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About the Independent Review Office

The Office of the Independent Review Officer (IRO) is an independent statutory office and public service agency established under the *Personal Injury Commission Act 2020* (PIC Act) and *Government Sector Employment Act 2013*. The IRO commenced operation in its current form on 1 March 2021.

The statutory functions of the Independent Review Officer are set out in clause 6 of Schedule 5 to the PIC Act, and include, as relevant:

- dealing with complaints made to the Independent Review Officer under Schedule 5,
- inquiring into and reporting to the Minister for Customer Service and Digital Government on any matters arising in connection with the operation of the PIC Act or the enabling legislation as the Independent Review Officer considers appropriate or as may be referred by the Minister, and
- to encourage the establishment by insurers and employers of complaint resolution processes for complaints arising under the enabling legislation.

The IRO welcomes the opportunity to provide a submission to the NSW Parliament Legislative Council Standing Committee on Law and Justice (Standing Committee) biennial review into the NSW Compulsory Third Party Insurance scheme.

Overview of submission

Section 1.3(2) of the *Motor Accident Injuries Act 2017* (MAIA) provides that the objects of the Act include:

> (a) to encourage early and appropriate treatment and care to achieve optimum recovery of persons from injuries sustained in motor accidents and to maximise their return to work or other activities,
>
> (b) to provide early and ongoing financial support for persons injured in motor accidents,
>
> ...
>
> (g) to encourage the early resolution of motor accident claims and the quick, cost effective and just resolution of disputes.

This submission reflects the IRO's observations on, and experiences with, complaints and enquiries received from claimants in the compulsory third party (CTP) scheme, offered with the system objectives in mind. It includes both data and case studies to illustrate concerns which have emerged about the operation of the scheme, in view of its stated objectives.

The IRO has only been dealing with CTP complaints for approximately 18 months. Our knowledge of the key issues impacting on injured persons that cannot be solved with insurers is still developing.

This submission builds on our submission in 2021 to the *Statutory Review of the Motor Accident Injuries Act 2017* – see Attachment A. We have generally not repeated here matters raised in that submission. We note that a number of our suggestions were adopted in the final report's recommendations[1].

The IRO observes that some deficiencies in the way claims are managed may be traced back to gaps in the legislative and statutory instrument frameworks. This may reflect the complexity of that framework as well as that the MAIA is a relatively new instrument, which

[1] Statutory-Review-of-the-Motor-Accidents-Injuries-Act-2017-Report.pdf (nsw.gov.au); see recommendations 13, 31 and 41.

has had only a short time to evolve. However, the issues that the IRO has identified offer opportunities for improvements.

We have suggested a range of reforms and actions for consideration, with a focus on better managing disputes and complaints, improving insurer case management, and increasing fairness for, and the experience of, claimants.

We also provide to the Committee information about the Independent Legal Assistance and Review Service (ILARS), administered by the IRO, which provides persons injured at work access to legal advice and representation. Given there is an identified and unmet need for legal assistance for persons injured in motor accidents, we make comments on whether ILARS can be adapted to assist these persons.

Background

The MAIA commenced on 1 December 2017 and applies to accidents occurring on or after 1 December 2017. The *Motor Accidents Compensation Act 1999* (MACA) applies to accidents occurring prior to 1 Dec 2017. The MAIA established a new CTP Green Slip scheme with the stated purpose of better supporting people injured on NSW roads.

Whilst the MACA continues to govern the rights and entitlements of those persons injured prior to 1 December 2017, this submission will focus primarily on the operation of the MAIA. In the context of IRO's complaint handling function.

Under the new scheme established by the MAIA, injured persons, regardless of fault, are entitled to claim up to 26 weeks of defined benefits for weekly income payments, medical and treatment costs, and commercial attendant care. Some limited exceptions are contained in Division 3.5 of the MAIA (for example, where the injured driver has committed a serious driving offence).

The IRO's functions with respect to the CTP scheme consist of dealing with complaints by and enquiries from injured persons concerning claims made as a result of injuries suffered in motor vehicle accidents in NSW. In accordance clause 8(1) of Schedule 5 to the PIC Act, injured persons (claimants) can make complaints to the IRO about:

> "any act or omission (including any decision or failure to decide) of an insurer that affects the entitlements, rights or obligations of the claimant".

The IRO commenced the CTP complaints function in March 2021.[2] As with complaints received in workers compensation matters, the IRO aims to provide a fast, accessible and fair avenue to resolve problems between claimants and insurers.

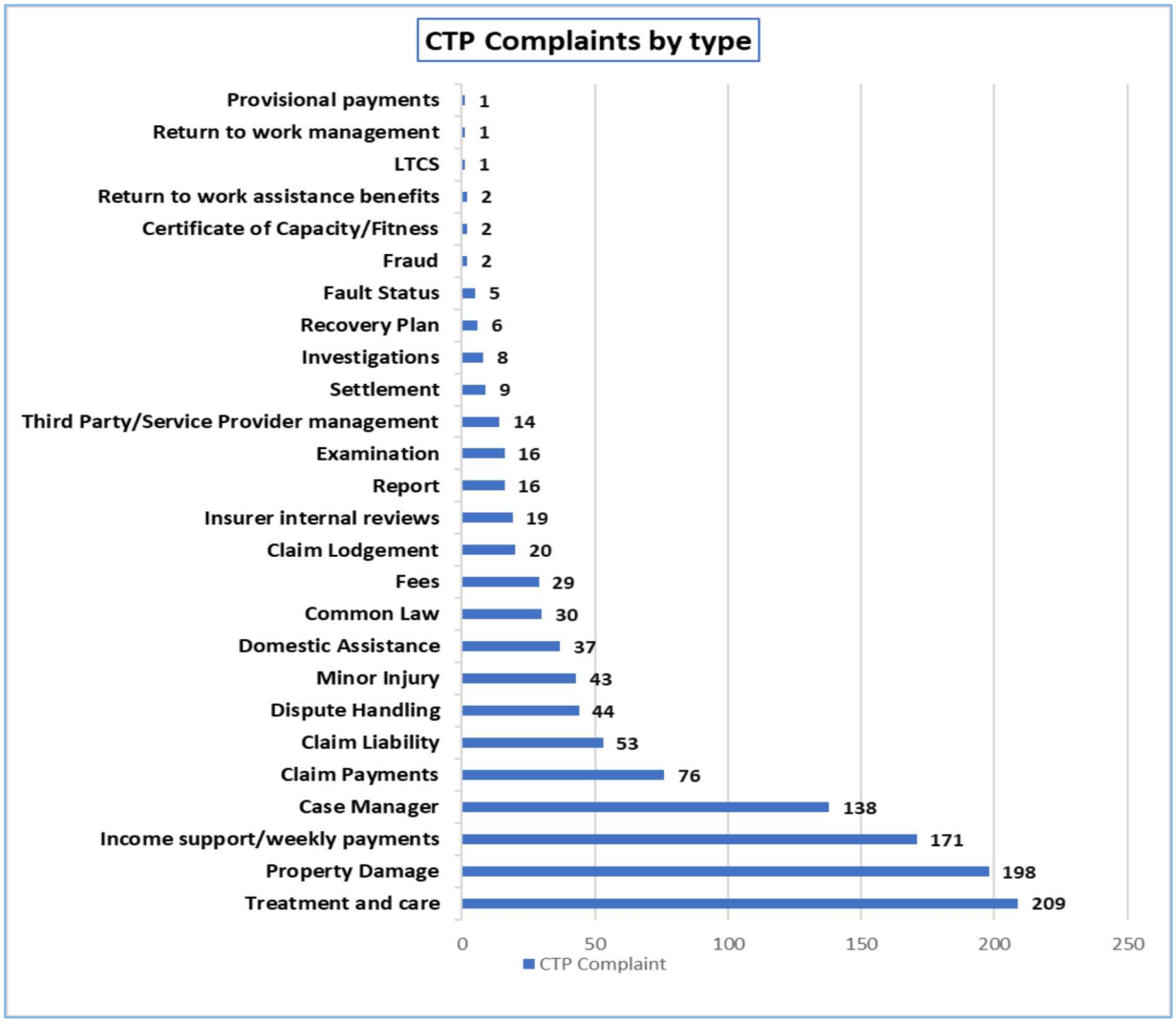
Data on complaints

The IRO carries out its complaints function through its Solutions Group, which handles complaints and enquiries from claimants. In FY2021/2022, the IRO received 923 complaints – addressing 1,150 issues - and 472 enquiries – addressing 506 issues - with respect to CTP claims.

