STANDING COMMITTEE ON LAW AND JUSTICE
2020 REVIEW OF THE COMPULSARY THIRD PARTY INSURANCE SCHEME
Pre-hearing questions for SIRA

1. **Recommendation 2 in the 2018 Report – The file review of the first 1,000 claims does not appear to be available on the SIRA website, can you please provide the Committee with a copy?**

SIRA has now published the independent research reports from the Australian Institute of Health Innovation and the John Walsh Centre for Rehabilitation Research, on the first 1,000 claims on its website. A copy is attached for the Committee at Tabs A and B.

2. **Can you please provide an overview of the scheme's performance over the last 12 months, including the number of claims**

Attached at Tab C is a snapshot of the performance of the scheme for the 12 months to February 2021. The detailed quarterly scheme actuarial monitoring pack with data to 31 December 2020 prepared by EY, the scheme actuary, is published on the SIRA website.

The 2019/2020 annual performance report outlining the performance of the scheme as at 30 June 2020 will be published shortly. A copy will be made available to Committee.

3. **What is the total spent in relation to these claims and the total profit kept by CTP insurers (for CTP products)?**

In the 2020 accident year (1 January 2020 to 31 December 2020), total claim payments were $108 million, and it is anticipated that 93 per cent of payments for this accident year are yet to be made.

Insurer premium filings to SIRA have included prospective profit margins at or below the benchmark of 8 per cent profit. SIRA is monitoring anticipated profit levels and will recoup insurer profit and cover losses that are excessive.

SIRA undertook its first Transitional excess profits and losses (TEPL) assessment for the 2018 accident year in 2020. It was determined that there was insufficient actual claims experience to determine ultimate profit levels, so the decision on whether to activate TEPL to recover excess profit for the 2018 year was deferred.

SIRA has commenced its second TEPL assessment for the 2018 and 2019 accident years. Once SIRA has received the actuarial advice (including an actuarial peer review), it will make an assessment on whether to trigger the next steps in the TEPL process.

SIRA publishes data on total claims payments in its Open data portal.

4. How much of the premium dollars received from October 2018 to date were:

a. Paid to claimants;
b. Paid to Medical and Allied Health;
c. Paid to Lawyers;
d. Paid to Insurers.

The table below provides the proportion of premium dollars received by various groups between 1 October 2018 and 31 December 2020:

Payment type	**Amount from scheme inception (December 2017)**	**Amount from October 2018**	**Percentage of premium from December 2017 to December 2020**	**Percentage of premium from October 2018 to December 2020**
Claimants	$379,000,000*	$351,000,000*	6.3%	8.1%
Medical and allied health	$294,000,000*	$269,000,000*	4.9%	6.2%
Legal	$30,000,000*	$30,000,000*	0.5%	0.7%
Premium collected by insurers (including ITC loading and excluding GST and levies)	$6,006,000,000	$4,321,000,000	N/A	N/A

**These amounts will continue to increase as claims continue to develop.*

While insurers collected approximately $6 billion in premiums during this period, it is too early to determine the proportion insurers will retain as profit.

Insurers will continue to use the collected premium amount for all future claim payments for accidents within this period. It is estimated that only 24 per cent of the total expected payments for the first year have been paid, with most remaining payments expected to relate to the settlement of damages claims.

5. Can you provide the following claim information:

a. The number of current claims for statutory benefits open on each CTP insurers' books;

b. The number of current open files that include a concession or determination that an injured person has exceeded the 10% whole person impairment threshold;

c. The number of current and open claims for damages for each insurer;

d. The number of current claims involving ongoing weekly benefits in the statutory benefits scheme.

5.a. The table below provides the number of current claims for statutory benefits open on each CTP insurers' books between 1 October 2018 and 31 December 2020 and their market share as at 31 December 2020:

Insurer	**Open Statutory Benefit Claims**	**Insurer Market Share**[1]
AAMI	1,042	9.1%
ALLIANZ	2,373	16.8%
CIC-ALLIANZ	395	0%
GIO	2,199	16.3%
NRMA	4,575	32.4%
QBE	3,000	25.4%
Total	**13,584**	**100%**

5.b. There were 617 current open files that included a concession or determination that an injured person has exceeded the 10 per cent whole person impairment threshold as at 31 December 2020.

5.c. The table below provides the number of current and open claims for damages for each insurer as at 31 December 2020:

Insurer	**Open Claims for Damages**
AAMI	192
ALLIANZ	316
CIC-ALLIANZ	155
GIO	456
NRMA	713
QBE	501
Total	**2,333**

5.d. There were 11,637 claims receiving ongoing weekly benefits in the statutory benefits scheme as at 31 December 2020.

[1] Market Share Expressed as Share of Green Slips (CTP Policies)

6. Your submission states that the Risk Equalisation mechanism objectives are largely being met. Which objectives have not been met?

SIRA is now wholly satisfied that the objectives of the Risk Equalisation Mechanism (REM) are being met. The three objectives of the REM are to:

- increase competition among insurers and price flexibility
- manage cross subsidies of motorcycle premiums
- encourage new entrants to the CTP market.

The review identified an increase in competition among insurers and price flexibility, but was unable to attribute this increase solely to the REM. It was likely that increased competition and competitive premium activity has been driven by a combination of factors, including initiatives such as the Green Slip calculator.

The review found that motorcycle premiums are being supported by the REM as per the objective.

At the time of the review of the REM, there had been no new entrants into the CTP market. However, in December 2020, a new insurer, Youi, entered the scheme.

More detail on the 2019 review is published in the SIRA Review of the risk equalisation mechanism (REM) report.

7. The NSW Taxi Council claim that Taxis Operators are unfairly disadvantaged in comparison to Rideshare Operators and contends that both classes of vehicles should be listed in the class 1 category. How does SIRA justify the difference in CTP premium calculation between the two categories?

Class 1 is the classification for an ordinary passenger car. The classification for taxis is class 7. Putting taxis in the same classification as ordinary passenger cars would pool those risks together. This would mean that taxis are not paying a premium in line with the costs of claims that they are responsible for.

Premium calculation for each vehicle class is strongly influenced by the claims experience of that vehicle class. Taxis are, on average, 11 times as likely to have a CTP claim as an ordinary passenger car. It is therefore appropriate to keep ordinary passenger cars and taxis in separate classes for the purpose of premium calculation and to encourage safer driving.

SIRA has put in place a premium calculation mechanism for hire vehicles that work for large providers of booked passenger services like Rideshare Operators. These vehicles are required to pay the base premium for the relevant vehicle class and additional premium based on distance travelled. The additional premium was set to be equivalent to taxis, taking into account the different data collection methods and time each vehicle spends carrying out passenger services. Early data for rideshare vehicles indicates that this classification is likely to have a higher frequency of a CTP claim compared to an ordinary passenger car in Class 1.

SIRA has recently consulted on a proposed CTP premium-setting solution for taxis and hire vehicles in the point to point industry. Submissions closed on 15 March 2021. SIRA

expects to implement new CTP requirements for the point to point industry by 1 December 2021.

8. **Please provide an update on any educational material that has been developed to address the lack of Product Disclosure Statements for CTP insurance as raised by the Motorcycle Council of New South Wales.**

All NSW CTP insurers provide a Product Disclosure Statement when a CTP policy is purchased. The Product Disclosure Statement is also published on the insurer's website.

SIRA has been working with the Motorcycle Council on new educational material. In November 2020, the SIRA website was updated to clarify CTP coverage for motorcycle accidents in NSW and interstate. SIRA is also currently working with the Motorcycle Council on additional material relating to interstate CTP coverage, including an interstate jurisdiction comparison table.

9. **Please provide an update on the feasibility of expanding the Independent Legal Assistance and Review Service (ILARS) to the CTP scheme.**

In December 2020, SIRA commenced a review of the provision of legal support for injured people in the CTP scheme. This review is considering the feasibility of expanding the Independent Legal Assistance and Review Service, as well as a person's legal support needs throughout the lifecycle of a claim.

SIRA expects the findings of this review by the end of July 2021, then will seek actuarial advice on the impacts to premium affordability.

10. **The Law Society suggests that the minor injury definition is denying incapacitated people proper compensation and instead contend that a 'narrative test' should be applied. Has SIRA considered if a 'narrative test' would be more appropriate?**

In 2016, the CTP Reference Panel considered establishing a 'narrative' or fairness test to identify people with lower severity injuries who may require additional assistance. The panel undertook extensive consultation and this option was specifically outlined in the CTP Reform options paper.

Ultimately the panel determined not to recommend the narrative test and Parliament passed the *Motor Accident Injuries Act 2017* without this provision.

SIRA recently undertook a review of the minor injury definition which found that the minor injury provisions are working effectively to incentivise recovery. The findings from this review are published in the report on the SIRA website.

11. **Have there been any complaints about medico-legal assessments? If so, how many have there been since October 2018 and what have been the key concerns?**

SIRA received four complaints about medico legal assessments since October 2018. These complaints related to conduct.

In addition to SIRA's consideration, the complainants were referred to the Health Care Complaints Commission as it has jurisdiction over complaints about professional conduct.

SIRA assesses all feedback and complaints about practitioners in the CTP scheme to determine the appropriate regulatory action. This may include cancelling a practitioner's authorisation or referral to the appropriate regulatory body.

In December 2019, SIRA made changes to Part 8 of the Motor Accidents Guidelines so that it could strengthen its supervision of authorised health practitioners. In determining eligibility and ongoing suitability, SIRA can now consider a range of criteria including; information relating to complaints, compliance, legislative breaches, disciplinary proceedings, criminal history or behaviours that may impact a practitioner's ability to undertake the role or the integrity of the scheme. These changes followed extensive consultation with industry and the public.

12. Is there a backlog of Dispute Resolution Service (DRS) medical and other assessments? If so, how long is the backlog? What is being done to reduce the backlog?

On 1 March 2021, the SIRA dispute resolution functions transferred to the Personal Injury Commission.

SIRA transferred in total 5,883 dispute matters to the Personal Injury Commission. Of these, some disputes had experienced delays, due to a range of reasons, including the impacts of COVID-19.

In March 2020, SIRA was required to cancel approximately 1,950 medical appointments scheduled for April, May and June 2020 to comply with COVID-19-related public health orders.

Once the COVID-19 public health order was amended in July 2020, SIRA undertook extensive work to facilitate medical appointments in a COVID-19 safe way and reduce the number of overdue disputes.

13. The Insurance Council of Australia and the Law Society have expressed concerns about the 3 month timeframe for the minor injury test determination in regards to psychological and other injuries. What reviews have or are being been undertaken in relation to this matter?

SIRA acknowledges concerns about the three-month timeframe to determine whether a physical or psychological injury caused by a motor vehicle accident is a minor injury.

In February 2020, SIRA completed a Review of the Minor Injury Definition in the NSW CTP Scheme. Through this review, SIRA considered the advice of medical experts that early diagnosis and treatment of physical or psychological injuries increases the likelihood that a person reaches optimum recovery. This was found to be particularly important for recovery from psychological injury.

Overall, the review found that the minor injury definition and its application is consistent with the intended outcomes. The 2017 Act has as one of its objects:

> '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'

SIRA continues to monitor this issue, also considering whether any change would be consistent with the above objective to encourage early and appropriate treatment and care.

It is important to note that the insurer's decision at the three-month timeframe can and should be reviewed under certain circumstances. Clause 4.42 of the Motor Accident Guidelines requires an insurer to review its liability decision - which includes the decision of minor injury - if the insurer receives new information. This could relate to a change in the injured person's condition.

SIRA will continue to monitor and assess the application of the minor injury definition and whether the 26-week threshold remains appropriate, to ensure that the scheme is delivering fair outcomes.

14. The Law Society contends that if small claims are removed from the scheme at the 26 week post-accident mark, then the 20 month waiting period to make a common law damages claim is unnecessary and contravenes the aim of encouraging 'early resolution of motor accident claims and the quick, cost effective and just resolution of disputes'. What is your response to this?

SIRA acknowledges the Law Society's views about the operation of the 20-month waiting period to make a common law damages claim.

The current provision in the legislation of a 20-month waiting period for injured people with less than 10 per cent whole person impairment (WPI) provides time for maximum recovery before lodging a claim for damages.

SIRA closely monitors the operation of the 2017 CTP scheme and its performance. In particular, SIRA monitors insurer behaviour to ensure that injured people are aware of the 20-month waiting period and has updated the Motor Accident Guidelines so that when insurers receive a request to concede that injuries are over 10 per cent WPI, they must accept or decline the decision within 90 days.

As at 31 December 2020, 2,475 statutory benefit claims had lodged a claim for damages. Of these, 142 were finalised and received settlement payments totalling $110.2 million. Total claim payments are expected to continue to grow each month as more claims for damages are lodged and settled. SIRA will continue to evaluate the cohort of claims affected by the 20-month waiting period as damages claims continue to be resolved.

Those with a WPI greater than 10 per cent are able to make a claim for damages at any time, including prior to the 20-month waiting period.

The upcoming statutory review of the *Motor Accident Injuries Act 2017* will provide the Minister with an opportunity to consider the merits of any change, including specifically the timeliness of provision of benefits to injured people.

15. Are regulatory determinations and penalties published in a central location? If not, can you please explain why?

SIRA publishes details of regulatory and enforcement action against insurers in its quarterly CTP Insurer claims experience and customer feedback comparison reports. The reports are available on the SIRA website.

SIRA will soon commence publishing a dedicated report on all CTP compliance and enforcement activity via its bulletin and on its website. SIRA will continue to publish these reports on a quarterly basis.

16. What preparatory work has been undertaken to ensure a smooth transition of the dispute resolution services provided by SIRA to the Personal Injury Commission?

SIRA undertook extensive work, in partnership with other relevant organisations, in preparation for the commencement of the Personal Injury Commission on 1 March 2021. This included updating guidelines, contributing as a member of the Personal Injury Commission Rules Committee, regular engagement and communication with stakeholders. and detailed planning and implementation of changes for SIRA employees and independent decision makers who were transferring to the PIC or otherwise impacted by the change.

17. Has SIRA investigated the possibility of extending access to statutory benefits until a dispute is resolved if the dispute continues past the six-month liability period? What was the outcome?

Under the *Motor Accident Injuries Act 2017,* an internal review and merit review do not operate to stay the insurer's decision.

Insurers have the discretion to continue to provide benefits in these circumstances and must still give the required period of notice before reducing or discontinuing statutory benefits.

To date, SIRA has not considered the possibility of extending access to statutory benefits until a dispute is resolved if the dispute continues past the six-month liability period.
However, the upcoming statutory review of the *Motor Accident Injuries Act 2017* will provide an opportunity for consideration of such a change. The review will assess whether the policy objectives of the Act remain valid and whether the terms of the Act (and those regulations and guidelines) remain appropriate for securing those objectives. The terms of reference for the statutory review as per section 11.13 of the *Motor Accident Injuries Act 2017* are:

> The Minister is to review this Act (and the regulations and guidelines under this Act) to determine whether the policy objectives of the Act remain valid and whether the terms of the Act (and those regulations and guidelines) remain appropriate for securing those objectives.

(2) The review is to be undertaken as soon as practicable after the period of 3 years from the commencement of this Act and a report of the outcome of the review is be tabled in each House of Parliament within 12 months after the end of that period of 3 years.

(3) The review is to consider all aspects of the scheme established by this Act, including the following matters—
(a) the effectiveness of the scheme ensuring insurers are receiving a fair but not excessive profit margin,

(b) the general performance of insurers in the scheme,

(c) the timeliness of the provision of benefits to injured persons,

(d) the proportion of each dollar of premiums collected that directly benefits injured persons,

(e) whether further changes are needed to the scheme.

18. Has SIRA considered extending statutory benefits for at fault claimants with non-minor injuries? If so, what was the outcome?

Under the 2017 scheme, all people injured in a motor accident in NSW, regardless of fault or injury severity, are provided with up to 26 weeks of statutory benefits from the date of the accident. Statutory benefits include weekly income payments if the person was an earner, medical and treatment costs, and commercial attendant care expenses.

To date, SIRA has not considered the possibility of extending statutory benefits for at fault claimants with non-minor injuries.

The upcoming statutory review of the *Motor Accident Injuries Act 2017* will provide an opportunity for entitlements of injured people to be considered as part of the assessment of whether the policy objectives of the Act remain valid and whether the terms of the Act (and those regulations and guidelines) remain appropriate for securing those objectives.

19. What interaction has SIRA had with the NSW Police Force, formal or otherwise, about information requests arising from CTP claims?

SIRA requests information from the NSW Police Force when a person makes a CTP claim against the Nominal Defendant in circumstances where the other owner or driver is uninsured, unidentified or insured interstate. In these instances, SIRA's CTP Assist contacts the NSW Police Force to request details of the vehicle or vehicles involved in the accident.

SIRA also engages with the NSW Police Force on operational matters, particularly in relation to Strike Force Mercury, and on an as needs basis to deter and investigate fraudulent activity in the CTP scheme.

20. Has SIRA considered developing a template to ensure claimants, regardless of which Insurer they engage with, provide the relevant information required to progress their claim?

SIRA provides the following standardised claim forms to help people progress their claim, regardless of who they are insured with:

- Agreed goals for rehabilitation
- Allied health recovery request
- Application for damages under common law
- Application for funeral expenses
- Application for personal injury benefits
- Application to compensate relatives
- Attendant care request
- Certificate of earnings
- Certificate of capacity/ certificate of fitness
- Certificate of capacity/ certificate of fitness – treating physiotherapist or psychologist
- Declaration (Collection of personal and health information to manage your claim)
- Dispute Resolution Service Application form (now defunct following commencement of the Personal Injury Commission on 1 March 2021)
- Dispute Resolution Service reply
- Equipment request
- Extra document information
- Neuropsychological assessment notification
- Rehabilitation services
- Section 6.26 Direction to produce particulars
- CTP vocational support application.

These forms are available on the SIRA website. SIRA has also reviewed insurer letter templates to ensure that the claims information requested is in accordance with the legislation and guidelines.

21. Has SIRA developed and made publicly available a set of case studies or fact sheets of frequently asked questions that provide information to claimants about their rights regarding entitlements to care?

SIRA has developed and published a broad range of resources to inform claimants about their rights and entitlements to care. These resources include:

- Fact Sheets, brochures and general information on:
    - how to make a claim and eligibility for benefits
    - procedural advice to support the claims process
    - creation of "scheme on a page" explanations
    - funeral and death benefits explanations
    - premium calculation.
- Stakeholder specific resources, including for motorcycle riders, taxi and rideshare operators, allied health professionals and clinicians.

- CTP video promotion campaigns and social media campaigns through YouTube, Facebook and LinkedIn. These campaigns shared YouTube animations to educate audiences about scheme rights and eligibility. These animations have been viewed over 500,000 times.

SIRA's CTP Assist telephone and online service help to share these resources with customers to increase understanding and awareness about CTP scheme eligibility. Approximately 40 per cent of inbound enquiries to SIRA's CTP Assist service relate to scheme eligibility. Ninety-five percent of these enquiries are successfully resolved within two working days.

CTP Assist also makes outbound contact to every person who makes a CTP claim three times within the first six-months to inform them of their rights and entitlement to care. There are also additional touch points for claims that go beyond six-months.

22. What would be the impact of making the determination of a minor injury non-binding for the purpose of a claim for damages?

