2024 Insurer Compliance and Assurance Program

Treatment and Care Assurance Audit

The Motor Accident Injuries (MAI) Commission is responsible for the regulation of the Motor Accident Injuries Scheme. This scheme provides cover on a no-fault basis to people injured in a motor accident in the ACT. As part of the compliance activities of the MAI Commission, the Commission intends to undertake audits on a yearly basis to assess compliance with respect to the delivery of defined benefits by insurers[1]. These audits are just one of the compliance activities to be undertaken. Insurers have been asked to undertake a self-assessment process each year since 2021 using a questionnaire provided by the MAI Commission. The MAI Commission also follows up on enquiries and complaints as part of its daily activities.

An assurance audit of the insurers was undertaken in March 2024. The MAI Commission chose to focus the audit on compliance with the provision of defined benefits, specifically treatment and care. This report provides a high-level overview of the audit.

Details of the audit

The MAI Commission gave notice to the insurers of the intention to undertake an assurance audit in December 2023, with further details on the audit provided in February 2024.

The audit dates were between 4 and 25 March 2024 and were conducted at the business premises of the Nominal Defendant and AAMI, APIA and GIO (Suncorp) in Canberra. For IAG, the audit team travelled to Sydney.

The audit was to assess compliance with the *Motor Accident Injuries Act 2019*, Parts 2.5 Treatment and Care Defined Benefits and 2.10 Defined Benefits Dispute Resolution; and the *Motor Accident Injuries (Treatment and Care) Guidelines 2021*. The audit was aimed at assessing insurer compliance in relation to the approval of treatment and care to motorists, cyclists, and pedestrians injured in ACT accidents that involved at least one motor vehicle. The auditors requested access to files for accidents from April 2022 to December 2023. This date range was to allow three months from the commencement of the 2021 updated guidelines, for implementation activities to have been completed. The later date (December 2023) mirrors when notice was given to the insurers regarding the audits.

The MAI Commission acknowledges the assistance of the insurers in ensuring the audit process was undertaken efficiently and concluded within the shortest time possible during the on-site visits. Insurers provided open and transparent access to their staff, files and record keeping systems during the audit.

[1] In this report, where 'insurers' is used this refers to MAI insurers and the Nominal Defendant. 'MAI insurers' is used where only the licensed insurers are being referred to.

Scope of the audit

The audit was to obtain assurance that insurers have the appropriate processes and procedures in place for treatment and care decisions. The selected scheme applications were audited for their compliance with the Motor Accident Injuries (Treatment and Care) Guidelines:

- Part 5 – Exceptional Circumstances – Late applications (Section 128)
- Part 6 – Approval of treatment and care benefits (Sections 129 and 131)
- Part 8 – Payment of treatment and care expenses by insurers (Sections 129 and 131).

Additionally, the audit also examined internal review decisions where this related to the provision of treatment and care benefits (MAI Act, Part 2.10 – dispute resolution).

Sampling

Stratified random sampling was used within the specified date range for the audit's data collection. Sampling was undertaken within a specified time frame to provide examples of applications that met one or more of the following criteria:

- Files that were inactive or had been closed;
- Files where applicants had sustained moderate to complex injuries;
- Files where applicants had multiple treatment and care requests;
- Files that had undergone an internal review relating to treatment and care decisions.

Files for audit were selected for accidents within the date range of April 2022 to December 2023 by the MAI Commission using a filter with the above criteria. This selected date range was selected as the MAI Treatment and Care Guidelines were updated in December 2021.

A total of 59 files were audited. Files were selected from across the above date range and on a percentage basis relative to volume of applications handled by each of the insurers. This consisted of 25 files each for the IAG and Suncorp licensees and nine files for the Nominal Defendant.

Audit process

Auditors were given an overview of MAI insurers' relevant software programs on the first day of the on-site audit with the intention of operating independently for the remainder of the audit process. The insurers also provided a team member as a conduit for orientation to their systems and practices.

In the case of the Nominal Defendant, claims officers assisted with the navigation of the claims system. This was necessary as during the relevant date range being audited, the government agency that manages the Office of the Nominal Defendant, the ACT Insurance Authority, had implemented a new IT system for the recording of claims. To ensure files were reviewed from either side of the change-over in systems, the auditors were assisted by claims officers to navigate to the selected files and were available for related questioning.