The main issues of complaint were: treatment and care (18 per cent); property damage (17 per cent); income support/weekly payments (15 per cent); and case manager behaviour (12 per cent); see Chart 1. Complaints relating to these issues made up 62 per cent of all CTP related complaints.

[2] The function was previously undertaken by SIRA.

Chart 1



The top four categories of enquiries, comprising 80 percent of the total, were: how to make a claim (31 per cent); query about CTP benefits (21 per cent); general case management (16 per cent); and denial of liability (12 per cent); see Chart 2.

Chart 2

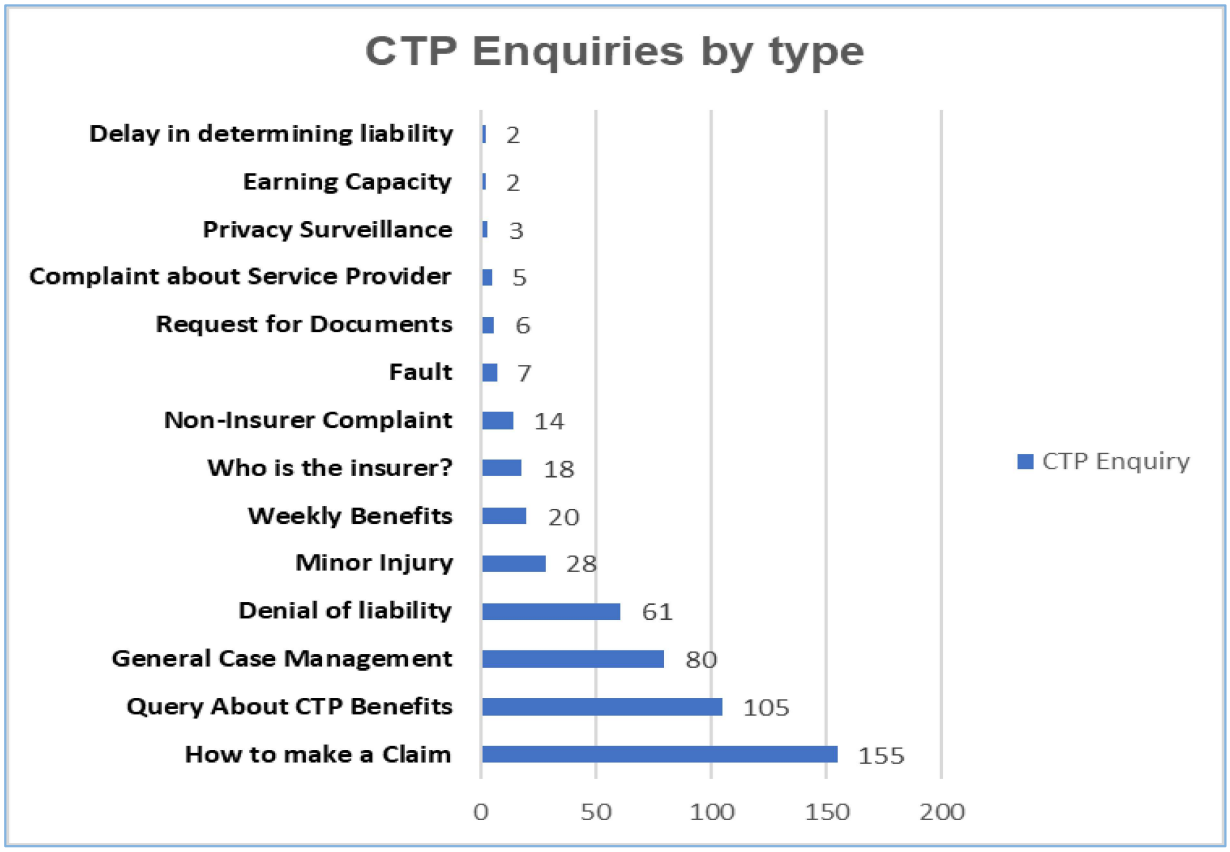
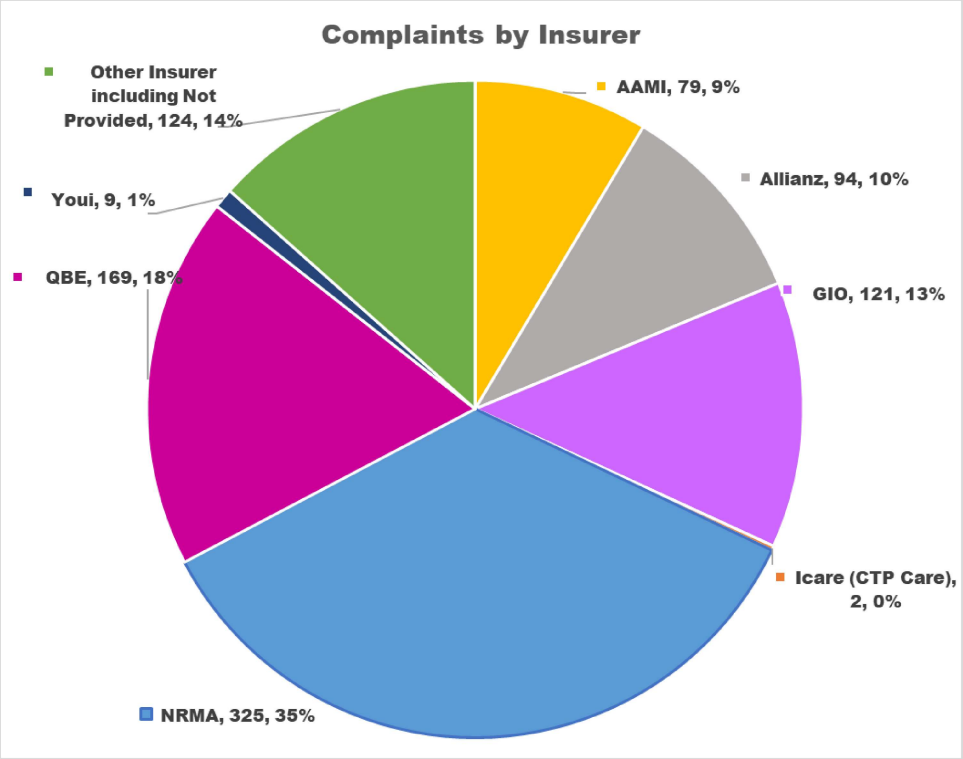


Chart 3 sets out the number of complaints the IRO received about individual insurers in FY2021/2022. The proportion of complaints does not necessarily align with an insurer's share of reportable claims. For example, of the total CTP complaints we received where the identity of the insurer was known, 35 per cent related to claims managed by NRMA. However, data available from the SIRA website shows that NRMA held only a 29 per cent share of reportable claims. Conversely, GIO held 26.5 per cent of reportable claims, but accounted for only 13 per cent of the complaints received by the IRO.

Chart 3



Complaints we received in FY2021/2022 were resolved as set out in Chart 4 below, which shows that the largest proportion of complaints were resolved on the basis that the insurer took some action in response to the complaint. Other common complaint outcomes include the insurer offering a benefit to the claimant or providing additional information about the complaint and their actions.

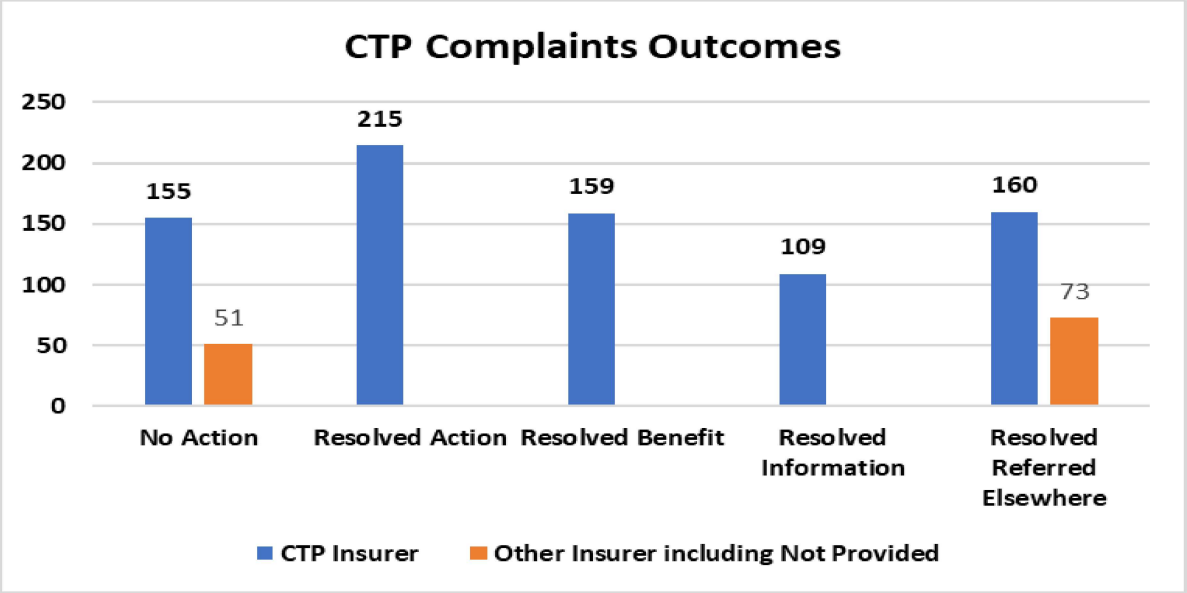
'Resolved action' refers to the insurer taking some type of action as a result of the IRO Notice of Claim (NOC) such as issuing a liability decision, changing case manager or referring for rehabilitation.