During the Review of the Minor Injury Definition in 2019/2020 the likely impact of making the determination of a minor injury non-binding for the purpose of a claim for damages was not considered. However, SIRA will consider this issue in preparation for the upcoming statutory review of the 2017 Act.

The minor injury threshold underpins the key objects of the 2017 Act and CTP scheme including:

- encouraging the early and appropriate treatment and care to achieve optimum recovery of people injured in a motor accident and to maximise their return to work or other activities
- providing early and ongoing financial support for people injured in motor accidents
- keeping premiums for third-party policies affordable by limiting benefits payable for minor injuries.

A preliminary analysis indicates there would be some risk that making the determination of a minor injury non-binding for the purpose of a claim for damages, may effectively remove the minor injury threshold from the scheme.

The Minor Injury Review found that "*42% of people with minor injuries completed their treatment and care claims within 13 weeks after a motor accident. That increased to 75% by 26 weeks and 98% by 52 weeks*."

"*For the people working before the accident, data indicated that 70% had returned to work by 13 weeks and 76% by 26 weeks*.[2]

[2] Review of the Minor Injury Definition of the NSW CTP Scheme, Executive Summary, page 2

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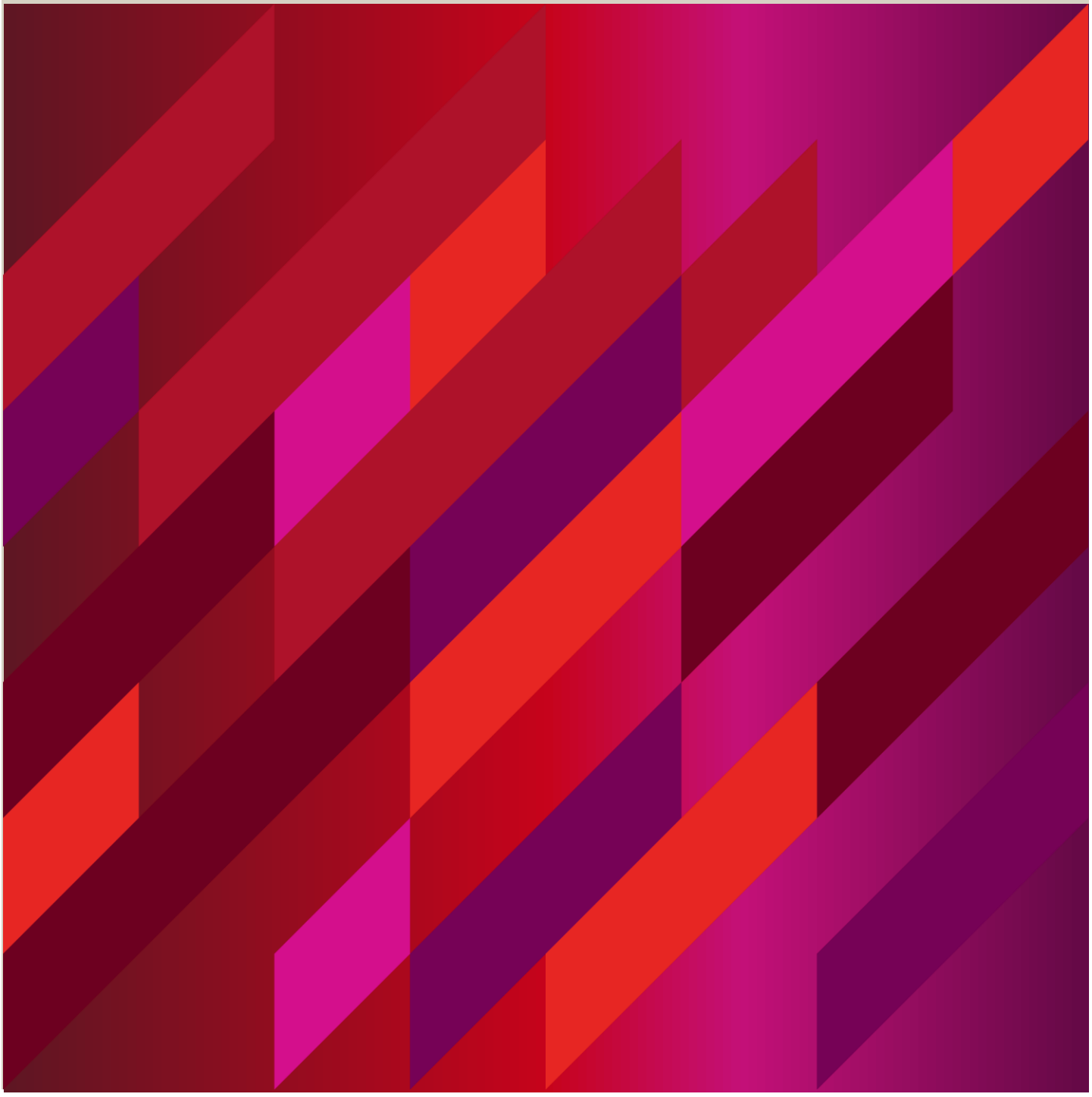
Review of the first 1000 claims in the new 2017 CTP Scheme: Final report

July 2020



Review of the first 1000 claims in the new 2017 CTP Scheme: Final report

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Australian Institute of Health Innovation | Macquarie University

July 2020

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Abbreviations

AIHI	Australian Institute of Health Innovation
CT	Computerised Tomography
CTP	Compulsory Third Party
JWCRR	John Walsh Centre for Rehabilitation Research
MRI	Magnetic Resonance Imaging
NSW	New South Wales
SIRA	State Insurance Regulatory Agency

Executive summary

One of the leading causes of injury-related hospitalisations in New South Wales (NSW) are injuries sustained in motor vehicle incidents. These injuries can lead to poor long-term health outcomes, have long recovery times, and can require substantial time off work. On 1st December 2017, the State Insurance Regulatory Authority (SIRA) launched a new compulsory third party (CTP) hybrid no-fault insurance scheme. The new scheme focuses on early intervention, reducing the length of time to resolve claims, and increasing the proportion of benefits to the most severely injured.

To evaluate the impact of the changes of new CTP scheme on injured people, SIRA initiated a project to review the first 1,000 new CTP claims made from 1st December 2017, investigating: (1) Minor injury determination; (2) Treatment; (3) Return-to-work; (4) Outcomes; and (5) Internal reviews and disputes.

This project reviewed claims at four insurers (i.e. Allianz, IAG, QBE, and Suncorp) at five time points during a 24-month follow-up period by researchers at the Australian Institute of Health Innovation (AIHI), Macquarie University, and the John Walsh Centre for Rehabilitation Research (JWCRR), University of Sydney. Each institution was randomly allocated 500 claims to review. This final report summarises the methods and results from all data collection points conducted by the AIHI.

Of the 500 claims that were allocated to AIHI, 478 were included in this final report. Twelve claims were excluded due to transferring to other insurers, no data system access to claim files, or duplicate claims; and ten claims were excluded because the state where the crash occurred was outside NSW.

At 13 weeks post-claim lodgement, minor injuries and non-minor injuries accounted for 55.4% and 24.5% of claims reviewed, respectively. Minor injury is defined as soft tissue (e.g. muscle, tendon, ligament, fat, fascia, blood vessels, and cartilage) injury or psychological injury not recognised as psychiatric illness. The proportion of claims without a minor injury determination declined during the follow-up period. At 24 months post-crash, minor injuries and non-minor injuries accounted for 59.6% and 33.9% of claims reviewed, respectively.

At 13 weeks post-claim lodgement, treatments paid for or approved by the insurer were identified for 74.9% of claims reviewed. The proportion of claims that had treatments

paid for or approved by the insurer declined during the follow-up period to 55.7% at 26 weeks post-crash, 35.6% at 12 months post-crash, 14.2% at 18 months post-crash, and 12.6% at 24 months post-crash. Treatments paid for or approved by the insurer was far less common for minor injury claims than non-minor injury claims at all data collection time points. The most common types of treatment paid for or approved by the insurer were physiotherapy treatments, general practitioner consultations, and medical specialist consultations.

Of the 297 claimants who were employed prior to being injured, 66.3% reported taking time off work by 13 weeks post-claim lodgement. The proportion of claimants who took time off work declined during the follow-up period to 16.2% at 26 weeks post-crash, 14.5% at 12 months post-crash, 9.1% at 18 months post-crash, and 6.1% at 24 months post-crash. Time off work was less common among claimants with minor injury than among claimants with non-minor injury at all data collection time points.

During the follow-up period, internal review of treatment was identified for 46 (9.6%) claims, dispute regarding minor injury determination was identified for 70 (14.6%) claims, and involvement of Dispute Resolution Services was identified for 49 (10.3%) claims. Of the 70 claims with a dispute regarding minor injury determination at any time point during the follow-up period, 14 (20.0%) had the decision overturned. Of the 49 claims that involved Dispute Resolution Services, 17 (34.7%) had the decision overturned.

The results described in this report suggest that minor injury determination is settled early for the majority of claims. Treatments paid for or approved by the insurer were less common for minor injury claims than non-minor injury claims at all data collection time points, which suggests that the most severely injured received a greater proportion of benefits. Time off work beyond 26 weeks post-crash was infrequent among claimants with minor injury, which suggests that the majority of minor injury claimants experience adequate recovery. About 1 in 7 claims involved a dispute regarding minor injury determination, of which 20% had the decision overturned. This suggests that although the majority of claims are initially assigned an appropriate minor injury determination, the severity of injury may be underestimated for a small proportion of claimants.

1. Introduction

Injuries arising from motor vehicle crashes have been associated with poor long-term health and decreased quality of life [1-6]. Recovery from motor vehicle crash injuries can be slow, with follow-up studies finding a substantial proportion of injuries are not resolved up to six years later [1, 3, 4]. An additional consequence of motor vehicle crash injuries is loss of earnings due to time off work [6, 7].

Compensation processes and schemes have been found to impact upon health outcomes and recovery following an injury sustained in motor vehicle crash [6]. One particular factor in the compensation process which may be associated with improved recovery is early intervention [5]. Given the poor long-term outcomes associated with injuries arising from motor vehicle crashes, compensation schemes need to optimise recovery.

On 1st December 2017, as part of the Motor Injuries Act 2017 (NSW), the State Insurance Regulatory Authority (SIRA) launched a new compulsory third party (CTP) hybrid no-fault insurance scheme. The new scheme was established in response to concerns over long claims processes which often took between three to five years to resolve, and the increasing cost of premiums [8]. The new scheme aims to improve the timeliness of benefits, increase the proportion of benefits for injured people, and improve CTP affordability [9].

To support the new scheme, SIRA developed a project to review CTP claims made under the new scheme from 1st December 2017, to evaluate the impact of the changes on injured people. The objectives of this project are to:

(1) Establish that insurers are proactively managing claims with a focus on early and appropriate treatment and care to achieve optimum recovery from injuries sustained in motor accidents and maximise their return-to-work or other activities;

(2) Monitor the soft tissue injury threshold of minor injury;

(3) Monitor the minor psychological injury threshold of minor injury;

(4) Provide an evidence base to inform future enhancements for data collection; and

(5) Provide an independent review of the operation of the new scheme with a focus on the operation of the minor injury threshold to achieve the objectives of the Act.

2. Methods

The first 1,000 sequential claims lodged from 1st December 2017 under the new CTP scheme through four insurers (i.e. Allianz, IAG, QBE, and Suncorp) were reviewed by researchers at the Australian Institute of Health Innovation (AIHI), Macquarie University, and the John Walsh Centre for Rehabilitation Research (JWCRR), University of Sydney. Each institution was randomly allocated 500 claims by SIRA.

To monitor the new CTP scheme, this project involves reviewing the same 500 claims at five time points: at 13 weeks post-claim lodgement, and at 26 weeks, 12 months, 18 months, and 24 months post-crash. Previous progress reports have described the main findings from the first four data collection points [10-12]. This final report summarises the methods and results from all data collection points conducted by the AIHI.

2.1. Sample

Of the 500 CTP claims provided by SIRA to the AIHI, 168 were from IAG (33.6%), 160 were from Suncorp (32.0%), 96 were from Allianz (19.2%), and 76 were from QBE (15.2%). Twenty-two of the allocated claims were excluded from the analysis: four claims had been transferred to another insurer (Allianz: n=1; IAG: n=1; QBE: n=2); two claims were duplicates (Allianz: n=1; Suncorp: n=1); six Suncorp claims were not able to be accessed by AIHI researchers due to security/IT restrictions; and ten claims involved a crash occurring outside of NSW (Suncorp: n=6; QBE: n=3; Allianz: n=1). Hence, a total sample of 478 claims were analysed for this final report.

2.2. Data collection

AIHI researchers reviewed and collected 13 weeks post-claim lodgement and 26 weeks post-crash data from June 2018 to July 2018; 12 months post-crash data from December 2018 to February 2019; 18 month post-crash data from July 2019 to September 2019; and 24 months post-crash data from January 2020 to February 2020. Data were collected using a tool developed in Microsoft Excel™ 2016, which

was previously tested in a pilot study for this project and found to have good reliability between AIHI and JWCRR data collectors (72.5%) [13]. The data tool consisted of mainly standardised response options, but also included some open-ended questions, which were coded into categories following data collection. After completing the 24 months post-crash data collection, the datasets for each time point were linked by claim number. To monitor the progress of the new CTP scheme, data relating to five areas was collected: (1) Minor injury determination; (2) Treatment; (3) Return-to-work; (4) Outcomes; and (5) Internal reviews and disputes.

3. Results

3.1. Characteristics of the sample

Of the 478 claims reviewed, more than half (54.2%) of claimants were female, and almost 2 in 3 (62.1%) claimants were employed in some capacity (i.e. full-time, part-time, or casual) prior to the claim (Table 3.1). Two in five (41.0%) claimants were aged between 25 to 44 years.

Table 3.1: Characteristics of individuals who lodged a CTP claim from 1st December 2017 (n=478)

	n	%
Sex:		
Female	259	54.2
Male	219	45.8
Age group:		
14 years or less	20	4.2
15-24 years	67	14.0
25-34 years	107	22.4
35-44 years	89	18.6
45-54 years	79	16.5
55-64 years	67	14.0
65 years or older	49	10.3
Employment status prior to injury claim:		
Full-time	218	45.6
Part-time	45	9.4
Casual	34	7.1
Not working	100	20.9
Not recorded	81	17.0
Insurer:		
Allianz	93	19.5
IAG	167	34.9
QBE	71	14.9
Suncorp	147	30.8

3.2. Main findings by data collection time point

Minor injury determination

At 13 weeks post-claim lodgement, minor injuries and non-minor injuries accounted for 265 (55.4%) and 117 (24.5%) of the 478 claims reviewed, respectively. Minor injury determination was not recorded for 86 (18.0%) claims, while 10 (2.1%) were recorded as too early to assess. The frequency and proportion of claims without a minor injury determination declined at subsequent data collection points. At 24 months post-crash, minor injuries and non-minor injuries accounted for 59.6% and 33.9% of claims reviewed, respectively. Of the 285 claims determined to be minor injury at 24 months post-crash, 282 (98.9%) were physical/soft tissue injuries and 3 (1.1%) were psychological injuries.

Table 3.2: Minor injury determination of CTP claims from 1st December 2017 by data collection time point (n=478)

	13 weeks post-claim lodgement		26 weeks post-crash		12 months post-crash		18 months post-crash		24 months post-crash	
	n	%	n	%	n	%	n	%	n	%
Minor injury:	265	55.4	258	54.0	287	60.0	294	61.5	285	59.6
Physical	*235*	*49.2*	*231*	*48.3*	*273*	*57.1*	*288*	*60.3*	*282*	*59.0*
Psychological	*6*	*1.3*	*4*	*0.8*	*3*	*0.6*	*2*	*0.4*	*3*	*0.6*
Both physical and psychological	*24*	*5.0*	*23*	*4.8*	*11*	*2.3*	*4*	*0.8*	-	-
Non-minor injury	117	24.5	120	25.1	156	32.6	164	34.3	162	33.9
Too early to assess	10	2.1	4	0.4	5	1.1	11	2.3	21	4.4
Not recorded	86	18.0	96	20.1	30	6.3	9	1.9	10	2.1

Treatment

At 13 weeks post-claim lodgement, one or more treatments paid for or approved by the insurer were identified for 358 (74.9%) claims. The number of claims that had one or more treatments paid for or approved by the insurer was reduced to 266 (55.7%) at 26 weeks post-crash, 170 (35.6%) at 12 months post-crash, 68 (14.2%) at 18 months post-crash, and 60 (12.6%) at 24 months post-crash. The most common types of treatment paid for or approved by the insurer were physiotherapy treatments, general practitioner consultations, and medical specialist consultations. Physiotherapy

treatments was paid for or approved by the insurer for 241 (50.4%) claims at 13 weeks post-claim lodgement, 191 (40.0%) claims at 26 weeks post-crash, 123 (25.7%) claims at 12 months post-crash, 40 (8.4%) at 18 months post-crash, and 34 (7.1) at 24 months post-crash. General practitioner consultation was paid for or approved by the insurer for 203 (42.5%) claims at 13 weeks post-claim lodgement, 121 (25.3%) claims at 26 weeks post-crash, 60 (12.6%) claims at 12 months post-crash, 22 (4.6%) at 18 months post-crash, and 36 (7.5) at 24 months post-crash. Medical specialist consultation was paid for or approved by the insurer for 77 (16.1%) claims at 13 weeks post-claim lodgement, 58 (12.1%) claims at 26 weeks post-crash, 46 (9.6%) claims at 12 months post-crash, 39 (8.2%) at 18 months post-crash, and 30 (6.3) at 24 months post-crash. Table 3.1 provides an overview of treatments paid for or approved by the insurer by data collection time point.

Table 3.3: Treatment paid for or approved by insurer of CTP claims from 1st December 2017 by data collection time point (n=478)[1,2]

	13 weeks post-claim lodgement		26 weeks post-crash		12 months post-crash		18 months post-crash		24 months post-crash	
	n	%	n	%	n	%	n	%	n	%
Treatment paid for or approved by insurer	358	74.9	266	55.7	170	35.6	68	14.2	60	12.6
Type of treatment paid for or approved by insurer[3]:										
Physiotherapist	241	50.4	191	40.0	123	25.7	40	8.4	34	7.1
General practitioner	203	42.5	121	25.3	60	12.6	22	4.6	36	7.5
Medical specialist	77	16.1	58	12.1	46	9.6	39	8.2	30	6.3
Occupational therapist	66	13.8	37	7.7	8	1.7	1	0.2	-	-
Psychologist	25	5.2	42	8.8	36	7.5	22	4.6	17	3.6
Pharmaceuticals	17	16.5	41	8.6	29	6.1	14	2.9	14	2.9
Chiropractor	15	3.1	11	2.3	4	0.8	-	-	1	0.2
Massage therapist	9	1.9	3	0.6	1	0.2	-	-	-	-
Other	8	1.7	9	1.9	4	0.8	3	0.6	1	0.2

[1] Data were collected based on payment invoices saved by insurer records.

[2] More than one type of treatment could be paid for or approved by insurer by each claimant.

[3] Percentages may add up to more than 100.0% because individual claims may have more than one type of treatment paid for or approved by insurer.