An initial summation of findings was verbally provided to MAI insurers on the last day of the on-site audit. MAI insurers were also requested to provide evidence of supporting documents that claims staff used for guidance in applying the Treatment and Care Guidelines. Copies of Recovery Plans and Approval Guidance documents were also requested and supplied.

Draft reports were provided to all insurers for their consideration after the on-site audits. Consideration of the reports was open for 5 business days. Only one insurer chose to follow up on the findings through discussion with the auditors. No formal comments were provided by any of the audited parties. The audit questions and results are below at Attachment A.

Audit outcomes

A high level of compliance with the Treatment and Care Guidelines was found from the audit. The reviewed files demonstrated that treatment and care approvals were undertaken within the required timeframes. Insurers were also able to demonstrate that they were providing benefits to applicants that focused on personal and domestic assistance that aided in the injured person's recovery. The documents submitted to the MAI Commission, e.g. the recovery plan templates and decision guides, were in general compliance with the legislation.

There were some examples found in the audit where improvements could be made, resulting in a less than 100 per cent result across all insurers from the audit (98.4 per cent). The auditors formed the view that the few instances where the audit criteria were not met may have been influenced by the claims management structure of a particular insurer, where functions were split based on experience and seniority. It was thought that the splitting of functions to make decisions could be a likely contributor to delay or unintended outcomes during the management of an application. It was not possible from the audit to conclude this was the case.

The auditors emphasise that while some oversights in handling an application were identified, all files audited provided assurance of activity consistent with the guidelines and legislation. The MAI Commission will continue to monitor these very few instances where the audit criteria were not met. The areas for improvement are highlighted below.

Engagement with applicants and treatment providers

The auditors noted from some of the files that there had been issues in establishing a positive relationship with an applicant. Early applicant engagement that also includes their treatment team is shown to improve outcomes. Insurers should continue to build relationships with applicants and treatment teams so that each of these parties understand the process and how the injured person can be helped to recover.

Further, there were a handful of instances where there was weak engagement with treatment providers and an underutilisation of one insurer's Injury Management Advisers (IMAs) evident on the files. The auditors were concerned that this may have hindered the decision-making capacity of insurers when they were considering the approval of certain treatment and care. The MAI Commission considers it appropriate for insurers through their claim consultants or IMAs to engage with local healthcare providers, including, if appropriate, to case conference with the treating team. Establishing these relationships is particularly important to build trust and rapport. This can also be beneficial to improve the understanding of an injured person if certain treatment and care requests are not going to be approved by an insurer and the reasons why.

Early intervention by health care providers is also shown to improve outcomes and reduce the costs associated with recovery from injury. If there is evidence that an injury is related to the motor vehicle accident, or an exacerbation of a pre-existing injury caused by the motor vehicle accident, the focus for managing the application should be on providing access to evidence-based care as quickly as

possible. Any delays in access to treatment and care can contribute to poorer outcomes for injured people.

The auditors noted some of the recovery plans on the files could better outline the treatment and care that has been proposed by the treating team and approved by the insurer, so that the injured person can keep track of what to expect in their rehabilitation and treatment goals. The recovery plan should include details of the person's injuries, treatment goals, capacity for undertaking activities (daily living and work) and the approved treatment and care. While it is important to outline the expectations placed on all parties related to compliance with the treatment and care guidelines and recovery plans, these should not be confused with treatment and care goals.

Taking steps to ensure providers are appropriately qualified

Treatment providers are required to be appropriately qualified and experienced to provide services within their scope of practice. This is a legal requirement that applies to all registered health practitioners. The audit found a medical report and certificate that was signed by a person who was not a medical practitioner[2]. The Medical Report (required with the personal injuries application) and the Fitness for Work Certificate is currently only able to be completed and signed by medical practitioners. It is also timely to remind insurers when approving treatment and care services to ensure the provider is appropriately qualified[3].