'Resolved benefit' refers to the claimant receiving a benefit as a result of the complaint, such as weekly benefits, reimbursements, acceptance of a claim or approval of surgery or treatment.

'Resolved information' refers to the insurer providing further information or explanation about a decision or action as a result of the NOC, that can be independently reviewed by the IRO.

In some matters – where for example the claimant had not provided the insurer a first opportunity to solve the complaint before making contact with the IRO – we took no action on the complaint but provided information to the claimant about how to complain to the insurer, and recommended they return to the IRO if their complaint was not solved. Where the complaint concerned a matter outside our role (for example, property damage complaints), we provided comprehensive referral information.

Chart 4



Delay in approving treatment and care

A person injured in a motor vehicle accident is, with some exceptions, entitled to payment of statutory benefits for treatment and care pursuant to sections 3.1 and 3.24 of the MAIA. For claimants whose injury is deemed to be a 'minor injury' (as defined in s.1.6), or where they were wholly or mostly at fault, this entitlement ceases after 26 weeks from the date of the accident.[3]

Insurers are required to determine liability for claims for statutory benefits within four weeks of a claim being made.[4] More specifically, in claims for items of treatment and care, an insurer is required to determine liability and inform the claimant of its decision within 10 days of receiving a request.[5]

A claimant can request an internal review of an adverse decision; generally, the insurer must complete the review and notify the claimant of the decision within 14 days (section 7.9 MAIA; clause 7.24 Motor Accident Guidelines (MAG)).

In some complaints received by IRO, insurers may dispute entitlements to treatment and care where there appears to be little basis to do so. This can delay claimants' access to diagnosis and treatment and can delay recovery.

Case study 1

The IRO received a complaint on behalf of the claimant in March 2022 concerning a 3-year delay in the insurer's determination of liability for their dental injuries. The claimant stated that the insurer was waiting on requested information from her treating doctor which should have already been provided to the insurer.

Following IRO enquiries, the insurer stated it had approved an initial consultation with a dentist, but the claimant had not received the approval. The insurer was willing to review the decision once requested information had been provided. The claimant made their own enquires with their GP and discovered the doctor was waiting to

[3] Section 3.28, MAIA.
[4] Section 6.19, MAIA.
[5] Part 4.98, MAG.

receive payment from the insurer before sending the medical reports. The insurer paid the GP upon further enquiry by IRO.

The claimant again contacted IRO after the insurer again denied their dental treatment, and stated the insurer was requesting now their dental records from before the accident. The claimant stated that they had tried to get the records which could not be found. The claimant complained that their case manager was 'nasty' when informed that the information could not be recovered and they lacked empathy. The claimant stated, 'I just want to be able to eat properly and not get reflux every time I eat'.

The IRO contacted the insurer in relation to the complaint and the insurer undertook an internal review. The internal review overturned the original decision and the claimant's dental treatment plan was approved. The claimant was very happy and thanked the IRO for its assistance.

The matter was raised as a significant matter to SIRA.[6]

The IRO has also dealt with matters where a claimant is originally diagnosed with a minor injury, but – whether on the advice of their treating medical practitioner or otherwise - requests investigations or referral to specialists which may result in the injury being classified as non-minor. The insurer may deny liability for the investigation or treatment on the basis the current 'minor injury' diagnosis and that the proposed investigation or treatment is not consistent with that diagnosis.

In this respect, it can be seen that a potential outcome of the existing regulatory framework is that insurers make determinations that injuries are minor, and as a consequence claimants may be denied access to treatment and care that may demonstrate that the injury is, in fact, non-minor.

Case study 2

The claimant contacted the IRO in April 2022 to advise that their insurer had declined to pay for an MRI scan and pain specialist referrals.

The claimant was originally diagnosed with a whiplash injury but had been experiencing pain in their neck, lower back and left leg. Their doctor had referred them for an MRI scan and to a pain specialist. The insurer declined the referrals on the grounds that SIRA's whiplash guidelines state that an MRI scan is not appropriate for cases of whiplash that are not severe.

The claimant complained that the timeframes for internal review were excessive given the pain they were suffering. The claimant disclosed that 'severe back and leg pain' had affected their sleep and has 'significantly impacted' on their performance at work.

The IRO confirmed that the claimant would need to request an internal review of the insurer's decision and confirmed the timeframes for the insurer to complete the review. The IRO advised the claimant that if no response was received, to again contact the IRO, and we would take up a complaint with the insurer. The

[6] Under a Memorandum of Understanding authorised by the PIC Act, IRO notifies SIRA of any significant matters that it becomes aware of subject to the relevant legal requirements regarding secrecy, privacy, confidentiality and privilege. Significant matters are relevantly those arising in the course of IRO's complaint-handling where the matter may concerns a risk of substantial physical, mental health or financial harm to an injured person, a serious contravention by a CTP insurer of the motor accidents legislation, a serious breach of the SIRA Customer Service Conduct Principles or Guidelines, or fraudulent conduct by any party in connection with a CTP claim; see Memorandum of Understanding between IRO and SIRA | IRO (nsw.gov.au)

IRO also provided information about appeal avenues open to the claimant if the insurer upheld the original decision.

The process to challenge a decision to deny liability for treatment or care can be protracted, and in some cases take longer than 26 weeks to finalise:

1. The claimant must first request an internal review of the decision by the insurer.[7] The claimant is not permitted to lodge an application for merit review with the Personal Injury Commission (PIC) until the dispute has been the subject of an internal review.[8]
2. If unsuccessful on internal review, the claimant may lodge the dispute with the PIC, seeking merit review, or medical assessment as appropriate.

Only after these processes have been completed, and if successful, can the claimant access the treatment or care recommended. These processes may take some months. For claimants with minor injuries, this may mean they miss out on some treatment altogether or miss out on further treatment and care within the 26-week time limit which would have been recommended if the claimant had undergone investigation or attended a medical specialist at an earlier date.

This is to some extent ameliorated by existing provisions in clause 5.16 of the MAG, which provide for payment of treatment and care expenses for minor injuries beyond the 26-week time limit where:

- the treatment and care will improve the recovery of the claimant
- the insurer delayed approval for the treatment and care expenses, or
- the treatment and care will improve the claimant's capacity to return to work and/or usual activities.

There is value in considering whether delays as a result of resolving a treatment and care dispute should also be included as another ground for extension beyond 26 weeks for treatment and care of minor injuries.

Weekly payments and failure to advise of entitlements

As with treatment and care, claimants have an entitlement to weekly payments if they have suffered a total or partial loss of earnings as a result of a motor accident.[9] Weekly payments are to commence within 10 working days of a decision to accept liability.[10] The basis for calculating an entitlement to weekly payments is a claimant's pre-injury average weekly earnings, or PAWE.

The complexity of calculating PAWE varies depending on a number of factors, including the claimant's number and type of income sources and the ease with which an insurer can obtain adequate information from an employer. Sometimes, an insurer is unable to determine PAWE prior to the time it is required to commence payments.

The MAG have no set timeframe within which an insurer is to complete its calculation of PAWE. The only timeframe provided in the MAG relates to processing weekly benefits after liability is accepted, which can be minimum, interim and or complete PAWE.