Return-to-work

Of the 478 claims reviewed, 297 (62.1%) were from claimants that were employed prior to injury, including 218 (73.4%) full-time workers, 45 (15.2%) part-time workers, and 34 (11.5%) casual workers. Of the 297 claimants who were employed prior to being injured, 197 (66.3%) reported taking time off work at 13 weeks post-claim lodgement, 48 (16.2%) reported taking time off work at 26 weeks post-crash, 43 (14.5%) reported taking time off work at 12 months post-crash, 27 (9.1%) reported taking time off work at 18 months post-crash, and 18 (6.1%) reported taking time off work at 24 months post-crash. Certificate of fitness forms were identified for 81 (30.61%) claims at 13 weeks post-claim lodgement, 55 (18.5%) at 26 weeks post-crash, 32 (10.8%) at 12 months post-crash, 27 (9.1%) at 18 months post-crash, and 21 (7.1%) at 24 months post-crash. Very few claims records reported that claimants were accessing vocational programs to support return-to-work (i.e. n=1 at 13 weeks post-claim lodgement, n=1 at 26 weeks post-crash, n=2 at 12 months post-crash, n=6 at 18 months post-crash, and 3 at 24 months post-crash. Table 3.2 provides an overview of return-to-work status by data collection time point.

Table 3.4: Return-to-work of CTP claims from 1st December 2017 by data collection time point (n=297)[1]

	13 weeks post-claim lodgement		26 weeks post-crash		12 months post-crash		18 months post-crash		24 months post-crash	
	n	%	n	%	n	%	n	%	n	%
Claimant took time off work due to injury	197	66.3	48	16.2	43	14.5	27	9.1	18	6.1
Capacity for work:										
Fit for pre-injury work	14	4.7	7	2.4	7	2.4	6	2.0	2	0.7
Capacity for some type of work	46	15.5	28	9.4	12	4.0	9	3.0	7	2.4
No capacity for any work	31	10.4	20	6.7	13	4.4	12	4.0	12	4.0
Not known	206	69.4	242	81.5	265	89.2	270	90.9	276	92.9
Vocational programs used for return-to-work	1	0.3	1	0.3	2	0.7	6	2.0	3	1.0

[1] Only claims where claimants were employed prior to injury are included in table.

Outcomes

Treatment had not ceased for 266 (55.7%) claims at 13 weeks post-claim lodgement, 135 (28.2%) claims at 26 weeks post-crash, 105 (22.0%) claims at 12 months post-crash, 94 (19.7%) claims at 18 months post-crash, and 69 (14.4%) claims at 24 months post-crash. Received benefits had not ceased for 317 (66.3%) claims at 13 weeks post-claim lodgement, 179 (37.5%) claims at 26 weeks post-crash, 118 (24.7%) claims at 12 months post-crash, 104 (21.8%) claims at 18 months post-crash, and 90 (18.8%) claims at 24 months post-crash. Payment of statutory benefits beyond 26 weeks post-crash was accepted for 129 (27.0%) claims at 12 months post-crash, 117 (24.5%) claims at 18 months post-crash, and 110 (23.0%) claims at 24 months post-crash. Table 3.3 provides an overview of outcomes by data collection time point.

Table 3.5: Outcomes of CTP claims from 1st December 2017 by data collection time point (n=478)

	13 weeks post-claim lodgement		26 weeks post-crash		12 months post-crash		18 months post-crash		24 months post-crash	
	n	%	n	%	n	%	n	%	n	%
Ceased treatment:										
No	266	55.7	135	28.2	105	22.0	94	19.7	69	14.4
Yes	37	7.7	133	27.8	319	66.7	379	79.3	408	85.4
Not known	175	36.6	210	43.9	54	11.3	5	1.1	1	0.2
Ceased receiving benefits:										
No	317	66.3	179	37.5	118	24.7	104	21.8	90	18.8
Yes – Liability declined due to insufficient support	22	4.6	31	6.5	8	1.7	7	1.5	22	4.6
Yes – Liability after 26 weeks completed	-	-	-	-	28	5.9	23	4.8	30	6.3
Yes – Liability up to 26 weeks completed	16	3.4	182	38.1	307	64.2	342	71.6	335	70.1
Not known	3	0.6	5	1.1	17	3.6	2	0.4	1	0.2
Payment of statutory benefits approved >26 weeks post-crash:										
Yes - Accepted	-	-	-	-	129	27.0	117	24.5	110	23.0
No - Rejected	-	-	-	-	334	69.9	360	75.3	365	76.4
Outcome not yet determined	-	-	-	-	15	3.2	1	0.2	3	0.6

Internal reviews and disputes

An internal review of treatment was identified for 10 (2.1%) claims at 13 weeks post-claim lodgement, 20 (4.2%) claims at 26 post-crash, 8 (1.7%) claims at 12 months post-crash, 7 (1.5%) claims at 18 months post-crash, and 10 (2.1%) at 24 months post-crash.I Internal reviews of treatment at any time point during the follow-up period were identified for a total of 46 (9.6%) claims. Table 3.6 provides an overview of internal reviews and disputes by data collection time point.

Disputes regarding the determination of minor injury were identified for 8 (1.7%) claims at 13 weeks post-claim lodgement, 45 (9.4%) claims at 26 post-crash, 21 (4.4%) claims at 12 months post-crash, 20 (4.2%) claims at 18 months post-crash, and 12 (2.5%) claims at 24 months post-crash. Disputes regarding minor injury determinations at any time during the follow-up period were identified for a total of 70 (14.6%) claims. Of the 70 claims with a dispute regarding minor injury determination during the follow-up period, 14 (20.0%) claims recorded the original decision being overturned. For the 14 claims where the minor injury determination was overturned, the minor injury determination status recorded at 13 weeks post-claim lodgement were: 6 (42.9%) physical injuries only, 3 (21.4%) non-minor injury, 2 (14.3%) both physical and psychological injuries, 1 (7.1%) psychological injury only, 1 (7.1%) too early to assess, and 1 (7.1%) where the type of injury was not recorded.

Dispute Resolution Services were involved for 22 (4.6%) claims at 12 months post-crash, 39 (8.2%) claims at 18 months post-crash, and 31 (6.5%) claims at 24 months post-crash.I Involvement of Dispute Resolution Services at any time point during the follow-up period were identified for a total of 49 (10.3%) claims. Of the 49 claims with involvement of Dispute Resolution Services at any time point during the follow-up period, 17 (34.7%) claims recorded the original decision being overturned. For the 17 claims with involvement of Dispute Resolution Services where the minor injury determination was overturned, the minor injury determination status recorded at 13 weeks post-claim lodgement were: 10 (58.8%) physical injuries only, 3 (17.7%) both physical and psychological injuries, 2 (11.8%) non-minor injury, and 2 (11.8%) where the type of injury was not recorded.

Table 3.6: Internal reviews and disputes of CTP claims from 1st December 2017 by data collection time point (n=478)

	13 weeks post-claim lodgement		26 weeks post-crash		12 months post-crash		18 months post-crash		24 months post-crash	
	n	%	n	%	n	%	n	%	n	%
Internal review about treatment	10	2.1	20	4.2	8	1.7	7	1.5	10	2.1
Minor injury determination dispute	8	1.7	45	9.4	21	4.4	20	4.2	12	2.5
Minor injury determination dispute outcome:										
Upheld	4	50.0	31	68.9	18	85.7	17	85.0	12	100.0
Overturned	2	25.0	6	13.3	3	14.3	3	15.0	-	-
Decision pending	2	25.0	8	17.8	-	-	-	-	-	-
Dispute Resolution Services	-	-	-	-	22	4.6	39	8.2	31	6.5
Dispute Resolution Services outcome:										
Upheld	-	-	-	-	13	59.1	21	53.9	15	48.4
Overturned	-	-	-	-	7	31.8	13	33.3	10	32.3
Decision pending	-	-	-	-	1	4.6	4	10.3	6	19.4
No dispute	-	-	-	-	1	4.6	1	2.6	-	-

3.3. Main findings by minor injury determination

Minor injury determination

At 24 months post-crash, minor injuries accounted for 285 (59.6%) of the 478 claims reviewed, while 162 (33.9%) were non-minor injuries. Of the minor injuries, 282 (98.9%) were physical/soft tissue injuries and 3 (0.7%) were psychological injuries.

Treatment

Of the 285 minor injury claims, 67 (23.5%) claimants had one or more treatments paid for or approved by the insurer during the period from 26 weeks post-crash to 12 months post-crash, 7 (2.5%) claimants had one or more had treatments paid for or approved by the insurer during the period from 12 months post-crash to 18 months post-crash, and 4 (1.4%) claimants had one or more had treatments paid for or approved by the insurer during the period from 18 months post-crash to 24 months post-crash.

For minor injury claims, the most common types of treatment paid for or approved by the insurer at 12 months post-crash were physiotherapy treatments (n=52; 18.3%) and general practitioner consultations (n=25; 8.8%). The most common types of treatment paid for or approved by the insurer at 18 months post-crash were general practitioner consultations (n=4; 1.4%), pharmaceuticals (n=4; 1.4%), and medical specialist consultations (n=3; 1.1%). The most common type of treatment paid for or approved by the insurer at 24 months post-crash was general practitioner consultations (n=4; 1.4%).

Of the 162 non-minor injury claims, 102 (63.0%) claimants had one or more had treatments paid for or approved by the insurer during the period from 26 weeks post-crash to 12 months post-crash, 61 (37.7%) claimants had one or more treatments paid for or approved by the insurer during the period from 12 months post-crash to 18 months post-crash, and 56 (34.6%) claimants had one or more had treatments paid for or approved by the insurer during the period from 18 months post-crash to 24 months post-crash.

For non-minor injury claims, the most common types of treatment paid for or approved by the insurer at 12 months post-crash were physiotherapy treatments (n=71; 43.8%), medical specialist consultations (n=38; 23.5%), and general practitioner consultations (n=35; 21.6%). The most common types of treatment paid for or approved by the insurer at 18 months post-crash were physiotherapy treatments (n=40; 24.7%), medical specialist consultations (n=36; 22.2%), and psychology consultations (n=20; 12.4%). The most common types of treatment paid for or approved by the insurer at 24 months post-crash were physiotherapy treatments (n=33; 20.4%), general practitioner consultations (n=32; 19.8%), and medical specialist consultations (n=29; 17.9%). Table 3.7 provides an overview of treatments paid for or approved by the insurer by minor injury determination at 24 months post-crash.

Table 3.7: Treatment paid for or approved by insurer by minor injury determination at 24 months post-crash[1,2,3]

	Minor injury (n=285)		Non-minor injury (n=162)	
	n	%	n	%
Treatment paid for or approved by insurer:				
At 12 months post-crash	67	23.5	102	63.0
At 18 months post-crash	7	2.5	61	37.7
At 24 months post-crash	4	1.4	56	34.6

[1] Claims without recorded minor injury determination at 24 months post-crash were excluded.

[2] Data was collected based on payment invoices saved by insurer records.

[3] More than one type of treatment could be paid for or approved by insurer by each claimant.

Return-to-work

Of the claimants that were employed prior to the crash and had a minor injury determination recorded at 24 months post-crash, 187 claimants had minor injury and 106 claimants had non-minor injury. Of the 187 claimants with minor injury, 11 (5.9%) took time off work during the period from 26 weeks post-crash to 12 months post-crash, 2 (1.1%) took time off work during the period from 12 months post-crash to 18 months post-crash, and none took time off work during the period from 18 months post-crash to 24 months post-crash. Of the 106 claimants with non-minor injury, 32 (58.5%) took time off work during the period from 26 weeks post-crash to 12 months post-crash, 25 (23.6%) took time off work during the period from 12 months post-crash to 18 months post-crash, and 18 (17.0%) took time off work during the period from 18 months post-crash to 24 months post-crash.

None of the minor injury claim records reported that claimants accessed vocational programs to support return-to-work during the period from 26 weeks post-crash to 24 months post-crash. Of the 106 claimants with non-minor injury, 2 (1.9%) claim records reported the claimant accessed vocational programs to support return-to-work during the period from 26 weeks post-crash to 12 months post-crash, 6 (5.7%) claim records reported the claimant accessed vocational programs to support return-to-work during the period from 12 months post-crash to 18 months post-crash, and 3 (2.8%) claim records reported the claimant accessed vocational programs to support return-to-work during the period from 18 months post-crash to 24 months post-crash.

Outcomes

Of the 285 minor injury claims, treatment had not ceased for 6 (2.1%) claims and payment of statutory benefits beyond 26 weeks post-crash were approved for 3 (1.1%) claims at 24 months post-crash. Of the 3 minor injury claims that were accepted to receive payment of statutory benefits beyond 26 weeks post-crash, the reasons identified in the record were: 1 (33.3%) because treatment will improve the recovery of the injured person, and for 2 (66.6%) claimants the reason was not identified. Of the 162 non-minor injury claims, treatment had not ceased for 63 (38.9%) claims and payment of statutory benefits beyond 26 weeks post-crash were approved for 107 (66.0%) claims at 24 months post-crash. For all non-minor injury claims that were accepted to receive payment of statutory benefits beyond 26 weeks post-crash, the reason identified was because they were non-minor injuries. It is important to note that in general there is no entitlement for treatment beyond 26 weeks post-crash for claimants that are deemed at-fault in the crash. Table 3.8 provides an overview of outcomes at 12, 18, and 24 months post-crash by minor injury determination at 24 months post-crash.

Table 3.8: Outcomes at 12, 18, and 24 months post-crash by minor injury determination at 24 months post-crash[1]

	Minor injury (n=285)		Non-minor injury (n=162)	
	n	%	n	%
Not ceased treatment:				
At 12 months post-crash	22	7.2	79	48.8
At 18 months post-crash	20	7.0	73	45.1
At 24 months post-crash	6	2.1	63	38.9
Not ceased receiving benefits:				
At 12 months post-crash	17	6.0	98	60.5
At 18 months post-crash	17	6.0	85	52.5
At 24 months post-crash	7	2.5	83	51.2
Payment of statutory benefits approved >26 weeks post-crash:				
At 12 months post-crash	15	5.3	114	70.4
At 18 months post-crash	8	2.8	108	66.7
At 24 months post-crash	3	1.1	107	66.0

[1] Claims without recorded minor injury determination at 24 months post-crash were excluded.

Internal reviews and disputes

Table 3.9 provides an overview of internal reviews and disputes by minor injury determination. Of the 285 minor injury claims, internal reviews of treatment were identified for 21 (7.4%) claims during the period from 12 months post-crash to 24 months post-crash. Dispute about minor injury determination was identified for 42 (14.7%) claims, of which the minor injury determination was overturned for 5 (11.9%) claims. Dispute Resolution Services were involved for 32 (11.2%) claims, of which the decision was overturned for 5 (15.6%) claims. Of the 162 non-minor injury claims, internal review for treatment was identified for 25 (15.4%) claims during the period from 12 months post-crash to 24 months post-crash. Dispute regarding minor injury determination was identified for 25 (16.1%) claims, of which the minor injury determination was overturned for 9 (34.6%) claims. Dispute Resolution Services were involved in 17 (10.5%) claims, of which the decision was overturned for 12 (70.6%) claims.

Table 3.9: Internal reviews and disputes during the period from 12 months post-crash to 24 months post-crash by minor injury determination[1]

	Minor injury (n=285)		Non-minor injury (n=162)	
	n	%	n	%
Internal review about treatment	21	7.4	25	15.4
Minor injury determination dispute	42	14.7	26	16.1
Minor injury determination dispute outcome:				
Overturned	5	11.9	9	34.6
Dispute Resolution Services	32	11.2	17	10.5
Dispute Resolution Services outcome:				
Overturned	5	15.6	12	70.6

[1] Claims without recorded minor injury determination at 24 months post-crash were excluded.

3.4. Minor injury, treatment, and return-to-work

Minor injury claims that require treatment beyond 26 weeks post-crash

At 12 months post-crash, there were 70 minor injury claims that had treatments paid for or approved by the insurer beyond 26 weeks post-crash. Of the 70 claims, 64 (91.4%) were for physical injuries, 1 (1.4%) was for psychological injury, and 5 (7.1%)

were for both physical and psychological injuries. The most common types of treatment were physiotherapy services (n=53; 75.7%) and general practitioner consultations (n=29; 41.4%). In regard to the treatments continuing beyond 26 weeks post-crash, 15 (21.4%) claims were because there was a delay in approval for treatment and care expenses by the insurer, 6 (8.6%) claims were because treatment would improve return to work and/or usual activities, and 4 (5.7%) claims were because treatment would improve recovery.

At 18 months post-crash, there were 3 minor injury claims that had treatments paid for or approved by the insurer beyond 12 months post-crash. All 3 (100.0%) claims were for physical injuries. The treatments approved or paid for by the insurer were general practitioner consultations (n=3; 100.0%), medical specialist consultations (n=2; 66.7%), psychologist services (n=2; 66.7%), and physiotherapy treatments (n=1; 33.3%).

At 24 months post-crash, there were 4 minor injury claims that had treatments paid for or approved by the insurer beyond 18 months post-crash. All 4 (100.0%) claims were for physical injuries. The treatments approved or paid for by the insurer were general practitioner consultations (n=4; 100.0%), medical specialist consultations (n=1; 25.0%), physiotherapy treatments (n=1; 25.0%), and pharmaceuticals (n=1; 25.0%).

Table 3.10 provides an overview of the characteristics of minor injury claims that had treatments paid for approved by the insurer beyond 26 weeks post-crash, beyond 12 months post-crash, and beyond 18 months post-crash.

Table 3.10: Characteristics of minor injury claims that had treatments paid for or approved by the insurer beyond 26 weeks post-crash (n=70), beyond 12 months post-crash (n=3), and beyond 18 months post-crash (n=4)

	Beyond 26 weeks post-crash (n=70)		Beyond 12 months post-crash (n=3)		Beyond 18 months post-crash (n=4)	
	n	%	n	%	n	%
Claimant characteristics						
Sex:						
Female	46	65.7	1	33.3	2	50.0
Male	24	34.3	2	66.7	2	50.0
Age group:						
14 years or younger	2	2.9	-	-	-	-
15–24 years	4	5.7	-	-	1	25.0
25–34 years	19	27.1	-	-	-	-
35–44 years	12	17.1	1	33.3	1	25.0
45–54 years	17	24.3	1	33.3	2	50.0
55–64 years	11	15.7	-	-	-	-
65 years or older	5	7.1	1	33.3	-	-
Employment status prior to injury claim:						
Full-time	32	45.7	1	33.3	3	75.0
Part-time	10	14.3	-	-	-	-
Casual	5	7.1	-	-	-	-
Not working	15	21.4	1	33.3	1	25.0
Not recorded	8	11.4	1	33.3	-	-
Minor injury						
Minor injury type:						
Physical	64	91.4	3	100.0	4	100.0
Psychological	1	1.4	-	-	-	-
Both physical and psychological	5	7.1	-	-	-	-
Treatment						
Treatments paid for or approved by insurer[1]:						
Physiotherapist	53	75.7	1	33.3	1	25.0
General practitioner	29	41.4	3	100.0	4	100.0
Pharmaceuticals	6	8.6	-	-	1	25.0
Medical specialist	6	8.6	2	66.7	1	25.0
Occupational therapist	1	1.4	-	-	-	-
Psychologist	8	11.4	2	66.7	-	-
Chiropractor	3	4.3	-	-	-	-
Other	1	1.4	-	-	-	-
Purpose of treatment:						
Treatment not approved beyond 26 weeks	36	51.4	2	66.7	2	50.0
Insurer delayed approval for treatment and care expenses	15	21.4	-	-	1	25.0
Treatment will improve return to work and/or usual activities	6	8.6	-	-	-	-
Treatment will improve recovery	4	5.7	-	-	-	-
Not minor injury	2	2.9	1	33.3	-	-
Not recorded	7	10.0	-	-	1	25.0

[1] Percentages may add up to more than 100.0% because individual claims may have more than one type of treatment paid for or approved by insurer.