Insurers should also consider the training, skills and specialisations of an Independent Medical Examiner (IME) when making a referral for a review of a treatment and care request. The insurer should take steps to explain the rationale for the referral (for example, insufficient information provided in the initial request), and ensure the IME chosen is appropriate to perform the review.

Late payments

Late payments made by insurers have the potential to negatively impact the injured person and damage the reputation of the insurer and should be avoided where possible. Late payment can sometimes occur when an injured person is seeking reimbursement for a bill they have paid. The insurers should ensure their processes remain robust and pay bills within the required timeframes. Wherever possible, an insurer should set up direct payment options with treatment providers and explain this is the preferred approach, though it is noted by the MAI Commission some providers may be reluctant to enter into such arrangements and will bill and/or expect payment from the applicant.

[2] A registered medical practitioner is defined in the *Legislation Act 2001* to mean a doctor and a doctor means a person registered to practice in the medical profession. Other health professions, as defined in the *Health Practitioner Regulation National Law (ACT)*, are excluded from signing these forms.

[3] 6.4.4 of the guidelines refers to providers generally. This can be any provider and does not need to be a health practitioner. Examples could be a physical trainer, a gym membership or something else, that has been or will be of benefit to the person's psychological or physical wellbeing.

Results

Criterion	Number Sampled	Number met	% met
Was the application late? If late, was the application deemed to be exceptional circumstances? If yes, were treatment and care expenses back paid?	59	59	100%
Is there evidence that decisions are made about approving treatment and care requests in a timely manner (within 10 days of receipt)? Is there evidence that all of the necessary details to make a decision have been obtained for the provider? If rejected, was a reason for the decision provided to the person making the claim and the provider?	59	58	98%
Is there evidence that the requested treatment and care is reasonable and necessary? Is there evidence that the treatment and care request is directly related to the injured person's injuries? Is there evidence that the treatment and care request is appropriate for the injured person's injuries? Is there evidence that the treatment and care will be of benefit to the injured person? Is there evidence that the treatment and care provider is appropriate for the requested service related to the injured person's injuries? Is there evidence that the treatment and care request is cost effective?	59	59	100%
Is there evidence that the requested treatment and care is directly related to injury(s) caused by the motor accident? Is there evidence that the requested treatment and care is directly related to an exacerbation of an existing injury(s) caused by a motor accident? Is there evidence that the requested treatment and care is related to an injury sustained after the motor vehicle accident as evidenced by the time elapsed since the motor accident?	59	59	100%
Is there evidence of the treatment and care being in line with the rehabilitation goals? Is there evidence of ongoing improvement related to the treatment and care being provided?	59	53	90%
Is the proposed/current treatment in line with available clinical evidence for treatment associated with the type of injury sustained?	59	59	100%

Is there evidence of the treatment providers i) qualifications, ii) registration/credentials, iii) service quality, iv) independence from the injured person, v) value for money,	59	58	98%
Is there evidence that consideration has been given during the decision-making process for approval of the treatment and care that it, i) will improve the outcome for the injured person in the short and long term so outweigh the cost, ii) is the best treatment and care option available, iii) if provided early will lessen the burden of disability in the future?	59	59	100%
Is there evidence that the fees charged by the provider are in line with other like service providers or close to the recommended rates? Is there evidence that the fees charged by the provider are third party payments? Have travel and accommodation expenses been required for i) the injured person? ii) a support person for the injured person.	59	59	100%
Is there evidence that the treatment and care has been provided (receipts, completion reports, reviews of rehabilitation goals)? Have payments been made for treatment and care within the timeframes (10 days of receiving a receipt)?	59	59	100%
Have attempts been made to set up a billing arrangement with the provider of treatment and care services? Is there evidence that direct billing for large costs has occurred? Is there any evidence that an injured person has missed a treatment and care service because of a late billing approval?	59	58	98%
INTERNAL REVIEW			
(Supplementary) if occurred. Was the applicant made aware of the internal review process at the time of rejection? Was a letter sent explaining the process for internal review? Did the applicant provide any new information for consideration and was it considered? If conducted did the internal review affirm or overturn the decision?	59	57*	97%

* All files were sampled for information being provided on internal review (as required by the legislation). For the date range 8 files were selected from a possible 17 requests for internal review of a treatment and care decision.