Section 3.6(5) of MAIA provides that where further information is required by the insurer to calculate the PAWE, it is to make interim payments in accordance with the MAG until the correct rate can be determined. However, as long as an insurer makes interim payments at

[7] Section 7.9, MAIA.
[8] Sections 7.11, 7.19 MAIA.
[9] Sections 3.6, 3.7 and 3.8, MAIA.
[10] Part 4.43, MAG.

the minimum rate, there is no specified timeframe for how long it may take to finally determine the PAWE. The minimum rate is 12.5 per cent of the maximum weekly statutory benefits rate, currently $550.38 (12.5 per cent of $4,403).[11] Payments at this rate may leave a claimant with a significantly reduced income for extended periods of time.

In addition, insurers will sometimes engage forensic accountants to assess PAWE in circumstances where the claimant's income from employment is not straightforward (e.g., where the claimant is self-employed or has more than one employer). The result can be significant delays and the provision of adequate income support to the claimant.

The IRO has dealt with a number of complaints where PAWE decisions have been substantially delayed. Including a timeframe for determination of PAWE, and a consequence if that timeline is not met, may offer greater certainty (and potentially financial support) for injured people and create an incentive for swifter determinations by insurers. In addition, including the failure to make a PAWE decision within a specified timeframe as a 'merit review matter' as defined by Schedule 2 to the MAIA will ensure claimants have access to review options where an insurer is delayed in making a decision.

Case Study 3

The claimant contacted IRO in April 2022 complaining that they had not received any weekly benefits since lodging their claim in January. The claimant advised this had caused financial stress and they were considering returning to work against medical advice.

Following IRO enquiries, the insurer conceded that interim payments should have been paid to the claimant upon the receipt of relevant information in early March, but they were not paid due to oversight by the case manager. The insurer had referred the calculation of PAWE to an integrated solutions provider (ISP) due to the claimant being self-employed and paid in cash. The ISP's report was received by the insurer in late April. The day following IRO seeking information in response to the complaint, the insurer sent a PAWE determination to the claimant, made payments to cover the January to April period and stated that they would continue fortnightly payments.

The IRO contacted the claimant who confirmed the insurer had been in touch and that they had received the payments. They thanked the IRO and expressed frustration at how long it took to receive the payments.

The matter was referred to SIRA as a significant matter.

Case Study 4

The IRO received a complaint on behalf of the claimant in December 2021 concerning a delay in the insurer calculating PAWE. The claimant's representative had provided relevant financial information to the insurer in October.

Following IRO enquires the insurer stated that the delay was due to a breakdown in communication between the insurer and an accounting firm the insurer had engaged to calculate the claimant's PAWE. The accounting firm was instructed to obtain any further information they needed directly from the claimant or their representative. It was not until IRO made enquiries that the case manager had realised the outstanding records needed to calculate PAWE had not been requested from the claimant.

[11] Part 4.45, MAG.

The outstanding documents were provided to the accounting firm and the PAWE calculation was fast tracked. The IRO monitored the matter to confirm that the PAWE determination had been received by the claimant's representative, which occurred several days later.

The matter was raised as a significant matter to SIRA.

In addition to the issue of delay, the IRO has also received complaints and enquiries with respect to insurers failing to inform claimants that they are entitled to interim weekly payments.

Case study 5

The claimant contacted IRO in May 2022 complaining that they had not received any weekly payments despite lodging their claim 8 weeks prior and provided information for the PAWE calculation 3 weeks prior. The claimant disclosed they were struggling without the weekly payments.

Following IRO enquiries, the insurer conceded it had not offered interim payments to the claimant and that PAWE should have been calculated in a timely manner upon receipt of the claimant's payslips. Further delay was caused by the insurer failing to clearly communicate to the claimant that an updated certificate of fitness was required before weekly payments could be processed. The insurer calculated the PAWE and made back payments to the claimant.

The IRO contacted the claimant and confirmed that payment had been received. The claimant thanked IRO.

The IRO has also handled cases where insurers have failed to inform a claimant of a right to request an internal review of an insurer's decision to deny liability for weekly payments. As the next case study shows, claimants can be left confused and unsure of how to proceed if they disagree with a liability decision.

Case study 6

In June 2021, the claimant's complaint was referred to the IRO by CTP Assist. The claimant had been experiencing difficulty contacting their case manager and was not receiving their weekly benefits.

Following IRO enquiries, the insurer informed the claimant that they had not been classified as an 'earner' for the purposes of the MAIA and, as a result, were not entitled to statutory benefits. However, the decision emailed by the insurer failed to inform the claimant of their right to request an internal review of that decision. The insurer subsequently provided this information to the claimant after enquiries from the IRO.

The IRO provided information to the claimant about how to request an internal review. Given the deficient notice of review rights by the insurer, the IRO raised the matter as a significant matter with SIRA.

Failure to provide adequate reasons for denial of liability

The MAG[12] provide that an insurer is to advise a claimant of its decision, in writing, within 10 days of a request for treatment, rehabilitation, vocational and care services. The notification is to include the reasons for the decision, reference to information relied upon, a list of

[12] Part 4.98, MAG.

relevant information, an explanation of the review process, and the claimant's rights to make a complaint to the IRO or proceed to the PIC.

The IRO finds that insurers do not take a consistent approach to how they advise claimants of decisions to decline liability for such expenses. Sometimes insurers provide fulsome explanations, with formal notices, accompanied by telephone calls to claimants to inform them that a decision had been made and to ensure they understand the decision. However, we have seen other instances where insurers send responses that contain scant information, only nominally comply with the MAG and leave claimants unclear about the decision and their rights.

Case study 7

The claimant who was seriously injured when their bicycle was struck by a motor vehicle, contacted the IRO in May 2022 to complain about a delay in reimbursement of assisted daily living costs claimed in November 2021. The claimant was also experiencing issues with their case manager and complained that all their treatment requests were initially declined by the insurer and required internal review.

Following IRO enquiries, the insurer advised that it had reimbursed some of the assisted daily living costs submitted in November 2021. The IRO facilitated the claimant resubmitting outstanding reimbursements to the insurer.

The IRO also reviewed the decline notices for specialist consultations and treatment. The reasons for decision in each matter were very brief (generally only 2-3 lines) and lacked detail. The insurer advised that, upon internal review, three of the five decline notices were overturned. For those that were declined on internal review, the reasons were more detailed and clearer. The IRO discussed the effect of the insurer's decisions with the injured person.

To respond to the claimant's concerns about the handling of their matter, the insurer agreed to appoint a new case manager.

The claimant stated they were happy about the change in case manager, and that they felt they could now focus on their recovery. The claimant was invited to contact IRO again if they had issues in the future.

In other matters, such as the following case study, the use of template correspondence, delayed responses and lack of detailed reasons for denying liability may result in the injured person losing confidence in the insurer's decision-making and complaining to the IRO.

Case study 8

The claimant contacted the IRO three times in May and June 2022 to complain about various matters including their insurer scaling back support for assisted daily living (ADL) costs. The claimant complained that the insurer's decision letter incorrectly spelt their name, failed to take into account new evidence, contained incorrect information, lacked detail and appeared to be a template response that did not consider their individual circumstances.

Following IRO enquiries, the insurer advised that it had relied on old evidence because the new evidence had not been received at the time the decision letter was sent. The insurer subsequently reviewed the new evidence and provided a new decision letter in which it accepted some, but not all, of the ADL support requested.

The claimant was unhappy that not all of the costs would be supported. They expressed frustration at the number of 'oversights and mistakes' the insurer had made and indicated that they believed the insurer was 'acting without care.'

The claimant then made a further request of ADL support to which the insurer did not respond. The claimant again complained to the IRO. An additional response was requested by the IRO from the insurer. The insurer subsequently agreed to the claimant's request, which resolved the complaint.

Notice provisions in the CTP scheme

Where an insurer makes a decision impacting an injured person, they are generally required to provide notice of the decision. Notices that ensure injured persons understand the reasons for a decision, the information relied upon to inform the decision and the person's right of review promote transparency and the agency of an injured person – as is reflected in the overarching claims management principles of the SIRA Workers Compensation *Standards of Practice*[13]. The above cases demonstrate some of the potential adverse outcomes for claimants where notices of decisions are not adequate or timely.

We have set out in Appendix A to this submission some of the relevant notice provisions under the CTP scheme and workers compensation scheme. A comparison of those provisions points to opportunities to improve the MAIA scheme. This includes requiring decisions about liability and entitlements to, for example:

- contain a concise and readily understandable statement of the reason for the insurer's decision and of issues relevant to the decision
- identify any provision of the legislation relied upon by the insurer to deny liability.