Medical imaging use beyond 26 weeks post-crash

Of the 478 claims reviewed, 23 (4.8%) claims were identified to have had medical imaging paid for by the insurer during the period from 26 weeks post-crash to 18 months post-crash. Of the 23 claims, 12 (52.2%) were for magnetic resonance imaging (MRI), 6 (26.1%) were for X-rays, and 5 (21.7%) were for computerised tomography (CT) scans. Of the 23 claims, 11 (47.8%) were for investigative purposes, 8 (34.8%) were to direct treatment, 2 (8.7%) were to assist diagnosis, and 2 (8.7%) were for unspecified reasons. Of the 23 claims that had medical imaging paid for by the insurer during the period 26 weeks post-crash to 18 months post-crash, 21 (91.3%) were requested by medical specialists and 2 (8.7%) were requested by general practitioners. Table 3.11 provides an overview of medical imaging use by minor injury determination.

Table 3.11: Medical imaging paid for by the insurer during the period from 26 weeks post-crash to 18 months post-crash by minor injury determination[1]

	Minor injury (n=285)		Non-minor injury (n=162)	
	n	%	n	%
Had any imaging:				
Yes	4	0.7	19	11.7
No	281	99.3	143	88.3
Type of imaging:				
Magnetic Resonance Imaging (MRI)	2	50.0	10	52.6
X-ray	-	-	6	31.6
Computerised Tomography (CT)	2	50.0	3	15.8
Purpose of imaging:				
Investigative	-	-	11	57.9
Direct treatment	2	50.0	6	31.6
Assist diagnosis	-	-	2	10.5
Other	2	50.0	-	-
Imaging requested by:				
Medical specialist	4	100.0	17	89.5
General practitioner	-	-	2	10.5

[1] Claims without recorded minor injury determination at 24 months post-crash were excluded.

Claimants with no capacity for work

Of the 296 claimants that were employed prior to injury, a certificate of fitness was located on the claim record for 54 (18.2%) claims at 26 weeks post-crash, 32 (10.8%)

claims at 12 months post-crash, 27 (9.1%) claims at 18 months post-crash, and 21 (7.1%) claim at 24 months post-crash.

Of the 54 claims that had a certificate of fitness on the claim record at 26 weeks post-crash, 7 (13.0%) were fit for pre-injury work, 27 (50.0%) had capacity for some type of work, and 20 (37.0%) had no capacity for work. Claimants across the three groups of work fitness status at 26 weeks post-crash did not differ significantly by sex (χ^2=0.79, df=2, p=0.737), age group (χ^2=7.47, df=10, p=0.757), or insurer (χ^2=9.73, df=6, p=0.110).

Of the 32 claims that had a certificate of fitness on the claim record at 12 months post-crash, 7 (21.9%) were fit for pre-injury work, 12 (37.5%) had capacity for some type of work, and 13 (40.6%) had no capacity for work. Claimants across the three groups of work fitness status at 12 months post-crash did not differ significantly by sex (χ^2=0.30, df=2, p=0.896), age group (χ^2=9.22, df=12, p=0.803), or insurer (χ^2=5.18, df=6, p=0.580).

Of the 27 claims that had a certificate of fitness on the claim record at 18 months post-crash, 6 (22.2%) were fit for pre-injury work, 9 (33.3%) had capacity for some type of work, and 12 (44.4%) had no capacity for work. Claimants across the three groups of work fitness status at 18 months post-crash did not differ significantly by sex (χ^2=0.88, df=2, p=0.867), age group (χ^2=8.77, df=10, p=0.521), or insurer (χ^2=1.33, df=6, p=0.977).

Of the 21 claims that had a certificate of fitness on the claim record at 24 months post-crash, 2 (9.5%) were fit for pre-injury work, 7 (33.3%) had capacity for some type of work, and 12 (57.1%) had no capacity for work. Claimants across the three groups of work fitness status at 24 months post-crash did not differ significantly by sex (χ^2=0.93, df=2, p=1.000), age group (χ^2=9.68, df=10, p=0.605), or insurer (χ^2=5.44, df=6, p=0.7619).

4. Discussion and conclusion

This report presents the findings from claim record reviews conducted at five time points during a 24-month follow-up period of CTP claims filed under the new CTP hybrid no-fault insurance scheme. The new scheme focuses on early intervention, reducing the length of time to resolve claims, and increasing the proportion of benefits to the most severely injured. The findings of this report provide insight into the impact of the new CTP scheme.

The proportion of claims without a minor injury determination declined during over the follow-up period. At 13 weeks post-claim lodgement, 55.4% of claims reviewed were determined to be minor injuries and 24.5% were non-minor injuries, while at 24 months post-crash, 59.6% of claims reviewed were determined to be minor injuries and 33.9% were non-minor injuries.

The proportion of claims that had treatments paid for or approved by the insurer declined during the follow-up period. Treatments paid for or approved by the insurer were less common for minor injury claims than non-minor injury claims at all data collection time points. The most common types of treatment paid for or approved by the insurer were physiotherapy treatments, general practitioner consultations, and medical specialist consultations.

The proportion of claimants who took time off work declined during the follow-up period, from 66.3% at 13 weeks post-claim lodgement to 14.5% at 12 months post-crash to 6.1% at 24 months post-crash. Time off work was less common among claimants with minor injury than among claimants with non-minor injury at all data collection time points.

During the follow-up period, internal reviews of treatment were identified for 9.6% of claims reviewed. Dispute regarding minor injury determination was identified for 14.6% of claims reviewed, of which 20.0% had the decision overturned. Involvement of Dispute Resolution Services were identified for 10.3% of claims reviewed, of which 34.7% had the decision overturned.

The results described in this report suggest that minor injury determination is settled early for the majority of claims. Treatments paid for or approved by the insurer was less common for minor injury claims than non-minor injury claims at all data

collection time points, which suggests that the most severely injured received a greater proportion of benefits. Time off work beyond 26 weeks post-crash was infrequent among claimants with minor injury, which suggests that the majority these claimants experience adequate recovery. About 1 in 7 claims involved a dispute regarding minor injury determination, of which 20% had the decision overturned. This suggests that although the majority of claims are initially assigned an appropriate minor injury determination, the severity of injury may be underestimated for a small proportion of the claimants.

5. References

1. Rebbeck, T., et al., *A prospective cohort study of health outcomes following whiplash associated disorders in an Australian population*. Injury Prevention, 2006. **12**(2): p. 93.
2. Gopinath, B., et al., *Health-related quality of life 24 months after sustaining a minor musculoskeletal injury in a road traffic crash: A prospective cohort study*. Traffic Injury Prevention, 2017. **18**(3): p. 251-256.
3. Giummarra, M.J., et al., *Associations between compensable injury, perceived fault and pain and disability 1 year after injury: A registry-based Australian cohort study*. BMJ Open, 2017. **7**(10).
4. Grant, G.M., et al., *Relationship between stressfulness of claiming for injury compensation and long-term recovery: A prospective cohort study*. JAMA Psychiatry, 2014. **71**(4): p. 446-453.
5. Littleton, S.M., et al., *The health status of people claiming compensation for musculoskeletal injuries following road traffic crashes is not altered by an early intervention programme: A comparative study*. Injury, 2014. **45**(9): p. 1493-1499.
6. Giummarra, M.J., et al., *Chronic pain following motor vehicle collision: A systematic review of outcomes associated with seeking or receiving compensation*. The Clinical Journal of Pain, 2016. **32**(9): p. 817-827.
7. Giummarra, M.J., et al., *Return to work after traumatic injury: Increased work-related disability in injured persons receiving financial compensation is mediated by perceived injustice*. Journal of Occupational Rehabilitation, 2017. **27**(2): p. 173-185.
8. State Insurance Regulatory Authority, *On the road to a better CTP scheme: Options for reforming Green Slip insurance in NSW*. 2015: Sydney, Australia.
9. State Insurance Regulatory Authority, *On the road to a better CTP scheme: CTP reform position paper*. 2016, State Insurance Regulatory Authority: Sydney.
10. Wadolowski, M. and R. Mitchell, *Monitoring the minor injury definition and threshold in the 2017 CTP scheme: Progress report September 2018*. 2018, Australian Institute of Health Innovation, Macquarie University: Sydney, Australia.
11. Lystad, R.P. and R. Mitchell, *Review of the first 1000 claims in the new 2017 CTP Scheme: Progress report June 2019*. 2019, Australian Institute of Health Innovation, Macquarie University: Sydney, Australia.
12. Lystad, R.P. and R. Mitchell, *Review of the first 1000 claims in the new 2017 CTP Scheme: Progress report October 2019*. 2019, Australian Institute of Health Innovation, Macquarie University: Sydney, Australia.
13. Wadolowski, M., et al., *CTP Scheme claim review: Monitoring the minor injury definition and reporting threshold*. 2018, Australian Institute of Health Innovation, Macquarie University: Sydney, Australia.

State Insurance Regulatory Authority of New South Wales

Independent File Review

Of 500 Allocated Insurer Files after the Introduction of the Motor Accident Injuries Act 2017

Final Report

June 2020

John Walsh Centre for Rehabilitation Research

Northern Sydney Local Health District

Kolling Institute of Medical Research,
University of Sydney

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Executive summary

This independent file review project has been established to monitor the initial cohort of injured people utilising the Compulsory Third Party (CTP) Scheme established by the Motor Accident Injuries Act 2017, particularly with reference to achieving the objects of the Act and its intentions of CTP reform.

Concurrent review has been undertaken independently by the two organisations the John Walsh Centre for Rehabilitation Research (JWCRR), Sydney University and the Centre for Healthcare Resilience and Implementation Science, Australian Institute of Health Innovation, Macquarie University.

Over a two-year period, this project focused on claimant recovery and return to work or other activities for 1000 injured people, of which 500 files were allocated to each reviewing organisation by the State Insurance Regulatory Authority (SIRA). An independent review has been conducted on the application of the minor injury threshold and other issues such as treatments provided.

This is the final report for the 500 cases allocated to JWCRR. The median age of injured people was 43 years and 52% are females. Two thirds of injured people are recorded as being in paid employment and almost all live in NSW.

Minor / non-minor injury threshold

Of the allocated cases, 424 (85%) were available for audit, and by two-years post injury, a total of 242 cases (57%) had been determined as minor and 182 (43%) had been determined as non-minor. Of the non-minor injuries 49% were “physical”, 18% were “psychological”, 28% were both physical and psychological (and for 5% the nature of the injury was unclear). Over the two-years of the audit, the injury decision changed from minor to non-minor for a total of 23 cases (5%).

At two-years after injury 25% of claims were shown as still be open. However, as expected about 60% of claims were closed or settled by one year after injury.

Injury types and locations

The most frequent physical injury type recorded at each time point is “pain”, with many physical “injuries” defined only with reference to pain. Thus, there is no recorded formal diagnosis.

For minor injuries the most common injured body region is the cervical spine (61%), followed by lumbar spine (35%), upper extremity (27%), lower extremity 20%. (More than one region is frequently listed and hence the percentages add to more than 100%). For non-minor injuries the distribution of body regions is different with upper extremity 65%, lower extremity 53%, cervical spine 22% and thorax 21%.

For non-minor injuries the most prevalent type of injury was fracture (78%).

Psychological injury continued to increase over time and appears to be sustained by about 27% of claimants. It, for the most part, is not being diagnosed early in the claims process.

Recovery plan

The regulations operating with the Act are innovative in specifying that an assessment with reference to recovery should be conducted. In the course of the Audit it became clear that

understanding of screening for risk of non-recovery varied considerably and therefore processes are not standardised.

In addition, the audit showed incomplete documentation of potential for poor recovery. For almost half of injured people, a recovery plan could not be located. It is noted that for some claims a risk assessment and recovery plan is not required.

Treatment

Considerable treatment has been approved across all of the time points, and there is no evidence of significant under treatment in the results overall. The data suggest that treatment was provided in a timely manner for most claimants.

By thirteen weeks after claim lodgment over 50% of injured people had both general practitioner and physiotherapy treatments. Treatment continued for longer in people with non-minor injuries and medical specialist treatment was more common in people with non-minor injuries. More than sixty percent of claimants had at least one allied health recovery request on file. These related mainly to physiotherapy but the number for psychology services increased with time.

Imaging was extensively requested and its use is unlikely to be as recommended in treatment guidelines.

Recovery focus

Limited data are available to demonstrate “recovery focus”. However, some conclusions can be drawn in specific areas.

It is not possible to provide reliable return to work data from the audit. The reasons are that there is limited data for a substantial proportion of injured people from six months after injury, the recording of work capacity on the Certificate from the medical practitioner may not match whether the injured person is actually working, and the insurer files generally do not record that the person has returned to work.

At 6 months after injury only 50% of people with minor injury and 27% of people with non-minor injury are certified has having full work capacity. At 12 months after injury these increase to 75% and 54% respectively and then do not change at two-years after injury. While these data are incomplete, they suggest limited return to work.

Data about return to usual health or usual daily routines or usual social activities are not available from the insurer files.

About a quarter of claimants had an initial rehabilitation assessment with an external rehabilitation provider.

To improve the recovery focus in NSW, it is suggested that SIRA consider the addition of a criterion that centres on assisting a person to “get their life back on track” as is an aim for the Victorian Transport Accident Commission.

Disputes

Internal insurer reviews occurred in about twenty percent of claims. These were relatively more frequent in those with non-minor injuries. Only a small percentage of decisions were reversed after

internal review. Dispute decisions are also subject to external review but the results of external reviews are outside the scope of this final report.

Conclusions

This audit concludes that people injured in motor vehicle crashes are receiving treatment that is generally timely and appropriate. On average, there is no evidence of undertreatment and there could be overtreatment compared to people who have similar injuries outside compensation schemes.

The minor injury definition does identify people with less severe injuries and there is a clear differentiation in the amount and types of treatment provided for people with minor and non-minor injuries. It is acknowledged that some people with “minor” injuries continue to have symptoms and restrictions in daily life beyond six months after injury. Because most of these people leave the Scheme at six months after injury this audit could not investigate the extent of those restrictions.

This audit could not draw definite conclusions about health and work outcomes for people with minor injuries. The reasons are that there is limited documentation about these issues in insurer files and there are structural issues with the CTP Scheme that make assessment of these outcomes difficult. This is principally due to people with minor injuries, and people who are “at fault”, leaving the insurance scheme six months after injury at which time health and work outcomes will not be stabilised for a moderate number of claimants.

The audit concludes that the minor injury definition and threshold has been implemented and is associated with early and extensive treatment. More treatment is clearly provided to people with non-minor injuries. There are limited disputes. It is difficult to determine whether there has been a recovery focus on health and work outcomes from the data that are available in the audit.

Contents

Abbreviations

AHRR	Allied Health Recovery Request
COF	Certification of Fitness
COW	Capacity for Work
JWCRR	John Walsh Centre for Rehabilitation Research
NSW	New South Wales
SIRA	State Insurer Regulatory Authority

Minor Injury Definition

Section 1.6(2) of the Act:

A **soft tissue injury** is (subject to this section) an injury to tissue that connects, supports or surrounds, other structures or organs of the body (such as muscles, tendons, ligaments, menisci, cartilage, fascia, fibrous tissues, fat, blood vessels and synovial membranes), but not an injury to nerves or a complete or partial rupture of tendons, ligaments, menisci or cartilage.

A **minor psychological or psychiatric injury** is (subject to this section) a psychological or psychiatric injury that is not a recognised psychiatric illness.

Schedule 1 [2] clause 4 of the Motor Accident Injuries Regulation 2017:

1) An injury to a spinal nerve root that manifests in neurological signs (other than radiculopathy) is included as a soft tissue injury for the purposes of the Act.
2) Each of the following injuries is included as a minor psychological or psychiatric injury for the purposes of the Act:
    1. acute stress disorder,
    2. adjustment disorder.

   Note. See section 1.6 (5) of the Act in relation to the making of Motor Accident Guidelines for or with respect to the assessment of whether an injury is a minor injury.
3) In this clause acute stress disorder and adjustment disorder have the same meanings as in the document entitled Diagnostic and Statistical Manual of Mental Disorders (DSM-5), published by the American Psychiatric Association in May 2013.

Background

The Motor Accident Injuries Act 2017 came into effect on 1 December 2017 and the objects of the Act include:

- 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,
- to keep premiums for third-party policies affordable by ensuring that profits achieved by insurers do not exceed the amount that is sufficient to underwrite the relevant risk and by limiting benefits payable for minor injuries.

The Minor Injury File Review Project addresses the following question and issues:

"Do the minor injury Regulations and the Motor Accident Guidelines achieve the objects of the Act and intentions of CTP reform to:

- focus on recovery, and the return to work or other activities and
- increase the proportion of benefits provided to the most severely injured, reduce the time it takes to resolve a claim and reduce the cost of Green Slip premiums".

The objective of this project was to monitor the application of the minor injury threshold and related matters in the new CTP Scheme through the conduct of an independent file review over a two-year period.

The project was undertaken by both the John Walsh Centre for Rehabilitation Research (JWCRR) and the Centre for Healthcare Resilience and Implementation Science, Australian Institute of Health Innovation, Macquarie University (MqU).

The deliverables for the project were:

- An interim report following the pilot.
- 6 monthly progress reports during the file review
- A final report regarding:
  - The minor injury definition and threshold
  - The impact of the early intervention, treatment and recovery focus on health and work outcomes for people with a minor injury
  - The impact of the proactive and customer focussed claims management on health and work outcomes for people injured on the road, with a focus on minor injury

This document is the final report. The findings of the 2-year (104 week) data collection are provided as an addendum.

