiving the account or request for reimbursement). (b) if declined, in whole or in part, provide: - the reasons for the decision with reference to the information relied upon in making the decision. - a list of all information relevant to the decision, regardless of whether the information supports the decision, including copies of all listed information - an explanation of the insurer's internal review process, including the timeframe in which an application for internal review must be made and/or right to make an application to the Personal Injury Commission - information on how a claimant may make a complaint with the Independent Review Office (IRO), including the IRO's contact details.
5	Motor Accident Guidelines: Treatment and care decisions - 4.98 (a)	The insurer must pay the account as soon as possible but within 20 days of receipt of an invoice or expense.
6	Motor Accident Guidelines: Treatment and care decisions - 4.99	If requested by the claimant or the claimant's nominated treating doctor subject to the claimant's authority, the insurer must copy the nominated treating doctor into all written correspondence concerning the claimant's treatment and care. The claimant can revoke the authority at any time by notifying the insurer.
7	Motor Accident Guidelines: Internal Review - 7.9 & 7.10	The insurer must acknowledge receipt of the application for internal review by notifying the claimant within 2 business days of receiving the application. The notification must be in writing and must be delivered either by post, email, online electronic delivery, or a combination of these methods, depending on the claimant's preference.
8	Motor Accident Guidelines: Internal Review - 7.11	The notification from the insurer must advise the claimant whether the insurer accepts that it can conduct an internal review of the decision, or alternatively whether the insurer does not accept it can conduct an internal review. The notification must include the date that the application was received and the date the internal review decision is due to be issued.

9	Motor Accident Guidelines: Internal Review - 7.12	If the insurer accepts that it can conduct an internal review of the decision, the insurer must advise the claimant as soon as practicable, and in any event within seven days of receiving the application, of: (a) issues under review – the elements of the original decision that the insurer understands are under review (b) internal reviewer – the person allocated as the internal reviewer to conduct the internal review (c) additional information – any additional relevant documents or information required from the claimant for the internal review, and any additional information or documentation that the insurer has that is relevant to the internal review and has not previously been provided to the claimant (d) how to make contact – how the claimant can contact the insurer about the internal review, and how the claimant can contact the advisory service about the internal review.
10	Motor Accident Guidelines: Internal Review - 7.13	If the insurer does not accept it can conduct an internal review, the insurer must notify the claimant in writing as soon as practicable and in any event within seven days of receiving the application, of: (a) reasons for decision – brief reasons for the decision to decline to conduct the review (b) the internal reviewer – the person who decided to decline to conduct the review (c) how to make contact – how the claimant can contact the insurer about the decision to decline to conduct the review, and how the claimant can contact the advisory service about the decision (d) next steps for the claimant – the options available to the claimant if they disagree with the decision, including that they can seek legal advice as to the options available (e) that the claimant may apply to the Personal Injury Commission to dispute a reviewable decision of the insurer because the insurer has declined to conduct an internal review.
11	Motor Accident Guidelines: Internal Review - 7.24. Refer to 7.25 for reasons outside the 14 days. Motor accident guidelines: Internal Review 7.26	The insurer must notify the claimant of the results of the internal review within 14 days as required by section 7.9(4) of the Act, unless the Guidelines provide for particular circumstances in which an insurer has a longer period. In any case, the maximum period including any longer periods above, must be no more than 28 days after the claimant's request for the insurer to complete and give notice of the result of the internal review.
12	Motor Accident Guidelines: Internal Review - 7.27	If the internal review decision results in the claimant being entitled to payment of benefits, the insurer must make that payment as soon as possible but in any event within 14 days after the internal review decision.
13	Motor Accident Guidelines: Internal Review - 7.28	In notifying the claimant of the result of the internal review, the insurer must provide the claimant with: (a) the internal reviewer's certificate including brief reasons for the decision and supporting documents (b) details of how and when the insurer will give effect to the internal reviewer's decision (c) details of the result of the internal reviewer's decision on the claimant's entitlement to statutory benefits (d) the claimant's right to seek independent legal advice (e) information on how a claimant may apply to the Personal Injury Commission to dispute the insurer's decision, including the Commission's contact details (f) information on how a claimant may make a complaint with the Independent Review Office (IRO), including the IRO's contact details.
14	Licence condition 2	In the management of the claim, did the insurer conduct itself in line with the Customer Service Conduct Principles?

Disclaimer

This publication may contain information that relates to the regulation of workers compensation insurance, motor accident compulsory third party (CTP) insurance and home building compensation in NSW. This publication does not represent a comprehensive statement of the law as it applies to particular problems or to individuals, or as a substitute for legal advice.

SIRA, Level 14-15, 231 Elizabeth Street, Sydney NSW 2000

Website www.sira.nsw.gov.au