In addition, a clear framework of consequences for non-compliance may further promote high quality decisions and notices. This may include, for example:

- ensuring where a report obtained by an insurer and not been provided to claimant it cannot be used to deny liability and is not admissible in proceedings before the PIC
- providing that a ground of dispute not notified to a claimant in accordance with the relevant notice provisions cannot be relied upon by an insurer in proceedings before the PIC, or a court
- providing consequences including offence provisions with monetary penalties where notice requirements are not met.

In this respect, the IRO observes there is an opportunity not only to improve CTP notice requirements, but also to promote harmonisation between the CTP and workers compensation schemes by ensuring, wherever appropriate, consistent and rigorous notice requirements to claimants under either scheme.

Damages claims

No damages can be awarded to a claimant unless their whole permanent impairment (WPI) is greater than 10 per cent.[14] Further, if there is a dispute about the degree of permanent impairment, damages cannot be awarded unless the impairment has been assessed by a medical assessor.[15] Despite this, there is nothing to prevent a damages claim from being settled.

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[13] Overarching claims management principles | SIRA: Workers compensation claims management guide (nsw.gov.au)
[14] Section 4.11 MAIA.
[15] Section 4.12, MAIA.

Once an insurer receives a claim for damages, it is required to give notice to the claimant of whether it accepts or denies liability for the claim - which is different to the question of whether it accepts liability for a specific amount of damages - within three months. There is a duty on the insurer to make an offer of settlement 'as soon as practicable' unless it wholly denies liability for the claim.[16] However, there is no explicit time limit for making an offer of settlement. The insurer also does not have to make an offer if a medical assessor has determined that the claimant's impairment has not yet become permanent.[17]

A claimant is required to submit themselves to a medical examination at the request of an insurer[18]; failure to comply means that the claim for damages cannot be referred for assessment by the PIC and the claimant cannot commence court proceedings.[19]

The IRO has observed that the practical effect of these provisions is that, whilst the insurer must determine the liability aspects of a damages claim within three months, there is no requirement to make an offer of settlement within any timeframe. Delays may occur in the insurer deciding the claim for damages where the claimant is required to attend multiple independent medical examinations (IMEs), which may have lengthy waiting periods.

The following case study illustrates the ways in which the failure to have strict time limits for all relevant insurer decisions on liability can result in a claim for damages stalling, impacting negatively on the claimant.

Case study 9

The IRO received a complaint on behalf of a claimant in March 2022 concerning issues with the insurer's management of the claim, and its failure to respond to a claim for damages and treatment.

Following IRO enquiries, the insurer confirmed that liability had been accepted for some treatment, but additional information was required to consider a further request. The insurer had accepted liability for the damages claim in August 2021, although it appeared that the claimant did not receive correspondence relating to this decision.

The insurer conceded that it had not made an offer of settlement in the damages claim because it did not have sufficient information about the claimant's permanent impairment. The insurer noted that the claimant had not requested that it make a concession with respect to the threshold, and it had not considered referring the issue to the PIC for determination. Similarly, the insurer did not arrange medicolegal assessments of the claimant's impairment until after it received an inquiry from the IRO.

The claimant stated that they were experiencing financial distress and were unable to meet daily expenses because they were unable to work due to their injuries and weekly payments ceasing after 156 weeks. After further enquiries by the IRO, the insurer agreed to advance the claimant an amount against their damages claim.

The IRO raised this case as a significant matter to SIRA.

Clause 4.121 of the MAG states that an insurer:

[16] Section 6.22(1), MAIA.
[17] Section 6.22(4), MAIA.
[18] Section 6.27(1), MAIA.
[19] Section 6.27(4), MAIA.

> "should concede an entitlement to non-economic loss when it is in possession of health service provider examination reports that indicate that a claimant's WPI is greater than 10%."

The IRO's observation is that insurers may maintain a dispute about this issue notwithstanding their own medical evidence assesses that the claimant has a WPI of greater than 10 per cent.

In addition, claimants whose permanent impairment is not greater than 10 per cent are not permitted to bring a claim for damages within 20 months of the date of injury. When insurers delay arranging medicolegal examinations and/or dispute the threshold, resulting in delayed decisions and proceedings, claimants may lose the right to ongoing weekly payments during the course of a damages claim.[20]

Case Study 10

> *The IRO received a complaint on behalf of a claimant in August 2022 concerning the insurer refusing to concede that the claimant's permanent impairment exceeded the 10 per cent WPI despite a jointly engaged medical assessment that did not support the insurer's decision.*
>
> *Following IRO enquiries, the insurer provided reasons for its refusal to concede the claimant's permanent impairment exceeded the 10% WPI threshold based on its own review of the available medical evidence. The insurer considered the evidence from both medical assessments and doctors' reports and x-rays taken in the months following the accident.*
>
> *Upon communication of the insurer's response to the claimant's representative they stated that 'this matter smacks of a situation where "we (the insurer) don't like the joint assessment report"'. The IRO explained discretion exists in part 4.121 of the MAG which states that an insurer 'should' concede the threshold where it has supportive evidence, not that it 'must' concede.*
>
> *Given an agreement could not be reached between the parties, IRO recommended, and the representative advised, that the matter would need to be resolved the PIC although the representative believed this course of action was not preferrable due to significant delays in the PIC and the claimant's advanced age.*
>
> *The IRO raised this case as a significant matter to SIRA.*

General case management issues

Case managers play a vital day-to-day role in assisting claimants to understand both their entitlements and what they are required to do in order to receive those entitlements.

Injured persons may complain to the IRO when a case is not well managed. As the following case study shows, failure to have consistent case management, and of case managers to provide adequate information on claims processes, can leave claimants in a position where they are unable to obtain the treatment or care they need.

Case study 11

> *The claimant contacted the IRO in April 2022 concerning issues with the case management of their claim. The claimant complained that they had experienced numerous changes in case managers, which caused confusion and disruptions in*

[20] Section 3.12, MAIA.

the progress of their claim. The claimant also complained that case managers had failed to advise them of the proper way of requesting pre-prepared meals, that they had experienced delays in receiving information from case managers, and they had received treatment that the claimant felt was rude and insensitive.

Following IRO enquiries, the insurer advised that the claimant had been assigned three different case managers over the previous six (6) months due to resignations which were beyond the control of the insurer. The insurer acknowledged that the claimant had not been advised of the proper way to request pre-prepared meals due to an oversight and noted that it was following up with the claimant's general practitioner to obtain more information. The insurer apologised for the treatment and delays the claimant had experienced due to the behaviour and changes in case managers.

Although the IRO was able to solve the complaint, the claimant stated that they felt that the case management had not been sufficient and had not aided their recovery. They expressed concern about "what would happen if someone older or more vulnerable than me were to experience this".

The IRO raised this as a significant matter to SIRA.

Case management requires both responsiveness and sensitivity to claimants who may be experiencing difficulties with the effects of their injuries.

The next brief case study demonstrates the impact on claimants when case managers do not respond appropriately to communications.

Case study 12

The claimant contacted the IRO in May 2022, to complaint that their case manager did not respond to emails or return phone calls and had laughed while on the phone which they found to be unprofessional.

Following IRO enquiries, the insurer reached out to the claimant to discuss the issues they were experiencing and how to improve future communication. The claimant requested that all future communications take place via email and for all emails to be acknowledged upon receipt. The insurer agreed to these requests.

These case studies and other matters dealt with by the IRO reinforce the importance of excellent case management. Some people injured in motor accidents will have lengthy relationships with the insurer; building a strong foundation of responsive, respectful and consistent service enables the injured person to focus on recovery.

Recommendations and conclusions arising from IRO's case work

Complaints made to the IRO demonstrate the management of some claims is impacting on the access by injured persons to the treatment and financial support to which they are entitled and require. Examples include:

- delays in accessing treatment caused by review and dispute processes
- the time taken for insurers to assess PAWE in some cases, resulting in financial hardship for injured persons
- some claimants not being aware of or informed about their entitlement to receive interim weekly payments whilst PAWE is being calculated

- some injured persons receiving inadequate information about decisions and review rights
- there is no time limit applying to an insurer's offer of settlement for a damages claim
- there is no time limit for an insurer to arrange medicolegal assessment it deems necessary to assess a damages claim.