Method

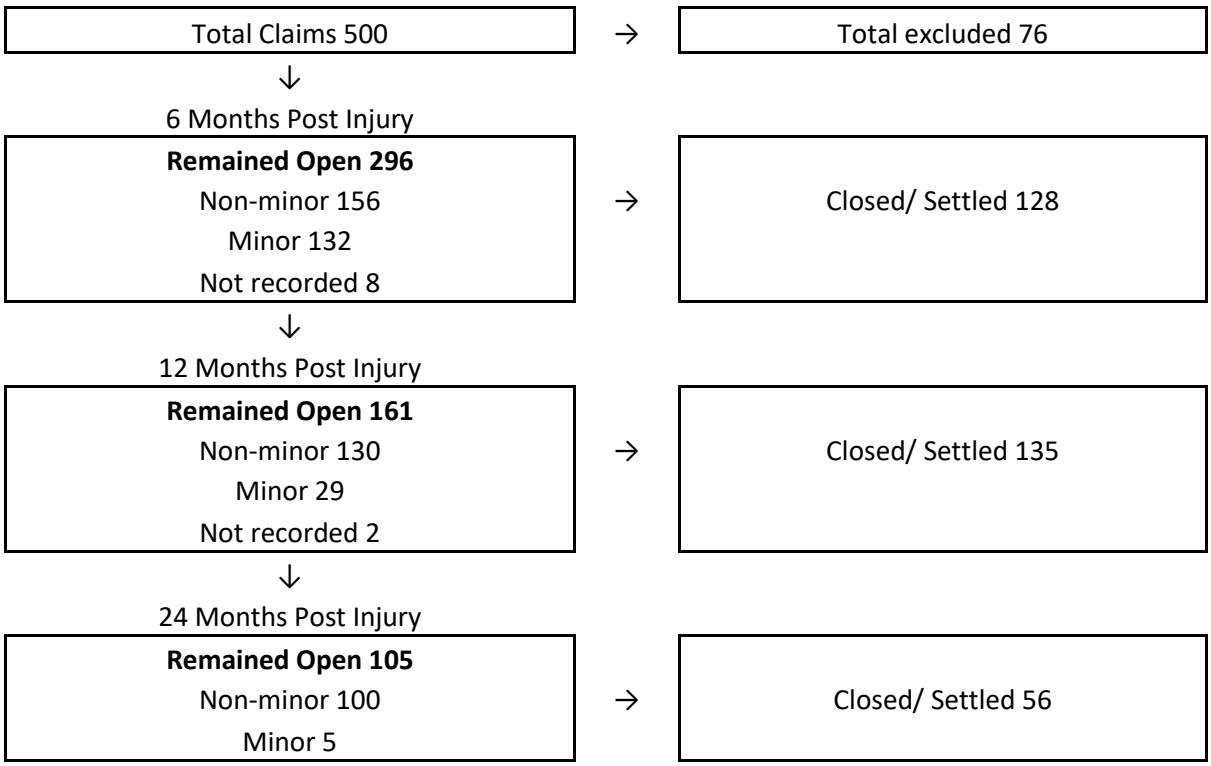
This audit was undertaken independently by the two organisations, but there were initial discussions, that included SIRA, to develop a data collection instrument and to clarify interpretation of the key variables for data collection. An Excel spreadsheet that included data items suggested by SIRA as being relevant to the review was initially prepared by the Macquarie University group and then piloted by both groups independently on the same sample of 40 claimants located in each of the four CTP insurers: IAG (NRMA), Suncorp (AAMI and GIO), Allianz and QBE, that had been provided by SIRA.

As a result, changes were collaboratively made with the involvement of SIRA to improve the data collection and a standardised Excel sheet was created for use by both research groups. Prior to commencing the 26-week data collection, the JWCRR developed a drop-down list for each data item on the spreadsheet in order to improve the efficiency of data collection and facilitate analysis. In addition, a manual for internal use was prepared to assist in reducing inconsistencies between the JWRRC researchers.

Access to the files was organised by each of the insurers so that the researchers entered their premises and collected the data from the insurer files for each of the allocated claimants. The data for each claimant was directly extracted from each insurer's secured claim management system and entered onto the standardised Excel sheet. Only one researcher was required for the final two data collection time points.

Figure 1 provides an overview of the data collection of the audit.

Figure 1. Summary of Case Status over Two-years



The claim files, which had been allocated for the length of the project, were accessed at the 26 week post injury time point (July/August 2018), the 52 week time point (February/March 2019), the 78 week time point (August 2019) and the 104 week time point (February 2020). The data were progressively analysed and interim reports were provided to SIRA every six months. This allowed for progress overtime with the claims to be mapped. The analysis for the data collected at 104 weeks post injury is provided as an addendum to this final report.

Analysis focused on many variables which included the identification of the type of injury that was collected from the medical certificates on each claimant file.

Treatment was assessed through analysis of the Allied Health Rehabilitation Review records, medical reports and requests for imaging.

Data for requests for review of an insurer decision, both internal and external, as well as data for screening for risk of poor recovery were collected and analysed.

Recovery plans and return to work data were also analysed.

Descriptive statistics were calculated to provide summaries in each area of interest.

Findings

Of the 500 files allocated to JWCRR, thirty-four percent of the claims were located at NRMA, 26% at GIO and the rest split between the other insurers. Table 1 provides details of the proportion of claims managed by each insurer.

Table 1. Distribution of CTP managing insurers for the total 500 allocated cases

Insurer	N	%
AAMI	37	7%
GIO	129	26%
Allianz	63	13%
CIC-Allianz	32	6%
NRMA	172	34%
QBE	67	13%
Total	**500**	**100%**

The findings are presented beginning with details of the cohort. A summary of the findings across the time points is presented, concluding at the two-year mark.

1.1 Cohort Summary

There were 76 non qualifying cases that were excluded from the data set. Table 2 provides the reasons for the exclusion of the 76 cases.

Table 2. Reasons for Exclusion

Reasons for Exclusion	n	%
Claim not lodged	38	50.0
Interstate claim	9	11.8
Lifetime care scheme	8	10.5
Transferred to another insurer	6	7.9
Workers compensation claim	5	6.6
Declined liability as charged for serious driving offence: alcohol intoxication	2	2.6
Claim rejected as lodged to incorrect insurer	2	2.6
Interstate Workers compensation claim	2	2.6
Managed by another insurer who applied for cost sharing	1	1.3
Not motor vehicle accident	2	2.6
Workers compensation claims, not lodged	1	1.3
Total	**76**	

Note: Percentages are based on the total number of claimants excluded in the analysis (n=76).

Table 3 shows the distribution of the 424 qualifying cases by CTP insurer for which data has been collected and analysed.

Table 3. Distribution of CTP Managing Insurers for the Remaining 424 Cases

Insurer	N	%
AAMI	32	7.5
GIO	118	27.8
Allianz	47	11.1
CIC-Allianz	27	6.4
NRMA	144	34.0
QBE	56	13.2
Total	**424**	

Note: Percentages are based on the total number of claimants (N=424).

Overtime, as would be expected, the number of opened cases reduced, with 38% remaining open at the 12 month time point. Table 4 provides a summary of case status over the two-years of the audit.

Table 4. Summary of Case Status Over Time for All 424 Claimants

Case Status	13-week post-claim		26-week post-injury		52-week post-injury		78-week post-injury		104-week Post-injury	
	N	%	n	%	n	%	n	%	n	%
Open	420	99	296	70	161	38	130	31	105	25
Closed	4	1	128	30	263	62	294	69	319	75

Note: Percentages are based on the total number of claimants (N=424).

1.2 Summarised Demographic Data for the Qualifying 424 Cases

The median age of all 424 claimants is 43 years and 19% of people are over the age of 60 years. 52% of participants are female. As expected almost all (97%) of participants live in NSW.

67% (282/424) of participants reported being in paid work prior to the incident and about two thirds (189/282, 67%) of these were engaged in full time employment, one-sixth (44/282, 16%) in part-time employment, and one-sixth (49/282, 17%) working on a casual basis. Table 5 provides a summary of the demographic details of the claimants.

Table 5. Demographic Information for the 424 Claimants

Demographics		n	%
Age at injury (years old)	Under 10	7	1.7
	10 to 19	27	6.4
	20 to 29	89	21.0
	30 to 39	85	20.0
	40 to 49	65	15.3
	50 to 59	70	16.5
	60 and over	81	19.1
Gender	Female	219	51.7
	Male	204	48.1
	Not recorded	1	0.2
Postcode	NSW	412	97.2
	Interstate	9	2.1
	Not recorded	3	0.7
Pre-injury employment Status	Working	282	66.5
	Not working	123	29.0
	Not available	19	4.5

Note: Percentages are based on the total number of claimants (N=424).

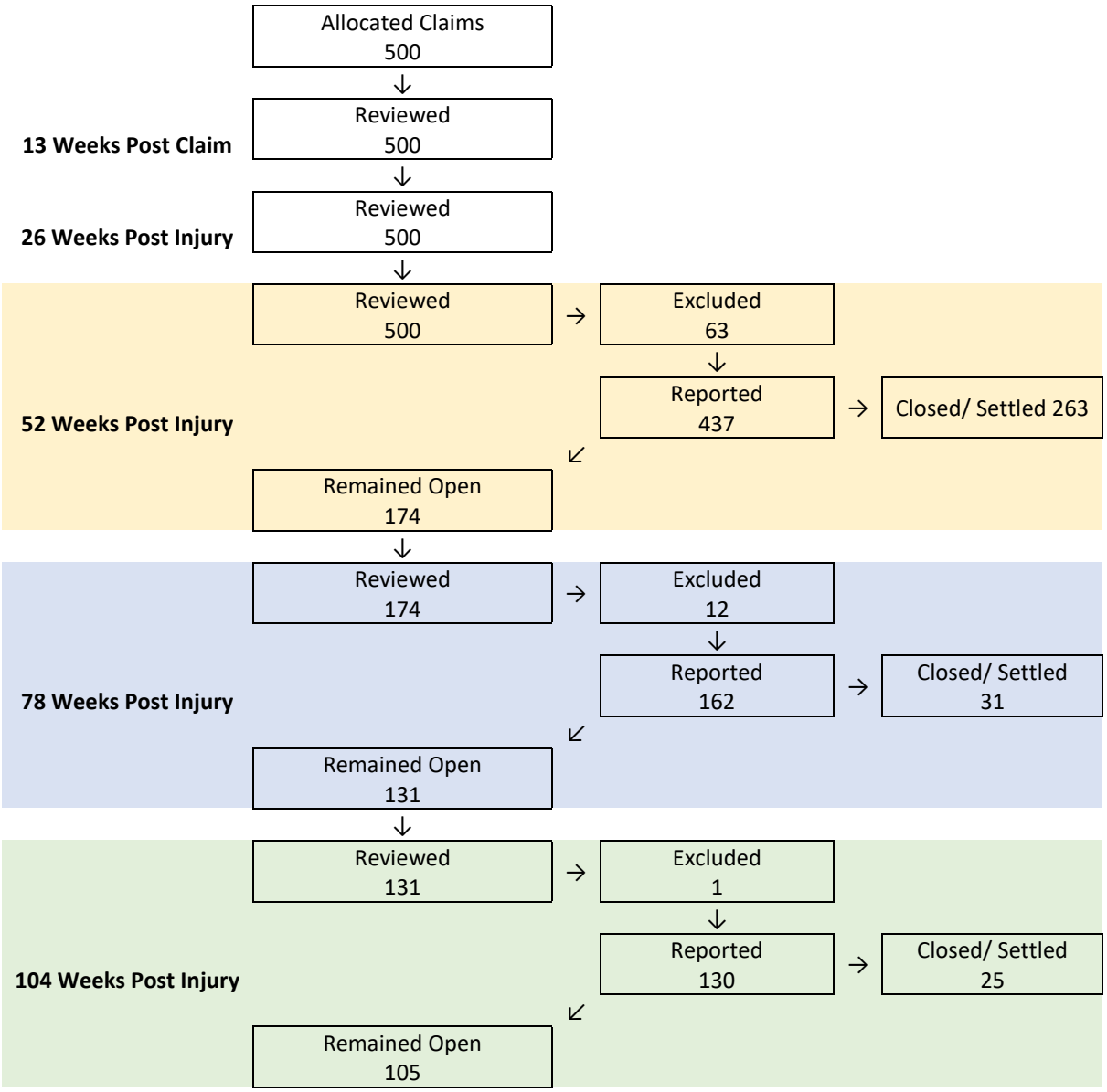
1.3 Minor / non-minor injury determination over time

Of the allocated cases, 424 (85%) were available for audit, and by two-years post injury, a total of 242 cases (57%) had been determined as minor and 182 (43%) had been determined as non-minor. Of the non-minor injuries 49% were “physical”, 18% were “psychological”, 28% were both physical and psychological (and for 5% the nature of the injury was unclear). Over the two-years of the audit, the injury decision changed from minor to non-minor for a total of 23 cases (5%).

At two-years after injury 25% of claims were shown as still be open. However, as expected about 60% of claims were closed or settled by one year after injury.

Figure 2 provides a summary of case progression overtime. At two-years post injury, 105 (25%) of 500 cases remained open of which 100 (24%) are non-minor.

Figure 2. Flow Chart of Case Status Over Time for All 500 Allocated Claimants



1.4 Change in the Minor Injury Decision Over Time

Whilst the reason for a change in the minor injury decision was not included in the agreed data collection set, this information was, for the most part, not included in the case files. However, where this data was available it was collected. For the 24 claims where the classification changed from minor to non-minor, one or more of the following injuries, physical and/ or psychological, were recorded. Further details are provided in Table 6.

Table 6. Classification changed from Minor to Non-minor- Commonly noted diagnoses Over Time

Final Minor Injury Type	**Psychological Injury**		**Fracture/ Dislocation/ Laceration**		**Nerve damage/ impingement/ neurological injury**		**WAD**	
	n	%	N	%	n	%	n	%
1. Physical (n=12)	3	25	4	33.3	6	0.5	7	58.3
2. Psychological (n=10)	10	100	0	0	5	50	4	40
3. Both physical and psychological (n=2)	2	100	1	50	0	0	2	100

It was however not possible to pinpoint the actual diagnoses that would confirm a change in the injury decision to non-minor injury due to data limitations.

Commonly recorded diagnoses that did provide some insight into the minor injury decision change include psychological Injury, fracture/ dislocation/ laceration, nerve damage/ impingement/ neurological injury and WAD. In two cases, only nerve damage/ impingement/ neurological injury was noted as a possible explanation for the change in the injury decision changing to non-minor physical only. For five cases where the minor injury decision changed to non-minor psychological only, nerve damage/ impingement/ neurological injury was recorded. Similarly, three non-minor physical only claimants had psychological injuries recorded on file, including Acute Stress Disorder, Post Traumatic Stress Disorder, or a combination of the two.

Further, it was also not possible to identify what factors precipitate the change in the minor injury decision. For example, in one case fracture was recorded at 13 weeks post-claim but the change in the minor injury was not found until 78 weeks post-injury.

Since commencement of this project, the injury decision changed from minor to non-minor for a total of 23 cases (5%). At 26 weeks post injury, 11 cases were identified as having the minor injury decision change to non-minor. At 52 week there were four cases, at 78 week there were five cases and at 2 years there were three cases.

Of the 23 cases with a change in the minor injury decision, 11 had a final decision of non-minor physical, with “pain” being recorded as the most frequent physical injury. Ten cases had been classified as non-minor psychological and two cases had been classified as both non-minor physical and psychological.

Treatment had ceased for four of these 23 cases, with 14 identified as still receiving treatment. However, treatment status was unable to be identified for the remaining 5 cases.

Ten out of the 23 cases had at least one Allied Health Recovery Requests over the two-year period. Of the 78 Allied Health Recovery Requests recorded, over half (43, 55%) were for physiotherapy treatment, another one-third (26, 33%) were for psychological treatment.

Referral for external rehabilitation along with internal review applications were more frequently associated with psychological injuries

Figure 3 provides a more detailed summary of the audit data over time. It is noted that only about 20% of the claims were for people “at fault”.

Figure 3. Summary Table of the 500 Allocated Claims

500 Allocated Cases			→	**Excluded Cases (76)**		
				Claim not lodge (57)	Interstate Claim (11)	Lifetime Care Scheme (8)
↓						
26 Weeks Post-injury				Case Closure/ Settlement		
Minor (242)	**Non-Minor (173)**	**Not Recorded (9)**		**Minor (110)**	**Non-Minor (17)**	**Not Recorded (1)**
Not at fault (215)	Not at fault (120)	Not at fault (1)	→	Not at fault (96)		
At fault (24)	At fault (51)	At fault (6)		At fault (12)	At fault (17)	
Others (3)	Others (2)	Others (2)		Others (2)		Others (1)
↓						
52 Weeks Post-injury				Case Closure/ Settlement		
Minor (132)	**Non-Minor (156)**	**Not Recorded (8)**		**Minor (103)**	**Non-Minor (26)**	**Not Recorded (6)**
Not at fault (119)	Not at fault (120)	Not at fault (1)	→	Not at fault (94)	Not at fault (8)	
At fault (12)	At fault (34)	At fault (6)		At fault (8)	At fault (18)	At fault (5)
Others (1)	Others (2)	Others (1)		Others (1)		Others (1)
↓						
78 Weeks Post-injury				Case Closure/ Settlement		
Minor (29)	**Non-Minor (130)**	**Not Recorded (2)**		**Minor (17)**	**Non-Minor (12)**	**Not Recorded (2)**
Not at fault (25)	Not at fault (112)	Not at fault (1)	→	Not at fault (15)	Not at fault (8)	Not at fault (1)
At fault (4)	At fault (16)	At fault (1)		At fault (2)	At fault (4)	At fault (1)
	Others (2)					
↓						
104 Weeks Post-injury				Case Closure/ Settlement		
Minor (12)	**Non-Minor (118)**			**Minor (7)**	**Non-Minor (18)**	
Not at fault (10)	Not at fault (104)		→	Not at fault (6)	Not at fault (14)	
At fault (2)	At fault (12)			At fault (1)	At fault (4)	
	Others (2)					
↓						
Cases open past 104 Week Post-injury						
Minor (5)	**Non-Minor (100)**					
Not at fault (4)	Not at fault (90)					
At fault (1)	At fault (8)					
	Others (2)					

Note: Minor injury status and case closure/ settlement are based on the final data collected at 104 weeks post-injury. Fault status was collected only at 78 weeks post-injury.

1.5 Injury Classification – Physical Injury Over Time

There are differences between the body region injured for those classified as physical minor and physical non-minor injuries. Injury to the neck/cervical spine is the most frequently injured region recorded in the minor injury group, over two times. In comparison, injury to the upper and the lower extremities are the most frequently injured region recorded in the non-minor injury group as shown in Table 7.

Table 7. Physical injury body region over time by minor and non-minor classification

Body Region - Physical Injury	First COF		13-week Post-claim		26-week Post-injury		52-week Post-injury		78-week Post-injury		104-week Post-injury	
	n	%*	N	%*	n	%*	N	%*	n	%*	n	%*
Minor (N=242)												
Neck/ Cervical spine	148	61.2	124	51.2	127	52.5	155	64.0	3	1.2	4	1.7
Upper extremity/ shoulders	66	27.3	47	19.4	47	19.4	56	23.1	1	0.4	1	0.4
Lower extremity	49	20.2	28	11.6	31	12.8	39	16.1	0	0	0	0
Lower back/ Lumbosacral spine	85	35.1	74	30.6	82	33.9	93	38.4	1	0.4	2	0.8
Upper back/ Thoracic spine	34	14.0	33	13.6	27	11.2	38	15.7	0	0	0	0
Head	26	10.7	16	6.6	17	7.0	16	6.6	0	0	0	0
Abdomen	3	1.2	1	0.4	1	0.4	1	0.4	0	0	0	0
Pelvis	10	4.1	5	2.1	5	2.1	2	0.8	0	0	0	0
Unspecified	30	12.4	25	10.3	27	11.2	11	4.5	0	0	0	0
Thorax	24	9.9	11	4.5	15	6.2	12	5.0	0	0	0	0
Face	12	5.0	6	2.5	5	2.1	4	1.7	0	0	0	0
Total	**487**	**201.2**	**370**	**152.9**	**384**	**158.7**	**427**	**176.4**	**5**	**2.1**	**7**	**2.9**
Non-Minor (N=173)												
Neck/ Cervical spine	39	22.5	42	24.3	41	23.7	52	30.1	26	15.0	24	13.9
Upper extremity/ shoulders	113	65.3	76	43.9	80	46.2	87	50.3	31	17.9	26	15.0
Lower extremity	92	53.2	65	37.6	79	45.7	78	45.1	25	14.5	26	15.0
Lower back/ Lumbosacral spine	24	13.9	19	11.0	25	14.5	31	17.9	15	8.7	18	10.4
Upper back/ Thoracic spine	1	0.6	12	6.9	10	5.8	15	8.7	6	3.5	7	4.0
Head	23	13.3	20	11.6	16	9.2	19	11.0	5	2.9	11	6.4
Abdomen	19	11.0	7	4.0	8	4.6	11	6.4	0	0	0	0
Pelvis	4	2.3	9	5.2	7	4.0	6	3.5	0	0	0	0
Unspecified	10	5.8	4	2.3	2	1.2	6	3.5	1	0.6	2	1.2
Thorax	37	21.4	21	12.1	22	12.7	21	12.1	3	1.7	2	1.2
Face	14	8.1	10	5.8	9	5.2	7	4.0	0	0	2	1.2
Total	**376**	**217.3**	**285**	**164.7**	**299**	**172.8**	**333**	**192.5**	**112**	**64.7**	**118**	**68.2**

Note: Percentages are based on the number of claimants per minor injury group per injury type at 104-week post-injury.