Given these issues, the IRO considers that there may be value in considering reforms to the CTP scheme to provide greater clarity for all parties, particularly around decision times and the content of decision notices; and where these timeframes are not met for injured persons not to be disadvantaged. This is likely to promote greater efficiencies, consistency and fairness across the scheme. Examples of the types of reforms which might be considered include:

- Making an exception to the 26-week time limit on treatment and care where requested investigations are directly relevant to the decision as to whether the claimant is suffering from a non-minor injury.
- Making an exception to the 26-week time limit on treatment and care for a minor injury, where the delay in accessing treatment is a result of resolving a dispute.
- Requiring insurers to advise claimants of the circumstances where treatment and care expenses will still be paid outside the relevant time limits for treatment.
- As regards PAWE:
    - requiring insurers to commence weekly payments at the minimum statutory rate if the insurer is unable to determine the PAWE within seven days of receipt of a claim
    - requiring insurers to make an interim determination of PAWE once in receipt of reasonably sufficient information, even if the insurer intends to have that information analysed further by appropriate experts
    - specifying the failure to determine PAWE within a specified period as a merit review matter.
- Requiring insurers that deny liability for any aspect of the claim to issue a more detailed notice (similar to a section 78 notice[21] in the workers compensation scheme) setting out full reasons for the denial of liability and attaching all evidence relevant to the decision.
- Prescribing time limits for insurers to make offers of settlement in damages claims unless there is an explicit reason for not doing so.
- Permitting claimants to proceed to assessment of their claims for damages – or assessment of impairment – if an insurer fails to notify its decision on the permanent impairment threshold within a specified time.

Legal assistance for claimants in CTP matters

We understand that, as a consequence of Clause 12 of Schedule 5 to the PIC Act, the Committee is required, in this review, to enquire into and report on whether the Independent

[21] Section 78, *Workplace Injury Management and Workers Compensation Act 1998* (WIMA); see also section 79 WIMA and clause 38, Workers Compensation Regulation 2016.

Legal Assistance and Review Service (ILARS) should be extended to claimants for statutory benefits under the MAIA.

We set out below brief information about recent reviews that have touched on this matter and information about ILARS for the assistance of the Committee.

Previous reviews

The Standing Committee's 2020 Review of the Compulsory Third Party insurance scheme (2020 Review) received submissions from a number of stakeholders who argued that claimants were at a disadvantage in "navigating the scheme and seeking reviews"[7] due to the scheme's complexity and the significant power and resource imbalance between claimants and insurers. The 2020 Review also noted the challenges faced by claimants when navigating the system without legal support.[8]

In SIRA's submission to the 2020 Review and in response to questions posed by the Committee, SIRA acknowledged that it was cognisant of concerns about the impact of limited legal funding and confirmed that it would consider the issue of legal support for claimants as part of the Statutory Review.[9]

One of the recommendations made by the 2020 Review was that the Statutory Review of the MAIA being conducted by SIRA consider:

> '...the provision of legal support to claimants in the scheme, particularly in relation to disputes, including the internal review process' (p. vii 2020 Review)[10]

SIRA commissioned Taylor Fry to undertake a review of legal support for people injured in the CTP scheme in late 2020 (Taylor Fry report). The review was undertaken to consider whether the legislative and regulatory framework and provision of legal support were promoting the objectives of the MAIA, including "encouraging the early resolution of motor accident claims and the quick, cost-effective and just resolution of disputes."

The executive summary to the Taylor Fry report, published 3 September 2021,[11] reflects upon the early stage of maturity of the MAIA scheme, and heavily caveats any findings that can be drawn from its analysis. The review findings include:

- legally represented claimants have a higher overall rate of success in achieving an overturn of initially unfavourable decisions and are more likely to claim damages
- there is an unmet need for claimant support which should be addressed.

The review lays out eight (not necessarily mutually exclusive) options for reform to meet this need, including to expand the role of CTP Assist and a review of the triggers for entitlements to paid legal support, to mitigate the risk an injured person will not be able to proceed with a claim and attain their entitlements.

Two options (3A and 3B) concern ILARS – to either implement a modified ILARS scheme in CTP, or to defer consideration until the scheme review (see Statutory Review below). Earlier in the Taylor Fry report, a 'rudimentary' analysis of level of legal expense following the introduction of ILARS is provided. Unfortunately, IRO was not consulted on this analysis, which includes a range of errors. These include:

- misunderstanding ILARS outcome data
- wrongly assuming that there are a number of ILARS grants per claim
- incorrectly including IRO complaint handling costs as ILARS costs
- failing to consider the impact of workers compensation legislation reforms on the need for injured workers to be assisted through ILARS
- misdescribing the manner in which fees are set under ILARS.

Full information about these errors has been provided to SIRA, with a request that the concerns be considered in any assessment of the Taylor Fry report, and that they be provided to the Statutory Review.

In November 2021, SIRA published the *Statutory Review of the Motor Accident Injuries Act 2017*[12] (Statutory Review) – undertaken by Clayton Utz and Deloitte. At section 3.7.8, the Statutory Review addresses restrictions on access by persons injured in motor accidents to paid legal advice. The Statutory Review notes the MAIA and associated regulations are complex for someone without legal training to read and understand, and that it is essential that injured persons are permitted to access advice on their rights and assistance to advocate their claims. The Statutory Review also notes that it did not have sufficient time to consider the Taylor Fry report or to consult with stakeholders. In considering an appropriate model for access to support, the Statutory Review proposed six (6) principles that may be relevant, briefly summarised below:

- restrictions on access to legal assistance and the fees to be charged are not ends in themselves – and that the legal support model must be a means to facilitate the objectives of MAIA
- many injured persons will benefit from access to legal assistance
- legally advised claimants are more likely to achieve a good outcome in terms of access to entitlements and their experience in the scheme, so they can focus on recovery
- CTP Assist is important, but cannot replace the role of a lawyer
- legal support includes both the appropriate presentation of a claim – assisting in good decisions made early – and the resolution of disputes
- access to legal assistance does not – of itself – make the scheme more or less adversarial.

In addition to recommending careful consideration to introducing ILARS into the MAIA scheme, the Statutory Review recommended a number of other issues be considered in reviewing legal supports, including relevantly:

- the need for straightforward and timely access to regulated fees due to claimant lawyers
- whether it remains appropriate to deny access to legal services for some types of statutory benefit disputes
- costs provisions for complex cases
- the need to ensure legal fees are sufficient to enable experienced practitioners to continue to remain active in the scheme.

Legal funding through ILARS in workers compensation

ILARS was established in the New South Wales workers compensation scheme in 2012 following amendments to section 341 of the *Workplace Injury Management and Workers Compensation Act 1998* (WIMA), requiring that '[e]ach party is to bear the party's own costs in or in relation to a claim for compensation'. ILARS was given a specific statutory basis from 1 March 2021, with Part 5 of Schedule 5 to the *Personal Injury Commission Act 2020* (PIC Act) establishing ILARS as a function managed and administered by the Independent Review Officer.

ILARS operates to ensure that eligible injured workers can access free, independent legal advice and assistance in relation to statutory workers compensation claims. This includes:

- providing funding for legal and associated costs for workers under workers compensation legislation seeking advice regarding the decisions of insurers under the legislation

- providing assistance in finding solutions for disputes between workers and insurers.[14]

The workers compensation scheme is complex – having been described by the Hon Robert McDougall as '*cumbersome, confusing and unwieldy*.' Mr McDougall also reflected that the current legislative provisions are '*Byzantine in their elaboration and labyrinthine in their detail, have resulted in a level of confusion, inconsistency and complexity that does nothing to assist the schemes to achieve their policy objectives*'.[15]

Given this, and the stated purpose of ILARS, the threshold for a worker to obtain access to initial advice is low. Provided the injured worker is 'eligible' (i.e., a worker who is required to bear their own costs under section 341 WIMA), initial funding will be provided to enable the lawyer to obtain instructions, provide comprehensive advice and, where appropriate, commence investigations.

Even though the workers compensation scheme is complex, many injured workers do not need legal assistance to make a claim or deal with a dispute. For example, in 2020-21 99,409 workers compensation claims were made in NSW[16] - this number has been fairly stable for the past 3-4 years. In the same period, the IRO received 21,530 ILARS applications from lawyers acting for injured workers. A similar number has also been received in 2021-22. As a proxy, this suggests that approximately 4 out of 5 claims can proceed without the need for legal assistance. This may reflect that the clear majority of workers compensation claims are accepted by insurers[17]. Where legal assistance is needed, however, it is readily available.