The most frequent physical injury type in the minor injury group recorded at each time point is "pain", with many physical "injuries" defined only with reference to pain, and so as such have no

recorded formal diagnosis. However, in the non-minor group, fracture/bony injury is most commonly recorded as the most prevalent injury in the first 12 months. “Pain” emerges as the most commonly recorded injury type after that time point. See Table 8.

Table 8. Physical injury type over time by minor and non-minor classification

Physical Injury Type	First COF		13-week Post-claim		26-week Post-injury		52-week Post-injury		78-week Post-injury		104-week Post-injury	
	n	%*	N	%*	n	%*	n	%*	n	%*	n	%*
Minor (N=242)												
Pain	164	67.8	112	46.3	117	48.3	128	52.9	0	0	1	0.4
Nerve damage/ impingement	18	7.4	23	9.5	25	10.3	22	9.1	3	1.2	1	0.4
Other/ unspecified	122	50.4	84	34.7	84	34.7	69	28.5	0	0	2	0.8
Fracture/ bony injury	3	1.2	2	0.8	4	1.7	5	2.1	0	0	0	0
Ligament/ tendon rupture	0	0	1	0.4	3	1.2	3	1.2	0	0	2	0.8
Sprain/ strain	53	21.9	48	19.8	52	21.5	63	26.0	1	0.4	1	0.4
Head injury/ concussion	0	0	0	0	0	0	2	0.8	0	0	0	0
Bruising/ abrasion/ hematoma/ superficial injury	37	15.3	9	3.7	9	3.7	39	16.1	0	0	0	0
WAD (unspecified)	83	34.3	87	36.0	86	35.5	61	25.2	0	0	0	0
WAD 1,2	-	-	-	-	-	-	27	11.2	0	0	0	0
WAD 3,4	-	-	-	-	-	-	3	1.2	1	0.4	0	0
Laceration/ cut/ open wound	5	2.1	3	1.2	3	1.2	4	1.7	0	0	0	0
Dislocation	2	0.8	1	0.4	1	0.4	1	0.4	0	0	0	0
Total	**487**	**201.2**	**370**	**152.9**	**384**	**158.7**	**427**	**176.4**	**5**	**2.1**	**7**	**2.9**
Non-Minor (N=173)												
Pain	65	37.6	28	16.2	44	25.4	64	37.0	29	16.8	37	21.4
Nerve damage/ impingement	15	8.7	20	11.6	20	11.6	21	12.1	14	8.1	20	11.6
Other/ unspecified	35	20.2	39	22.5	43	24.9	40	23.1	25	14.5	16	9.2
Fracture/ bony injury	135	78.0	117	67.6	112	64.7	108	62.4	21	12.1	18	10.4
Ligament/ tendon rupture	4	2.3	9	5.2	11	6.4	12	6.9	9	5.2	9	5.2
Sprain/ strain	10	5.8	9	5.2	9	5.2	12	6.9	7	4.0	5	2.9
Head injury/ concussion	0	0.0	0	0.0	0	0.0	5	2.9	2	1.2	4	2.3
Bruising/ abrasion/ hematoma/ superficial injury	64	37.0	22	12.7	22	12.7	28	16.2	0	0.0	4	2.3
WAD (unspecified)	12	6.9	22	12.7	16	9.2	14	8.1	2	1.2	3	1.7
WAD 1,2	-	-	-	-	-	-	1	0.6	0	0.0	0	0.0
WAD 3,4	-	-	-	-	-	-	2	1.2	0	0.0	0	0.0
Laceration/ cut/ open wound	27	15.6	12	6.9	14	8.1	8	4.6	1	0.6	0	0.0
Dislocation	9	5.2	7	4.0	8	4.6	9	5.2	2	1.2	2	1.2

Internal/ organ injury	0	0.0	0	0.0	0	0.0	9	5.2	0	0.0	0	0.0
Total	**376**	**217.3**	**285**	**164.7**	**299**	**172.8**	**333**	**192.5**	**112**	**64.7**	**118**	**68.2**

Note: Percentages are based on the number of claimants per minor injury group per injury type at 104-week post-injury.

1.6 Injury Classification – Psychological Injury Over Time

Psychological injury type in the minor injury group peaks at 12 months, with Post-Traumatic Stress Disorder, Anxiety and "other" being the most prevalent diagnoses. However, in the non-minor group, Post-Traumatic Stress Disorder is most prevalent and continues to be recorded as a diagnosis across the two-year period on investigation. Table 9 provides further details.

The delay in the diagnosis of psychological injury suggests that unlike physical injury, it appears to take time to develop in both groups. Table 9 shows details of psychological injury over time.

Table 9. Psychological injury over time by minor and non-minor classification

Psychological Injury	First COF		13-week Post-claim		26-week Post-injury		52-week Post-injury		78-week Post-injury		104-week Post-injury	
	n	%*	n	%*	N	%*	n	%*	n	%*	N	%*
Minor (N=242)												
Post-traumatic Stress Disorder	-	-	-	-	-	-	7	2.9	1	100	1	100
Others	5	2.1	9	3.7	8	3.3	12	5.0	0	0	0	0
Major Depressive Episode	-	-	-	-	-	-	2	0.8	0	0	0	0
Anxious	13	5.4	12	5.0	15	6.2	16	6.6	0	0	0	0
Adjustment Disorder	-	-	-	-	-	-	4	1.7	0	0	0	0
Insomnia	7	2.9	0	0	3	1.2	5	2.1	0	0	0	0
Generalised Anxiety Disorder	-	-	-	-	-	-	1	0.4	0	0	0	0
Stress	8	3.3	6	2.5	7	2.9	3	1.2	0	0	0	0
Total	**33**	**13.6**	**27**	**11.2**	**33**	**13.6**	**50**	**20.7**	**1**	**100**	**1**	**100**
Non-Minor (N=173)												
Post-traumatic Stress Disorder	-	-	-	-	-	-	28	16.2	17	9.8	21	12.1
Others	5	2.9	10	5.8	15	8.7	13	7.5	6	3.5	9	5.2
Major Depressive Episode	-	-	-	-	-	-	10	5.8	7	4.0	8	4.6
Anxious	4	2.3	6	3.5	12	6.9	14	8.1	9	5.2	8	4.6
Adjustment Disorder	-	-	-	-	-	-	6	3.5	6	3.5	3	1.7
Insomnia	0	0	0	0	3	1.7	1	0.6	1	0.6	2	1.2
Generalised Anxiety Disorder	-	-	-	-	-	-	2	1.2	1	0.6	1	0.6
Stress	7	4.0	6	3.5	10	5.8	1	0.6	2	1.2	1	0.6
Total	**16**	**9.2**	**22**	**12.7**	**40**	**23.1**	**75**	**43.4**	**49**	**28.3**	**53**	**30.6**

Note: Percentages are based on the number of claimants per minor injury classification.

Psychological injury continued to increase over time and in general appears to be sustained by about 27% of claimants, irrespective of the injury classification. It for the most part is not being diagnosed early in the claims process. It also raises the question whether it may be possible to identify claimants at risk of emerging psychological injury and intervene to reduce its occurrence. Tables 10 and 11 show details.

Table 10. Summary of Psychological Diagnosis Over Time

With Any Psychological Diagnosis	First COF		Latest COF at 13-week post-claim		Latest COF at 26-week post-injury		Latest COF at 52-week post-injury		Latest COF at 78-week post-injury		Latest COF at 104-week post-injury		Overall	
	n	%	N	%	n	%	n	%	n	%	n	%	n	%
Yes	36	8.5	38	9	52	12.3	91	21.5	30	7.1	32	7.5	113	26.7
No	388	91.5	386	91	372	87.7	333	78.5	394	92.9	392	92.5	311	73.3

Note: Percentages are based on the total number of claimants included in the analysis (n=424).

Table 11. Psychological Diagnosis by Injury Classification

Final Minor Injury Decision	With Any Psychological Diagnosis	
	n	%
1.Physical	55	48.7
2.Psychological	20	17.7
3.Both physical and psychological	32	28.3
4.Not determined	6	5.3

Note: Percentages are based on the total number of claimants with any psychological diagnosis recorded overtime (n=113)

2.0 The Implementation of the Minor Injury Definition and Threshold

As noted above, for the most part, minor injury was found to be physical in nature, with a higher rate of case non closure / non settlement in the non-minor injury group. Importantly, treatment and recovery rely on the recording of the type of injury, meaning a specific diagnosis and the subsequent relevant clinical intervention, yet a significant number of diagnoses could not be found at each time point. Additionally, the source of diagnoses is not currently recorded and therefore may impact on inconsistencies in diagnosis and recovery. This may be especially important in regard to the sources of psychological diagnoses.

Some minor cases were found to require treatment past the 26 week time point and some were found open at 12 months. Further, investigation is needed to identify the reasons and issues associated with minor cases that remain open beyond the 26 week time point, with a view to identifying action that might be adopted to improve the assessment of minor injury within the statutory time period.

There is also a need for record/data standardisation to occur across the insurers as without this, fully accurate comparisons in how the Act is being implemented is problematic. For instance, the official SIRA certificates of fitness (COF)/ capacity for work (COW) document has both the components of diagnosis related to injury and capacity for activities and work. In cases where the SIRA COF/ COW were used, the documents are commonly found to be missing either the diagnoses or the capacities for activities and work. In some cases when both fields were completed, it was found that the diagnoses maybe have remained unchanged over a long period and may not reflect the updated diagnoses, while other documents containing diagnosis-only information seemed to better reflect descriptions of claimants' medical conditions.

In fact, different variations of document were used to indicate claimants' diagnoses, and capacities for activities and work separately. For example, diagnoses may be found in specialist reports and AHRR, when the capacities for activities and work were not available on such documents. Similarly, capacities for activities and work were available on documents such as hospital discharge documents and medical certificates, where a diagnosis was not listed. To maximise the documentation of both the component of diagnosis related to injury and capacity for activities and work, COF was defined as documents with diagnoses related to the motor vehicle accident, while COW was defined as documents with estimated capacities for activities and work. This seemed to be consistent with the insurers' use of COF and COW.

Table 12 provides a summary of claims split by minor and non-minor injury at each timepoint.

Table 12. Summary of Qualifying Cases at Each Time Point

	26 weeks	52 weeks	78 weeks	104 weeks	**Overall**
Total Cases Qualifying	399	385	162	130	**399**
Exclusions	101[1]	115[2]	238[3]	370[3]	**101**
Minor cases	258 (65%)	232 (60%)	32 (10%)	12 (9%)	
Non-minor cases	141 (35%)	153 (40%)	130 (80%)	118 (91%)	

1. Liability denied, Not recorded, Claim not lodged
2. Closed/ settled, Liability denied, Not recorded, Claim not lodged
3. Many cases have been closed/ settled by this time

2.1 Assessment of Risk of Poor Recovery for Minor and Non-Minor Injury Groups

As reported previously, screening for risk of poor recovery could not be identified for 22% of claimants and only 8% were identified as having a high risk of non-recovery. In the course of the audit it became clear that understanding of screening for risk of non-recovery varied considerably and therefore processes are not standardised.

Table 13. Summary of screening for risk of poor recovery

Screening for risk of poor recovery	13-week Post-claim		26-week Post-injury		52-week Post-injury		78-week Post-injury		104-week Post-injury	
	n	%*	n	%*	n	%*	n	%*	n	%*
Minor (N=242)										
1. No screening	61	25.2	219	90.5	225	93.0	240	99.2	242	100
2. Low/ Good risk recovery	117	48.3	17	7.0	9	3.7	0	0.0	0	0
3. Medium risk recovery	54	22.3	4	1.7	6	2.5	1	0.4	0	0
4. Poor/ High risk recovery	10	4.1	2	0.8	2	0.8	1	0.4	0	0
Non-minor (N=173)										
1. No screening	45	26.0	163	94.2	152	87.9	164	94.8	173	100
2. Low/ Good risk recovery	51	29.5	2	1.2	9	5.2	4	2.3	0	0
3. Medium risk recovery	57	32.9	3	1.7	8	4.6	3	1.7	0	0
4. Poor/ High risk recovery	20	11.6	5	2.9	4	2.3	2	1.2	0	0

Note: Percentages are based on the number of claimants per minor injury classification.

The data for screening for risk of recovery is not only incomplete but there is a lack of standardisation across the insurers in assessing the potential for poor recovery. People with a high risk of poor recovery require a more structured and extensive recovery plan, yet for almost 50% in this group, a recovery plan could not be located. Suggesting that this may be related to rationing of services as once the risk of poor recovery is identified it requires significant clinical intervention. From a health outcomes point of view, people with a high risk of poor recovery require a more structured and extensive recovery plan. It is recognised that not all people with injury require screening for risk of non-recovery based on what the relevant regulations require.

2.2 Treatment Over Time for Minor and Non-Minor Injury Groups

Considerable treatment has been approved across all of the time points, and there is no evidence of significant under treatment in the results overall. The total number of treatments decreases between the time points with the most prevalent types of treatment across the minor injury cohort being physiotherapy followed by medical consultations, both GP and specialist. There is very little treatment occurring at the two-year mark. On the other hand, for the non-minor injury group as would be expected there is more treatment occurring at the two-year mark. Treatment in this group has a greater range of treatment types, with significantly more surgical and psychological treatment. See Table 14.

Table 14. Summary of Treatment over time

Treatment Paid for by Insurer	13-week Post-claim		26-week Post-injury		52-week Post-injury		78-week Post-injury		104-week Post-injury	
	n	%*	n	%*	n	%*	N	%*	n	%*
Minor (N=242)										
1. GP	127	52.5	90	37.2	39	16.1	3	1.2	1	0.4
2. Physiotherapist	142	58.7	122	50.4	71	29.3	3	1.2	0	0
3. Medical specialist	13	5.4	9	3.7	9	3.7	2	0.8	1	0.4
4. Pharmaceutical	41	16.9	18	7.4	7	2.9	3	1.2	0	0
5. Orthotist/Prosthetist /Aids or Appliances	31	12.8	18	7.4	5	2.1	0	0	0	0
6. Surgeon/ Surgical procedure	1	0.4	2	0.8	2	0.8	1	0.4	0	0
7. Psychologist	7	2.9	7	2.9	6	2.5	1	0.4	1	0.4
8. Hospital medical officer	4	1.7	1	0.4	1	0.4	0	0	0	0
10. Occupational therapist	1	0.4	2	0.8	0	0	0	0	0	0
11. Other	1	0.4	0	0	0	0	0	0	1	0.4
12. Hospital rehabilitation	0	0	0	0	1	0.4	0	0	0	0
13. Chiropractor/Osteopath	17	7.0	9	3.7	9	3.7	0	0	0	0
14. Masseur/ Acupuncturist/ TCM	8	3.3	5	2.1	2	0.8	0	0	0	0
15. Exercise physiologist	4	1.7	11	4.5	9	3.7	0	0	0	0
16. Dentist/ Orthodontist	0	0	1	0.4	0	0.0	0	0	0	0
TOTAL	**397**	**164.0**	**295**	**121.9**	**161**	**66.5**	**13**	**5.4**	**4**	**1.7**
Non-minor (N=173)										
1. GP	78	45.1	63	36.4	64	37.0	49	28.3	42	24.3
2. Physiotherapist	73	42.2	78	45.1	71	41.0	43	24.9	31	17.9
3. Medical specialist	59	34.1	47	27.2	57	32.9	42	24.3	31	17.9
4. Pharmaceutical	51	29.5	29	16.8	18	10.4	19	11.0	15	8.7
5. Orthotist/Prosthetist /Aids or Appliances	39	22.5	19	11.0	26	15.0	7	4.0	7	4.0
6. Surgeon/ Surgical procedure	31	17.9	19	11.0	31	17.9	15	8.7	14	8.1
7. Psychologist	16	9.2	28	16.2	34	19.7	30	17.3	24	13.9
8. Hospital medical officer	8	4.6	5	2.9	10	5.8	0	0	1	0.6
9. Hospital overnight stay	9	5.2	5	2.9	4	2.3	0	0	1	0.6
10. Occupational therapist	5	2.9	5	2.9	0	0	0	0	0	0
11. Other	5	2.9	2	1.2	1	0.6	0	0	2	1.2

12. Hospital rehabilitation	5	2.9	3	1.7	3	1.7	2	1.2	1	0.6
13. Chiropractor/Osteopath	5	2.9	4	2.3	7	4.0	3	1.7	4	2.3
14. Masseur/ Acupuncturist/ TCM	3	1.7	3	1.7	1	0.6	3	1.7	2	1.2
15. Exercise physiologist	2	1.2	8	4.6	8	4.6	9	5.2	11	6.4
16. Dentist/ Orthodontist	2	1.2	2	1.2	0	0	0	0	0	0
17. Nurse/Wound dressings	2	1.2	1	0.6	0	0	0	0	0	0
18. Psychiatrist	0	0	1	0.6	4	2.3	2	1.2	6	3.5
TOTAL	**393**	**227.2**	**322**	**186.1**	**339**	**196.0**	**224**	**129.5**	**192**	**111.0**

Note:
1. Percentages for individual treatments are based on the number of claimants per minor injury group at 104-week post-injury, n=242 for minor and n=173 for non-minor.
2. As there can be multiple treatments for each person, the total percentage does not add to 100%.

2.3 Imaging over time for Minor and Non-Minor Groups

The prevalence of requests for imaging is high initially and continues at a higher than expected level over time. Associated tests and requests are both consistently more prevalent and have a greater range for non-minor cases, as would be expected. Table 15 provides details. The purpose for imaging was not found for over 40 percent of imaging requests in both the minor and non-minor groups. Where the purpose was found, it was largely being used to assist with diagnosis again at over 40 percent in both groups. In the minor injury group, GPs are the main imaging requestor. In the non-minor injury group, more imaging is requested by specialists.

Table 15. Summary of imaging over time for minor and non-minor injury groups

	13-week Post-claim		26-week Post-injury		52-week Post-injury		78-week Post-injury		104-week Post-injury	
	n	%	n	%	n	%	n	%	n	%
Imaging Type										
Minor (N=242)										
1. X-ray	10	4.1	4	1.7	2	0.8	0	0.0	0	0
2. CT scan	7	2.9	5	2.1	1	0.4	1	0.4	0	0
3. MRI	28	11.6	9	3.7	6	2.5	0	0.0	0	0
4. 1+2	1	0.4	0	0.0	0	0.0	0	0.0	0	0
5. 2+3	0	0.0	0	0.0	0	0.0	0	0.0	0	0
6. 1+3	1	0.4	0	0.0	0	0.0	0	0.0	0	0
7. 1+2+3	1	0.4	0	0.0	0	0.0	0	0.0	0	0
8. Ultrasound	4	1.7	1	0.4	2	0.8	0	0.0	0	0
9. Bone scan	0	0.0	1	0.4	1	0.4	0	0.0	0	0
10. Other	0	0.0	1	0.4	0	0.0	0	0.0	0	0
11. No imaging	190	78.5	221	91.3	230	95.0	241	99.6	242	100
Non-minor (N=173)										
1. X-ray	16	9.2	10	5.8	9	5.2	12	6.9	2	1.2
2. CT scan	3	1.7	3	1.7	5	2.9	2	1.2	2	1.2
3. MRI	14	8.1	11	6.4	12	6.9	11	6.4	1	0.6

4. 1+2	8	4.6	2	1.2	0	0.0	2	1.2	1	0.6
5. 2+3	1	0.6	1	0.6	2	1.2	2	1.2	3	1.7
6. 1+3	11	6.4	3	1.7	2	1.2	1	0.6	1	0.6
7. 1+2+3	1	0.6	0	0.0	3	1.7	0	0.0	1	0.6
8. Ultrasound	4	2.3	5	2.9	7	4.0	2	1.2	3	1.7
9. Bone scan	2	1.2	0	0.0	0	0.0	0	0.0	0	0.0
10. Other	1	0.6	0	0.0	4	2.3	1	0.6	0	0.0
11. No imaging	112	64.7	138	79.8	129	74.6	140	80.9	159	91.9
Purpose of Imaging										
Minor (N=242)										
1. Assist diagnosis	21	40.4	5	23.8	3	25.0	0	0	0	0
2. Direct treatment	1	1.9	0	0.0	3	25.0	1	100	0	0
3. Investigative	8	15.4	4	19.0	2	16.7	0	0	0	0
4. Not specified/Other/ Can't tell	22	42.3	12	57.1	4	33.3	0	0	0	0
Non-minor (N=173)										
1. Assist diagnosis	25	41.0	10	28.6	7	15.9	5	15.2	2	14.3
2. Direct treatment	2	3.3	1	2.9	11	25.0	5	15.2	5	35.7
3. Investigative	5	8.2	13	37.1	10	22.7	14	42.4	6	42.9
4. Not specified/Other/ Can't tell	29	47.5	11	31.4	16	36.4	9	27.3	1	7.1
Imaging Requested by										
Minor (N=242)										
1. GP	35	67.3	14	66.7	9	75.0	0	0	0	0
2. Medical specialist	2	3.8	1	4.8	1	8.3	0	0	0	0
3. Physiotherapist	0	0.0	0	0.0	0	0.0	0	0	0	0
4. 1+2	0	0.0	0	0.0	0	0.0	0	0	0	0
5. Hospital medical officer	3	5.8	3	14.3	2	16.7	1	100	0	0
6. Not specified/Other/ Can't tell	12	23.1	3	14.3	0	0.0	0	0	0	0
Non-minor (N=173)										
1. GP	22	36.1	15	42.9	10	22.7	9	27.3	3	21.4
2. Medical specialist	15	24.6	10	28.6	28	63.6	24	72.7	10	71.4
3. Physiotherapist	0	0.0	2	5.7	1	2.3	0	0.0	0	0.0
4. 1+2	0	0.0	1	2.9	1	2.3	0	0.0	0	0.0
5. Hospital medical officer	15	24.6	2	5.7	4	9.1	0	0.0	0	0.0
6. Not specified/Other/ Can't tell	9	14.8	5	14.3	0	0.0	0	0.0	1	7.1

Note:

1. Percentages for imaging type are based on the number of claimants per minor injury group at 104-week post-injury, n=242 for minor and n=173 for non-minor.
2. Percentages for purpose of imaging and imaging requested by is based on number of imaging paid for by insurers per timepoint per minor injury classification.

2.4 Rehabilitation Over Time for Minor and Non-Minor Groups

Where an external rehabilitation provider determined that claimants had ongoing needs for rehabilitation, a rehabilitation plan was developed and submitted for approval. Further, psychological injury cases that remain open are more likely to be referred for external rehabilitation and have a higher rate of internal review. The non-minor injury group were more likely to have a rehabilitation plan, irrespective of their injury type, and those with both a physical and psychological injury were more likely to have an internal review. Over the two-year period of the audit 76 claims had at least one internal review recorded of which 36 were classified as a minor injury. Of those 36 claims, 27 had a physical injury diagnosis, one a psychological injury diagnosis and eight were both. Of the 40 non-minor claims, 23 had a physical injury diagnosis, 11 a psychological injury diagnosis and six had both. Table 16 provides details.

Table 16. Rehabilitation Plan and Internal Review by Injury Classification

	Minor Injury Type					
	Physical		Psychological		Both physical and psychological	
	n	%	n	%	n	%
Number of Rehabilitation Plans						
Minor (N=237)	**(n=212)**		**(n=3)**		**(n=22)**	
0	200	94.3	3	100	20	90.9
1	8	3.8	0	0	2	9.1
2	3	1.4	0	0	0	0
3	1	0.5	0	0	0	0
Non-minor (N=161)	**(n=132)**		**(n=17)**		**(n=12)**	
0	97	73.5	12	70.6	4	33.3
1	13	9.8	1	5.9	4	33.3
2	6	4.5	3	17.6	1	8.3
3	7	5.3	1	5.9	1	8.3
4	4	3	0	0	1	8.3
5+	5	3.8	0	0	1	8.3
Total no. of Internal Reviews						
Minor (N=237)	**(n=212)**		**(n=3)**		**(n=22)**	
0	185	87.3	2	66.7	14	63.6
1	22	10.4	0	0	6	27.3
2	1	0.5	1	33.3	1	4.5
3+	4	1.9	0	0	1	4.5
Non-minor (N=161)	**(n=132)**		**(n=17)**		**(n=12)**	
0	109	82.6	6	35.3	6	50
1	16	12.1	9	52.9	4	33.3
2	4	3	2	11.8	0	0
3+	3	2.3	0	0	2	16.7

Note: Percentages are based on the number of claimants per minor injury group per injury type at 104-week post-injury. Five minor injury cases and 12 non-minor injury cases with no injury type available were excluded.

Those with a psychological injury were found to be more likely to be referred for external rehabilitation and also to have a higher rate of internal review. See Table 17.

Table 17. Rehabilitation Plan and Internal Review by Psychological Injury

	With any psychological diagnoses			
	Yes (N=113)		No (N=311)	
	n	%	n	%
Number of Rehab Plan				
0	76	67.3	282	90.7
1	16	14.2	16	5.1
2	7	6.2	6	1.9
3	6	5.3	4	1.3
4	4	3.5	1	0.3
5+	4	3.5	2	0.6
Total no. of Internal Review				
0	74	65.5	273	87.8
1	27	23.9	31	10
2	6	5.3	3	1
3+	6	5.3	4	1.3

Note: Percentages are based on the number of claimants with any psychological diagnosis (n=113) or with no psychological diagnosis (n=311) recorded overtime.

Over 40 percent of those with a psychological injury have been referred for external rehabilitation. Table 18. It should be noted that there are currently no guidelines on external rehabilitation referral, nor any requirement for claimant consent prior to referral.

Table 18. External Rehabilitation Referral by Psychological Injury

Number of External Rehabilitation Referral	13-week Post-claim		26-week Post-injury		52-week Post-injury		78-week Post-injury		104-week Post-injury		Overall	
	n	%	n	%	n	%	N	%	n	%	n	%
With any psychological diagnosis												
Yes (N=113)	27	23.9	28	24.8	42	37.2	22	19.5	18	15.9	48	42.5
No (N=311)	24	7.7	21	6.8	43	13.8	10	3.2	8	2.6	51	16.4

Note: Percentages are based on the number of claimants with any psychological diagnosis (n=113) or with no psychological diagnosis (n=311) recorded overtime.

2.5 Allied health recovery request over time

Table 19. Allied Health Recovery Requests over Time

	First AHRR		Latest AHRR at 13-week post-claim		Latest AHRR at 26-week post-injury		Latest AHRR at 52-week post-injury		Latest AHRR at 78-week post-injury		Latest AHRR at 104-week post-injury	
	n	%	n	%	n	%	n	%	n	%	n	%

Number of AHRR												
Minor (N=242)												
0	-	-	107	44.2	92	38	87	36	87	36	87	36
1	-	-	82	33.9	75	31	72	29.8	72	29.8	72	29.8
2	-	-	41	16.9	50	20.7	52	21.5	52	21.5	52	21.5
3	-	-	12	5	15	6.2	18	7.4	18	7.4	18	7.4
4	-	-	0	0	7	2.9	9	3.7	9	3.7	9	3.7
5	-	-	0	0	3	1.2	3	1.2	3	1.2	3	1.2
5+	-	-	0	0		0	1	0.4	1	0.4	1	0.4
Non-minor (N=173)												
0	-	-	98	56.6	83	48	77	44.5	74	42.8	72	41.6
1	-	-	40	23.1	31	17.9	23	13.3	26	15	25	14.5
2	-	-	24	13.9	28	16.2	17	9.8	13	7.5	14	8.1
3	-	-	8	4.6	10	5.8	19	11	15	8.7	13	7.5
4	-	-	3	1.7	9	5.2	11	6.4	12	6.9	12	6.9
5	-	-	0	0	8	4.6	7	4	9	5.2	7	4
5+	-	-	0	0	4	2.3	19	11	24	13.9	30	17.3
Type of AHRR												
Minor (N=242)												
Physiotherapist	129	53.3	48	19.8	57	23.6	69	28.5	0	0	0	0
Psychologist	3	1.2	1	0.4	2	0.8	5	2.1	0	0	0	0
Exercise physiologist	2	0.8	2	0.8	5	2.1	5	2.1	0	0	0	0
Chiropractor/Osteopath	6	2.5	2	0.8	3	1.2	4	1.7	0	0	0	0
Masseur/ Acupuncturist/ TCM	1	0.4	0	0.0	0	0.0	0	0.0	0	0	0	0
Other	**3**	1.2	0	0.0	0	0.0	0	0.0	0	0	0	0
No AHRR	98	40.5	189	78.1	175	72.3	159	65.7	242	100	242	100
Non-minor (N=173)												
Physiotherapist	72	41.6	29	16.8	36	20.8	48	27.7	12	6.9	9	5.2
Psychologist	10	5.8	3	1.7	15	8.7	19	11.0	12	6.9	11	6.4
Exercise physiologist	4	2.3	1	0.6	7	4.0	9	5.2	7	4.0	5	2.9
Chiropractor/Osteopath	3	1.7	0	0.0	0	0.0	2	1.2	0	0.0	0	0.0
Masseur/ Acupuncturist/ TCM	1	0.6	1	0.6	0	0.0	0	0.0	0	0.0	0	0.0
Other	0	0.0	1	0.6	1	0.6	0	0.0	1	0.6	1	0.6
No AHRR	83	48.0	138	79.8	114	65.9	95	54.9	141	81.5	147	85.0
AHRR Goal												
Minor (N=242)												
1. Increase pre-injury (normal activity/ employment duty) capacity	19	13.2	9	17.0	10	14.9	12	14.5	0	0	0	0
2. Increase function/ movement	17	11.8	5	9.4	6	9.0	9	10.8	0	0	0	0
3. Decrease pain	7	4.9	5	9.4	4	6.0	6	7.2	0	0	0	0
4. Improve mood	1	0.7	0	0.0	1	1.5	3	3.6	0	0	0	0
5. 1+2	21	14.6	11	20.8	14	20.9	12	14.5	0	0	0	0
6. 2+3	37	25.7	11	20.8	12	17.9	15	18.1	0	0	0	0

7. 1+3	14	9.7	3	5.7	6	9.0	4	4.8	0	0	0	0
8. 1+2+3	27	18.8	9	17.0	12	17.9	20	24.1	0	0	0	0
9. Not specified/ Other	1	0.7	0	0.0	2	3.0	2	2.4	0	0	0	0
Non-minor (N=173)												
1. Increase pre-injury (normal activity/ employment duty) capacity	13	14.4	6	17.1	14	23.7	16	20.5	4	12.5	4	15.4
2. Increase function/ movement	21	23.3	5	14.3	11	18.6	13	16.7	6	18.8	4	15.4
3. Decrease pain	2	2.2	0	0.0	0	0.0	3	3.8	1	3.1	1	3.8
4. Improve mood	7	7.8	3	8.6	10	16.9	17	21.8	9	28.1	5	19.2
5. 1+2	19	21.1	9	25.7	9	15.3	8	10.3	6	18.8	6	23.1
6. 2+3	7	7.8	4	11.4	2	3.4	3	3.8	4	12.5	1	3.8
7. 1+3	5	5.6	2	5.7	3	5.1	1	1.3	1	3.1	1	3.8
8. 1+2+3	13	14.4	6	17.1	9	15.3	14	17.9	1	3.1	3	11.5
9. Not specified/ Other	3	3.3	0	0.0	1	1.7	3	3.8	0	0	1	3.8

Note:

1. Percentages for number of AHRR and AHRR type are based on the number of claimants per minor injury group at 104-week post-injury, n=242 for minor and n=173 for non-minor.
2. Percentages for AHRR goal is based on number of AHRR per timepoint per minor injury classification.

2.6 Domestic Assistance over time

Domestic assistance recorded in the minor injury group was very low and ceased at 26 weeks. However as would be expected, domestic assistance in the non-minor injury group was somewhat more prevalent and continued for a small number of people. Table 20 provides details.

Table 20. Summary of domestic assistance by injury status over time

Types of Domestic Assistance	13-week Post-claim n	26-week Post-injury n	52-week Post-injury n	78-week Post-injury N	104-week Post-injury n
Minor (N=242)					
1. Personal care	1	0	0	0	0
2. Indoor home duty	2	2	0	0	0
3. Outdoor home duty	1	0	0	0	0
4. Shopping and appointment	1	0	0	0	0
Non-minor (N=173)					
1. Personal care	5	4	0	0	1
2. Indoor home duty	12	11	9	7	4
3. Outdoor home duty	4	4	6	3	1
4. Shopping and appointment	1	0	3	0	0

3 Recovery focus on health and work outcomes

3.1 Return to work

It is not possible to provide reliable return to work data from the audit. The reasons are that there are limited data for a substantial proportion of injured people from six months after injury, the recording of work capacity on the Certificate from the medical practitioner may not match whether the injured person is actually working, and the insurer files generally do not record that the person has returned to work. Further, only one vocational program was identified for the cohort.

Determining outcomes from the return to work, study and usual activities data is difficult due to incompleteness in this data in the claim files and variation between insurers. Capacity to work to full increases over time, with the non-minor injury rate of return to work being consistently less than the minor group. Table 21 provides details.

Table 21. Returned to Full Work Capacity by Minor Injury Group and Working Pre-injury

Returned to Full Work Capacity		All Claimants		Work Pre-injury	
		n	%	N	%
Minor		(N=242)		(n=165)	
	13-week post-claim	80	33.1	65	39.4
	26-week post-injury	101	41.7	84	50.9
	52-week post-injury	161	66.5	124	75.2
	78-week post-injury	161	66.5	124	75.2
	104-week post-injury	161	66.5	124	75.2
Non-Minor		(N=173)		(n=113)	
	13-week post-claim	23	13.3	21	18.6
	26-week post-injury	34	19.7	31	27.4
	52-week post-injury	77	44.5	61	54.0
	78-week post-injury	81	46.8	65	57.5
	104-week post-injury	84	48.6	68	60.2

Note: Percentages are based on the number of claimants per minor injury classification and number of claimants working pre-injury.

3.2 Recovery plan over time for Minor and Non-Minor Groups

Further, those who were working preinjury were more likely to have a recovery plan, and recovery plans are more prevalent in the non-minor group. Despite this, the plans themselves were found to be similar for both the minor and non-minor groups. Table 22 provides details of recovery plans.

Table 22. Number of Recovery Plan by Minor Injury Group and Working Pre-injury

Number of Rehab Plan	All Claimants		Work Pre-injury	
	n	%	n	%
	(N=242)		(n=165)	
Minor				
0	188	77.7	125	75.8
1	50	20.7	38	23.0
2	4	1.7	2	1.2
Non-minor	(N=173)		(n=113)	
0	91	52.6	51	45.1
1	50	28.9	38	33.6
2	16	9.2	12	10.6
3+	16	9.2	12	10.6

Note: Percentages are based on the number of claimants per minor injury classification and number of claimants working pre-injury.

There is difficulty assessing return-to-work data due to the large amount of missing information, and the inconsistencies in the work capacity data, making it is difficult to identify the specific work status of claimants. There are also issues with the quality of return-to-work data, with the current source of the information not recorded.

3.3 Return to usual health

No data are available from the insurer files that permit as assessment of the extent to which injured people return to their usual health status. No data were available that systematically assessed health outcomes.

In addition, no data were available that allowed an assessment of return to usual community or recreational activities.

4 Internal Review and Disputes for Minor and Non-Minor Injury Groups

Over the two-year period of the audit in total 77 claims were identified as having had at least one internal review of which 37 were classified as a minor injury. Table 23 shows details of reviews.

Table 23. Number of Internal Review Over Time

Number IR	52-week Post-injury		78-week Post-injury		104-week Post-injury	
	n	%	n	%	n	%
Minor (N=242)						
0	206	85.1	205	84.7	205	84.7
1	28	11.6	29	12	29	12
2	3	1.2	3	1.2	3	1.2
3	5	2.1	5	2.1	5	2.1
4	0	0	0	0	0	0
5	0	0	0	0	0	0
5+	0	0	0	0	0	0
Non-minor (N=173)						
0	138	79.8	138	79.8	133	76.9
1	27	15.6	27	15.6	29	16.8
2	5	2.9	5	2.9	6	3.5
3	3	1.7	2	1.2	3	1.7
4	0	0	0	0	1	0.6
5	0	0	0	0	0	0
5+	0	0	1	0.6	1	0.6

Note: Percentages are based on total number of claimants per minor injury group at 104 weeks post injury.

Internal review was undertaken for 33 claims that had been classified as a minor injury. In contrast, internal review was undertaken for 22 claims that had been classified as a non-minor injury. Internal review of only three minor injury claims related to liability as opposed to 14 for the non-minor group. The largest number of internal reviews were related to treatment decisions. Some differences can be seen between the minor and non-minor groups in the treatment types that were the subject of internal review. Table 24 gives a summary of types of internal reviews over time.