A number of the key features of ILARS are set out below. Full details can be found in the *Guidelines for approval as an IRO Approved Lawyer* [18] and the *ILARS Funding Guidelines*[19], which are published on the NSW Legislation website and have been tabled before the NSW Parliament[20]:

- Only lawyers who can demonstrate an expertise in workers compensation law and practice are able to seek ILARS Grants on behalf of workers – the IRO has an established process to approve lawyers for this purpose.
- Injured workers are able to choose the lawyer they wish to instruct – the IRO publishes a geo-mapped list of Approved Lawyers for this purpose.
- Funding extends both to the professional costs of the lawyer, and in addition any necessary disbursements, in particular the costs of obtaining medical evidence and reports.
- While the initial (Stage 1) threshold for approval of an ILARS Grant is low, Approved Lawyers must demonstrate, as the grant progresses, that it meets a merit test in order to receive a grant extension:
    - Stage 2 funding is available to investigate and pursue a claim for compensation – including to seek to assert a threshold or resolve a dispute – prior to the commencement of proceedings in the Personal Injury Commission (PIC). This stage may include the lawyer obtaining medical reports, clinical notes, statements and other information relevant to the claim. It may also include the lawyer lodging a permanent impairment claim on behalf of the worker, or seeking an internal review of an insurer's decision. The test for funding at Stage 2 is that the claim '*have some merit*' – that is, that there is a basis in fact and law to conclude that the worker has a claim or dispute to pursue which may result in a successful outcome.
    - Stage 3 funding – which is available to commence proceedings before the PIC – is only granted where an arguable case for the worker can be demonstrated, and reasonable steps have been taken to achieve early resolution of the matter with the insurer. There are some specified matters that may not be funded at this stage

unless additional criteria are met (for example, in some cases where the amount in dispute is small).
    - Stage 4 funding is provided in some cases where there is an appeal from the decision of the PIC. Where the worker is the respondent in the appeal (i.e., it is the insurer that appeals the decision), the IRO will generally provide full funding. Where the worker is the appellant, generally only conditional funding is provided – that is, funding will only be paid if the worker achieves a successful outcome. There is a limited exception to this approach, in particular where the appeal has reasonable prospects of success and raises an important question of law.
- The ILARS Grant is paid at the conclusion of the legal relationship or where a final outcome is achieved. The amount of costs and disbursements are, for the most part, clearly specified in a Schedule to the ILARS Guidelines.
    - Professional costs for lawyers are fixed and determined based on the resolution achieved in the matter – ranging at present from $800 for Stage 1 matters (where comprehensive legal advice is provided which may include the lodging of a claim form and advising on the insurer decision) to $7,800 for matters that resolve after a hearing commences at the PIC. Wherever possible, these costs are benchmarked against resolution types specified in Schedule 6 to the *Workers Compensation Regulations* (WCR). Consistent with the WCR, complexity increases may be granted in matters that require significant additional work, or where there are multiple parties and multiple resolutions.
    - Disbursements are also generally fixed, and in particular all medical report fees are set in accordance with the relevant SIRA Fee Order[21].
    - In 2021/22, 62 per cent of ILARS payments were made for the professional costs of Approved Lawyers, and 38 per cent to disbursements – with the majority of disbursements (almost 85 per cent) paid for medical examinations and reports and associated expenses.
- There is a review process where Approved Lawyers do not agree with Grant decisions, including a review by the Director of ILARS, and if requested a further and final review undertaken by the Independent Review Officer.
- In terms of timeliness of decision making and payment:
    - IRO aims to assess applications for funding within 5 working days of receipt (as at August 2022 this was achieved in 87% of matters)
    - IRO aims to approve invoices for professional services within 20 working days of receipt (as at August 2022 this was achieved in 84% of matters)
    - approved invoices are paid within 30 calendar days.
- In terms of outcomes of ILARS grants:
    - In 2021/22, 54 per cent of ILARS Grants were completed with a final outcome – such as a decision by the PIC or a complying agreement between the worker and insurer:
        - most of these outcomes (55 per cent) were reached without the need for PIC proceedings, demonstrating the value of legal assistance being provided prior to a dispute being lodged with the PIC – and the costs for these matters, on average, are about 40 per cent of the cost of matters that require a PIC decision[22]
        - in more than 93 per cent of ILARS Grants with a final outcome, the worker improved their position.
    - In 2021/22, 46 per cent of matters were finalised without a final outcome. In these matters, injured workers received comprehensive legal advice and may have been assisted to complete a claim form or have decided not to proceed with a claim. Alternatively, the worker's claim may have been investigated (including by obtaining specialist medical evidence) but the relevant impairment threshold or pre-requisites

to pursue a claim were not met. There are also some matters where the worker ceases to instruct the lawyer.
    - Matters where an outcome was achieved by the worker as a result of the ILARS Grant[23] account for approximately 80 per cent of total ILARS expenditure[24].

Three other matters are relevant to IRO's administration of ILARS:

- IRO continues to refine processes that integrate our functions in resolving workers compensation complaints and administering ILARS Grants. Examples of this include:
    - Where a lawyer applies for Stage 3 funding (to commence a dispute at the PIC), the IRO makes an assessment as to whether the matter is appropriate to attempt an early resolution. The most common example is where the insurer has not responded to a worker's claim. For these matters, before approving funding, the IRO will seek a further response from the insurer. Where matters can be solved (almost 100 matters in 2021-22), substantial costs and time savings are achieved for the worker, insurer and PIC.
    - IRO dispute resolution officers are able to provide integrated information and assistance to injured workers where an insurer disputes a claim, including to provide detailed information about the legal assistance available at no cost to workers.
    - Where minor issues arise during the course of a claim, a worker's lawyer may refer them to the IRO to seek a quick solution. This might include concerns about missed payments, delayed reimbursements and the scheduling of medical examinations. This ensures speedy responses to claims issues for the worker and insurer, while freeing up the lawyer to focus on more substantive aspects of a worker's claim.
- There is strong transparency in the provision of legal assistance to injured workers. The IRO publishes detailed data each quarter about the types, outcomes and costs of ILARS applications[25], and reports annually on the operations of ILARS in our Annual Report.
- The data and information obtained in administering ILARS contributes to the IRO role to inquire into and report upon matters arising in the statutory compensation schemes. A very recent example of this is the IRO's submission to the Committee's 2022 Review of the Workers Compensation Scheme[26].

The IRO has recently surveyed injured workers and Approved Lawyers about their experience with ILARS – a full report of the survey will be included in the IRO 2021-22 Annual Report.

Responses from injured workers indicate satisfaction with the services of Approved Lawyers, with 69 per cent recording they were satisfied with the overall experience. Positive feedback was received in particular about aspects such as the knowledge of and communication by Approved Lawyers. Only 18 per cent of workers were dissatisfied with the services of their lawyers.

Responses from Approved Lawyers demonstrated an overall high satisfaction with ILARS, with 82 per cent of Approved Lawyers stating they were satisfied with their overall experience (and only 6% dissatisfied), and 89 per cent finding ILARS easy to deal with.

ILARS for CTP?

There are a number of similarities about the workers and motor accident compensation schemes that point to a need for legal assistance to be available. These include the following:

- persons generally have limited knowledge of the compensation schemes before they are required to engage with them following an injury

- both schemes are complex – with certain entitlements being determined by threshold events that may require specialist knowledge to properly understand and apply for – pointing to a need for expert assistance for injured persons in some circumstances, which may include information services (such as CTP Assist) and the services of an expert lawyer
- legal assistance, when available, tends to result in positive outcomes for injured persons in terms of accessing rights and entitlements
- legal assistance can be valuable at various points in the management of a claim, and not only when a dispute arises.

For injured workers and their legal representatives, ILARS addresses many of the issues identified for legal supports when accessing statutory entitlements identified in the Statutory Review:

- ILARS supports injured workers who require assistance in accessing statutory entitlements at each stage of a claim
- ILARS supports scheme outcomes[27] – including:
  - promoting access to reasonably necessary treatment for injured workers
  - ensuring access to income support and compensation where there is a legal entitlement
  - promoting fairness and affordability by encouraging early solutions to matters while still funding claims where there is a proper case to be decided by the PIC
- ILARS provides a straightforward and transparent approach to legal costs, which are anchored to the resolution of a claim, and timely payment of invoices to lawyers and others
- ILARS funding is sufficiently flexible to ensure appropriate legal fees for complex cases
- ILARS fees are regularly reviewed, most recently in 2019 and again in 2021 – ensuring they are referenced to appropriate benchmarks and reflect the professional services provided.

Subject to appropriate modification, ILARS is a model that can address current unmet needs for legal assistance in the CTP scheme in an effective manner.

If ILARS was to be adopted and adapted to provide assistance to persons who are injured in motor accidents, our recommendation is that this function be undertaken by the IRO. Reasons for this include:

- IRO's strong track-record in delivering an effective and respected ILARS
- IRO already has established business processes for delivering grants to lawyers to provide legal assistance to injured persons, and has earned the confidence of lawyers and other representatives of workers in doing so
- it would promote integration of our CTP complaints work with seamless referral to no-cost legal assistance, and the more effective referral of appropriate matters to IRO for quick solutions between injured persons and insurers – encouraging early solutions without the need for formal proceedings, while promoting the fair and efficient resolution of disputes that should be decided by the PIC
- this approach would also contribute to a consistent and harmonised framework across personal injury schemes, consistent with recent reform directions in NSW.

Appendix A – notice requirements

Set out below are examples of some of the notice requirements under the workers compensation and CTP schemes. The summary is not meant to be a comprehensive survey of all notice requirements, and provided to highlight opportunities to harmonise and strengthen the requirements for the CTP scheme.

Notice provisions in the workers compensation scheme

In workers compensation matters section 78 of the Workplace Injury management and Workers Compensation Act 1998 (WIM Act) provides that insurers must give notice of any decision to dispute liability 'in respect of a claim or any aspect of a claim' as well as any decision to discontinue or reduce weekly payments of compensation. The notice is required to 'contain a concise and readily understandable statement of the reason for the insurer's decision and of issues relevant to the decision' (section 79(2)) and must identify any provision of the legislation relied upon by the insurer to deny liability (section 79(3)). An insurer which fails to comply with sections 78 and 79 is guilty of an offence, with a maximum penalty of 50 penalty units (section 85).

The Workers Compensation Regulation 2016 (WC Regulation) contains comprehensive provisions for the contents of a notice denying liability pursuant to section 78:

(1) A notice under section 78 of the 1998 Act of an insurer's decision to dispute liability in respect of a claim or any aspect of a claim (except in connection with a work injury damages matter), or to discontinue or reduce the amount of weekly payments of compensation, is to contain the following information (except in connection with a work injury damages matter), or to discontinue or reduce the amount of weekly payments of compensation, is to contain the following information--

(a) a statement identifying all the reports and documents submitted by the worker in making the claim for compensation, and by the employer in connection with the claim,

(b) a statement identifying all the reports of the type to which clause 41 applies that are relevant to the decision, whether or not the reports support the reasons for the decision,

(c) a statement advising that a copy of a report required to be provided by the insurer under clause 41(3) (except as provided by clause 41(5) or (6)) accompanies the notice,

(d) details of the procedure for requesting a review of the decision,

(e) a statement to the effect that the worker can seek advice or assistance from the worker's trade union organisation, from an Australian legal practitioner, from the Independent Review Officer or from any other relevant service established by the Authority,

(f) the contact details for the Independent Review Officer,

(g) the street address and the email address of the President,

(h) a summary, in the approved form, of the effect of the decision, the worker's rights of review, the procedure for requesting a review and the legal and other services that may be available to the worker to provide advice or assistance in relation to the dispute.

The workers compensation legislation supports the requirements around providing adequate notice of disputes with provisions that create consequences for any failure to comply. Section 289A of the WIM Act is in the following terms:

> *(1) A dispute cannot be referred for determination by the Commission unless it concerns only matters previously notified as disputed.*
>
> *(2) A matter is taken to have been previously notified as disputed if--*
>
> > *(a) it was notified in a notice of dispute under this Act or the 1987 Act after a claim was made or a claim was reviewed, or*
> >
> > *(b) it concerns matters, raised in writing between the parties before the dispute is referred to the President for determination by the Commission, concerning an offer of settlement of a claim for lump sum compensation.*
>
> *(3) The Commission may not hear or otherwise deal with any dispute if this section provides that the dispute cannot be referred for determination by the Commission. However, the Commission may hear or otherwise deal with a matter subsequently arising out of such a dispute.*
>
> *(4) Despite subsection (3), a dispute relating to previously unnotified matters may be heard or otherwise dealt with by the Commission if the Commission is of the opinion that it is in the interests of justice to do so.*

In addition, clause 41(3) of the WC Regulation states:

> *For the purposes of sections 73(1) and 126(2) of the 1998 Act, if an employer or insurer makes a decision to which this clause applies, the employer or insurer must provide a copy of any relevant report to which this clause applies to the worker, as an attachment to a notice under Division 3 of Part 2 of Chapter 4 of the 1998 Act or section 287A of the 1998 Act, as the case may be, except where the report has already been supplied to the worker and that report is identified in a statement under clause 38(1)(d).*

Pursuant to section 73 of the WIM Act, where a report has not been provided to a worker, an insurer cannot use it to deny liability, the report is not admissible in proceedings before the PIC and may not be provided to a medical assessor.

Taken together, the various provisions create a strong framework for insurers to make decisions on any aspect of liability in a claim, supported by meaningful consequences where an insurer fails to comply with its obligations.

These provisions have been interpreted by the PIC (and its predecessor) in cases such as *Cannon v The Healthy Snack People Pty Ltd* [2009] NSWWCCPD 32 (27 March 2009) - which considered earlier iterations of the same provisions – and concluded at 132:

> *What is necessary is clear and precise statement of the reason the insurer disputes liability and the issues relevant to the decision to dispute liability.... Insurers are again reminded that they have a statutory duty to fully and properly comply with the terms of section 74 [now s.78] ... It is not sufficient to merely refer to particular sections of the legislation.*

Notice provisions in the CTP scheme

Sections 4.32 to 4.41 of the MAG set out the way in which an insurer is to notify a claimant of decisions about liability for statutory benefits. The primary section is 4.34 which states:

If the insurer denies liability in whole or in part for the payment of statutory benefits, the notice must include:

(a) an explanation of why the insurer must determine liability

(b) an explanation of the consequences of the decision, including any effects on the claimant's entitlement to statutory benefits or damages

(c) the reasons why the insurer has made the decision with reference to the information relied upon in making the decision (where the insurer denies liability on the basis of fault, the insurer must still include its assessment of contributory negligence and minor injury)

(d) where the insurer declines the payment of statutory benefits on the basis that the claimant's injury was not caused by the motor accident, an explanation of which injury the insurer asserts is not covered and why

(e) a list of all information relevant to the decision, regardless of whether the information supports the decision, including copies of all listed information

(f) 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

(g) the claimant's right to seek independent legal advice

(h) information on how a claimant may make a complaint with the Independent Review Office (IRO), including the IRO's contact details.

However, these sections appear to be concerned primarily with liability for statutory benefits as a whole, rather than claims for specific items of, say, treatment and care.

For weekly payment decisions, insurers are required to give claimants procedural fairness (MAG 4.49) including: giving the claimant the opportunity to provide information; providing the claimant with all the information the insurer is considering; and giving the claimant a right to respond if a decision may adversely affect them.

In addition, if an insurer makes a decision to discontinue or reduce weekly payments it must provide notice in accordance with section 3.19 of the MAI Act and the notice must be in writing (including electronically) and include information about the right of review (MAG 4.61). However, there do not appear to be any penalties imposed for failure to comply with these provisions.

Where claims for specific treatment and care are concerned, part 4.98(b) of the MAG sets out the requirements for an insurer to notify a claimant of a decision:

- 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.

There is no penalty for failure to comply with the provision other than the general provision in part 6.1 relating to compliance being a condition of an insurer's licence.

Clause 12 of the Regulation provides that an insurer is required to notify a claimant in writing of a right to request an internal review or apply for a merit review of a decision. This clause imposes a maximum penalty of 5 penalty units.

Comparison of notice provisions

The MAIA does not contain comprehensive and strict notice provisions backed by Standards of Practice. In CTP matters reviewed by the IRO, an insurer may deny liability for a treatment on the basis that it is not reasonable and necessary and send notice by way of an email which informs the claimant of that decision with minimal advice as to the basis of the decision, and the claimant's rights in response. This makes it more difficult for a claimant to know what evidence is required to seek a review, or the full nature of the dispute which may ultimately come before the PIC.

Similar provisions to those included in workers compensation legislation could be added to the MAIA and the Regulation and may provide greater clarity to insurers on their obligations, enable claimants to fully understand the decisions made in their claims and facilitate the PIC's ability to determine disputes in a timely and efficient manner.