Table 24. Summary of Types of Internal Review Over Time

IR Type/ Decision made	13-week Post-claim	26-week Post-injury	52-week Post-injury	78-week Post-injury	104-week Post-injury	**Overall**	
	n	n	n	n	n	**n**	**%**
Minor Injury Decision							
Minor (N=242)						**(n=33)**	
1. Overturned	0	0	0	0	0	**0**	**0**
2. Upheld	1	14	15	0	0	**30**	**90.9**
3 Decision Pending	-	-	-	-	3	**3**	**9.1**
Non-minor (N=173)						**(n=22)**	
1. Overturned	0	7	2	0	0	**9**	**40.9**

2. Upheld	0	8	3	1	0	**12**	**54.5**
3 Decision Pending	-	-	-	-	1	**1**	**4.5**
Causation							
Non-minor (N=173)						**(n=1)**	
2. Upheld	0	0	1	0	0	**1**	**100**
Liability							
Minor (N=242)						**(n=3)**	
1. Overturned	0	1	0	0	0	**1**	**33.3**
2. Upheld	1	0	0	1	0	**2**	**66.7**
3 Decision Pending	-	-	-	-	0	**0**	**0**
Non-minor (N=173)						**(n=14)**	
1. Overturned	0	0	1	0	0	**1**	**7.1**
2. Upheld	0	0	4	6	0	**10**	**71.4**
3 Decision Pending	-	-	-	-	3	**3**	**21.4**
Treatment							
Minor (N=242)						**(n=15)**	
1. Overturned	1	0	4	0	0	**5**	**33.3**
2. Upheld	1	2	6	1	0	**10**	**66.7**
3 Decision Pending	-	-	-	-	0	**0**	**0**
Non-minor (N=173)						**(n=22)**	
1. Overturned				1	2	**3**	**13.6**
2. Upheld	3	5	6	1	2	**17**	**77.3**
3 Decision Pending	-	-	-	-	2	**2**	**9.1**
Type of Treatment							
Minor (N=242)						**(n=15)**	
Medical specialist	0	1	2	0	0	**3**	**20.0**
Physiotherapist	0	0	1	1	0	**2**	**13.3**
Occupational therapist	0	0	2	0	0	**2**	**13.3**
Psychiatrist	0	0	1	0	0	**1**	**6.7**
Masseur/ Acupuncturist/ TCM	1	0	0	0	0	**1**	**6.7**
Other	1	1	4	0	0	**6**	**40.0**
Non-minor (N=173)						**(n=22)**	
Medical specialist	1	0	2	2	1	**6**	**27.3**
Physiotherapist	0	1	2	0	0	**3**	**13.6**
Surgeon/ Surgical procedure	0	0	0	0	3	**3**	**13.6**
Orthotist/Prothetist/Aids or Applicances	0	1	0	0	0	**1**	**4.5**
Hospital rehabilitation	0	0	1	0	0	**1**	**4.5**
Other	2	3	1	0	2	**8**	**36.4**

Note:

1. Numbers per timepoint represent when the internal review decision was recorded.
2. 2. Percentages are based on total number of internal review per type of internal review.

Whilst the majority of internal reviews were identified as being for non-minor injury cases, internal review withdrawal was not recorded as part of the agreed data collection tool nor was rejection of the AHRR for further/ongoing treatment. This was also true for rejection of imaging, rehabilitation plan, and domestic assistance. This data is important for assessing the consumer experience of the claim's management process and so was not possible to perform for this review.

5 Observations

In summary, the audit suggests that the insurers are focused largely on the administrative and financial management of claims. There is significant variation in the claim records maintained both within and between the insurers can be identified in terms of both completeness and accuracy. There is little evidence of customer focused claims management beyond the initial stage of the claims' management process.

5.1 Data Quality

Within any given insurer, there is significant variation in both the standard and quality of the data that is being entered into a claim's records. This includes where information is located in a claimant's file and how it is being recorded.

Many certificates of fitness in the cohort sample were found to be inaccurate or incorrect. They lacked important detail, with some not even specifying the parts of the body that had been injured. It is recognized that these are completed by the treatment medical practitioners (mainly general practitioners) and insurers currently have no direct input into how they are completed.

Accurate and complete insurer claims records, provided by health professionals, are essential for the quality of case management. To improve insurer records, an essential element that requires attention is a decision as to what extent an insurer is responsible for ensuring that the reports/documents supplied to them by service providers are accurate. As without this accurate information, the effective assessment and determination of treatment needs is difficult.

Discussion

This Independent File Review Project has monitored the application of the minor injury threshold over a period of two-years following the change to the Motor Accident injuries Act 2017.

The data collection focused on retrieving answers to the SIRA specified 83 data parameter questions for 500 claimants. The 500 claimants had been identified by SIRA. It was known that these files would contain a mixture of claims with some meeting the Minor Injury criteria and some including "non-minor" injuries.

Several issues have been identified that point to the need for improvement in file/case record management and follow up, notably related to documents/data being incorrect, inaccurate or absent. From the insurer perspective these are:

- Whether treatment has ceased for all claimants whose liabilities had been rejected is not recorded
- Whether treatment was continuing for all claimants whose classification has changed to non-minor is not recorded
- Screening of risk of poor recovery is being implemented in different ways by the different insurers.
- Recovery and rehabilitation plans are absent for some cases that have changed from a minor to a non-minor injury classification
- Return to work data was incomplete/absent

From the service provider perspective these are:

- The SIRA COF with both details of diagnosis and capacity for work is not commonly being used by health professionals
- There is inaccurate recording of diagnoses on Certificates of Fitness
- The clinical purpose/reasons for the use imaging are not recorded.

Insurers operate out of a business model, which is underscored by economics. Decisions with regards to the minor injury classification are therefore most likely to not be aligned with best practice clinical management and health outcomes, but rather with operational practices and business management. This is particularly evident with the identification of the risk of poor recovery, where the risk of recovery is being implemented in different ways by the different insurers, with no screening found for almost one fifth of the claimant sample, and less than expected numbers of claimants identified as having a high risk of poor recovery.

it is suggested that consideration be given to establishing a mechanism to systematically measure health outcomes that relate to the clinical management of injured claimants. Best practice clinical management focused on clinical outcomes is paramount to the recovery of the injured person. Further, the measurement of quality of life would provide valuable information about recovery from the injured person's perspective.

Additionally, our investigation found no evidence of efforts to specifically assist a person to "get their life back on track" as is a focus for the Victorian Transport Accident Commission - https://www.tac.vic.gov.au/clients/how-we-can-help/treatments-and-services/policies/returning-to-work]

The data show that people injured in motor vehicle crashes are receiving treatment that is generally timely and appropriate. Furthermore, there is no evidence of undertreatment.

The minor injury definition does identify people with less severe injuries and there is a clear differentiation in the amount and types of treatment provided for people with minor and non-minor injuries.

Some people with “minor” injuries continue to have symptoms and restrictions in daily life beyond six months after injury. Also people who are “at fault” exit the Scheme at six months after injury and hence this audit could not investigate the extent of restrictions in health, work and daily life in these people.

The audit concludes that the minor injury definition and threshold has been implemented in accord with the Act and the associated regulations. More treatment is clearly provided to people with non-minor injuries.

There are limited disputes. It is difficult to determine whether there has been a recovery focus on health and work outcomes from the data that are available in the audit.

Limitations

At fault status was not included as a variable in the agreed SIRA data collection tool, but it was collected at the 78 week time point. In a case where the claimant is at fault, the insurer is not required but is recommended to make a minor injury determination. Therefore, the minor injury decisions are only relevant to those not at fault. In reality the insurer may or may not have a preliminary minor injury determination on file. Therefore, the final minor injury determination at 52 weeks may include preliminary minor injury decisions for at fault cases.

Consequently, there are likely to be lags in data recording, this is particularly an issue for documents that we do not collect dates for, including when treatment was paid, when imaging was paid, the capacity for work decision and internal reviews. Date of payment was recorded rather than the treatment date due to the wording of the agreed data collection instrument.

Additionally, whilst it is known that risk screening may not be required for those with early notifications and those with major injury severity such as those accepted into Lifetime Care Scheme, the accuracy of the current early notification data is unclear. Although few cases of Lifetime Care Scheme have been identified and excluded in the analysis, this information was not recorded as part of the routine data collection, it is not currently part of the agreed data collection tool, and it is unclear if all claimants with inappropriate injury severity had been captured and excluded in the analysis.

According to our protocol, the data collected were mainly based on documents uploaded into the claimants’ case folders. Some information has relied on insurers’ tabs and insurers’ field notes due to a combination of time limitations, an overwhelming amount of information in some files particularly for severe non-minor cases and difficulty locating information due to the lack of standardisation within insurers’ documentation. In these cases, some information may have been missed.

There are some further limitations resulting from our collection protocol. These include:

- Only the initial and latest diagnoses were recorded between the timepoints, therefore key diagnoses that were used to determine the final minor injury decision may not be captured
- When multiple imaging had been paid for, the most “detailed imaging” (MRI) was collected. Therefore, there will likely be under reporting of the imaging that has been performed.

- Treatment and imaging recorded were based on the timepoint these were paid for, instead of when claimants received the services.
- At each time point, the total number of AHRRs and recovery plans were counted. When there were more than one AHRR or recovery plan updated at either timepoint, the AHRR or recovery plan details such as goals, dates and/or treatment were only recorded for the latest AHRR and recovery plan.
- Rehabilitation plans could have had a domestic assistance component embedded and so not be recorded separately, yet in this case would be approved by insurer as part of the plan.

Further, the return-to-work data had a large amount of missing information, and the inconsistencies in the work capacity data, made it is difficult to identify the specific work status of claimants. There were also issues with the quality of return-to-work data, with the current source of the information not recorded, making it impossible to identify if this data has been reported by health professionals, employers, insurers or claimants.

It should be noted that a small number of cases were settled by the insurers, with an agreed amount of payment. Again, this information was not recorded as part of the routine data collection, as it was not part of the agreed data collection tool. Further, it is not known how many of these cases were contained in the allocated files. This means that some cash settlement cases may not have had a complete record of information such as treatment and RTW status on file.

There is much consistency in the data across all the data collection points, and the number of people determined to have non-minor injuries has progressively increased. It is therefore important to properly understand how injury classification is being implemented over the first six months after the accident where a claim can be classified as minor or non-minor.

There is a need for record/data standardisation to occur across the insurers as without this, fully accurate comparisons in how the Act is being implemented are problematic. This could best be supported by the development of guidelines that specify the documents to be used, including where diagnoses must be recorded, and the actual assessment processes to be performed, such for identifying risk of poor recovery.

The insurers and SIRA staff are thanked for their assistance with the completion of the independent insurer file study.

Appendix 1 Project Findings at 104 Weeks Report

Executive summary 104 week time point data analysis

1. Evaluation of data to 104 weeks after injury for 500 people with motor traffic injury has been successfully completed. In total, 76 out of 500 cases (15%) have now been excluded from the analysis.
2. At the 104 weeks post injury audit, of the 424 claimants included in the overall analysis, 130 remained open at 78 weeks post injury and were revisited at 104 weeks, of which 118 were determined as having a non-minor injury, with the increase in non-minor injury continuing to be observed overtime. Non-minor injury is more likely to be physical (89/118, 75%) than psychological. At 104 weeks a total of 105 cases remained open, of which 100 (95%) claimants sustained a non-minor injury and the remaining 5 (5%) sustained a minor injury.
3. The most prevalent injured body parts at 104 weeks are neck/ cervical spine injuries, closely followed by upper extremity/shoulder and lower extremity injuries. The most prevalent type of physical injury, really mainly symptoms, at 104 weeks is pain, followed by nerve damage/ impingement, other/ unspecified and fracture/ bony injury.
4. The most prevalent type of psychological injury at 104 weeks remains post-traumatic stress disorder.
5. At 104 weeks, almost 10 percent of open minor claims and over one quarter of open non-minor claims can be identified as having a psychological injury.
6. At 104 weeks, re-screening for risk of poor recovery was not found for any of the 130 claimants. The latest screening outcome on file for 28% (36/130) of claimants were low risk, 16% (21/130) of claimants did not have any screening results recorded.
7. Treatment has continued to decrease over time. At each time point the most prevalent types of treatment are physiotherapy and medical treatment provided by the general practitioner or specialist consultations.
8. At 104 weeks post-injury, most people receiving treatment had non-minor injuries (60/64, 94%).
9. The number of claimants with imaging paid for at 104 weeks post-injury has decreased, with no imaging in the minor group. Imaging studies are being requested by medical specialists and general practitioners (71% and 21% respectively).
10. Allied health recovery requests on file at 104 weeks after injury continued to relate to physiotherapy, with the number relating to psychology services continuing to increase since the 52 week time point.
11. At 104 weeks post-injury, 48% of the claimants did not have a recovery plan, 29% of claimants had one recovery plan and another 11% of claimant had two recovery plans.
12. The increasing trend for psychological allied health recovery request continues.
13. At 104 weeks post-injury, no active rehabilitation plans were identified for minor injury claimants. However, 23% (27/118) of non-minor cases were still receiving external rehabilitation services.
14. At 104 weeks, the majority of active claims did not have an updated capacity for work, 18% (16/87) of claimants working pre-injury had no capacity for work.
15. At 104 weeks, 39% (34/87) of active claims working pre-injury had not returned to any level of work.
16. At 104 weeks of the active claims, new 11 internal review decisions were recorded for non-minor cases, all internal reviews were related to insurers' decisions related to treatment, with 5 (46%) upholding the original decision, 5 (46%) overturning the original decision and 1 (9%) still pending. Overall, 45 (35%) of the 130 claimants with open claims had requested an

internal review, the majority were related to the minor injury decision determination (28, 62%).

17. In summary at 104 weeks post injury, of the 130 included cases 9% (12) had minor injury, 91% (118) had non-minor injury, 49% (43/87) of those employed prior to injury had returned to work, 17% (22/130) were recorded as being at risk of non-recovery, 43 (33%) had treatment from their general practitioner, 32 (25%) had treatment from medical specialists, 31 (24%) had physiotherapy treatment, 25 (19%) had treatment with psychologist, 6 (5%) had treatment with psychiatrist and 11 (8%) had requested an internal review.

Methods

The 131 claim files, which had been open past 78-week post-injury, were accessed in February 2020 at the 104 week time point. Data collection was completed by one JWCRR researchers over this three-week period (1 February 2020 to 14 February 2020).

In total 76 cases out of the 500 cases (15%) were identified as lacking information and have now been excluded from the report. Half (50%) of those excluded were notification only cases. Other cases that were excluded include interstate claims (12%), claims that were accepted as an interim participant into the lifetime care scheme (11%), claims that were no longer managed by the assigned insurers (8%), and workers compensation claims (7%).

Findings

The findings are presented with reference to sub-headings that are largely based on the SIRA specified key areas of data collection. Some changes have been made for clarification and clarity of reporting.

There are data items that are not applicable or missing. These are left labelled as such for this report for identification purposes.

Important data are reported in tables which are interpreted in the text. Comments about less important data items are also provided in the text.

A1 Minor Injury Determination

At 104 weeks after injury, 57% of claimants were determined as having sustained minor injuries, 41% of claimants had non-minor injuries. The minor injury decision could not be identified or was not required for the remaining 2% of claimants. Table A1 shows the final minor injury determination at 104 weeks after injury.

Table A1. Latest Minor Injury Determination at 104-Week Post-injury for all 424 claimants

Final Minor Injury Determination	N	%
1. Minor - Physical/Soft tissue	212	50.0
2. Minor – Psychological	3	0.7
3. Minor - Both physical and psychological	22	5.2
4. Minor - Not specified	5	1.2
5. Non-minor - Physical/Soft tissue	132	31.1
6. Non-minor – Psychological	17	4.0

7. Non-minor - Both physical and psychological	12	2.8
8. Non-minor - Not specified	12	2.8
9. Not recorded	9	2.1
Total	**424**	

Note:
1. Percentages for individual minor injury decisions are based on the total number of claimants (N=424).
2. Only 130 claimants whose claims remained opened past 78-week post injury were followed up at 104-week post-injury.

Table A2. Fault Status per Minor Injury Group for all 424 claimants

	Final Fault Status		
Final Minor Injury Decision	1.Not at fault	2.At fault	3.Other
1. Minor - Physical (n=212)	188	21	3
2. Minor - Psychological (n=3)	3	0	0
3. Minor - Both physical and psychological (n=22)	21	1	0
4. Minor - Not specific (n=5)	3	2	0
5. Non-minor - Physical (n=132)	89	41	2
6. Non-minor - Psychological (n=17)	17	0	0
7. Non-minor - Both physical and psychological (n=12)	10	2	0
8. Non-minor - Not specified (n=12)	4	8	0
9. Not recorded (n=9)	1	6	2

Note: Minor injury status is based on final decision at 104-week post-injury. Fault status was collected only at 78-week post-injury.

Twenty-four claimants initially classified as having sustained minor injuries were determined to have sustained non-minor injuries at later audit points. The change in the minor injury decision occurred at 26 weeks post injury for five claimants, 52 weeks post injury for ten claimants, and 78 weeks post injuries for six claimants, and 104 weeks post injury for the remaining three claimants. Of these 24 claims, 11 were managed by Suncorp, 11 by NRMA and 2 by Allianz. Twenty-three of those cases that had their minor injury decision changed to non-minor remained open at 78 weeks post injury, and were reviewed at 104-week post-injury. Of the 23 claimants, 11 were determined to have sustained non-minor physical injuries only, 10 were non-minor psychological injuries only, and 2 was both physical and psychological non-minor injuries.

Table A3. Summary Minor injury determination for all 424 claimants

Minor Injury Decision	13-week post-claim	26-week post-injury	52-week post-injury	78-week post-injury	104-week Post-injury
	%	%	%	%	%
1. Minor - Physical/Soft tissue	46.7	54.2	45.0	50.2	50.0
2. Minor – Psychological	1.4	1.7	1.4	0.9	0.7
3. Minor - Both physical and psychological	3.8	3.3	4.7	5.7	5.2
4. Minor - Not specified	-	-	2.4	1.2	1.2

5. Non-minor - Physical/Soft tissue	-	-	-	28.8	31.1
6. Non-minor – Psychological	-	-	-	4.7	4.0
7. Non-minor - Both physical and psychological	-	-	-	0.5	2.8
8. Non-minor - Not specified	26.9	30.7	35.4	5.9	2.8
9. Not recorded	21.2	10.1	11.1	2.1	2.1

Note:
Percentages for individual minor injury decisions are based on the total number of claimants (N=424), the percentages on the 13-week post-claim column add up to 100.

At the 104 week time point, of the 130 claims that had not been closed/ settlement at 78-weeks post-injury, 12 (9%) claimants were determined to have sustained a minor injury. Table 8 shows the latest minor injury decision for the 130 claimants followed-up at 104 weeks post injury.

Table A4. Latest Minor Injury Determination for 130 claimants followed up at 104-week post-injury.

Final Minor Injury Decision	N	%
1. Minor - Physical/Soft tissue	7	5.4
2. Minor – Psychological	1	0.8
3. Minor - Both physical and psychological	4	3.1
4. Minor - Not specified	0	0
5. Non-minor - Physical/Soft tissue	89	68.5
6. Non-minor – Psychological	17	13.1
7. Non-minor - Both physical and psychological	12	9.2
8. Non-minor - Not specified	0	0
9. Not recorded	0	0

Note: Percentages for individual minor injury decisions are based on the total number of claimants followed up at 104-week post-injury (N=130).

Like 52 weeks and 78 weeks post-injury, at 104 weeks post-injury a maximum number of four physical diagnoses and two psychological diagnoses were recorded per claimant per certificate of fitness.

A2 Injury Type - Physical

At the 104 weeks post-injury time point, injuries to neck/ cervical spine were most commonly recorded (n=28), followed by upper extremity/ shoulders (n=27) and lower extremity (n=26). Table 9 shows the body regions reported as injured by claimants.

Further, the number of total injuries affecting specific body parts was 125 for the 130 claimants, with 37 people having had more than one physical injury. A total of 51 claimants had an updated COF at 104 weeks post injury. The maximum number of physical injuries recorded per claimant is four per certificate of fitness. The latest physical diagnoses were dated at the median date of 9th January 2020, with the earliest dated 6th August 2019, and latest dated 12th February 2020.

Table A5. Body Region - Physical Injury at 104-week Post-injury for 130 claimants

Body Region - Physical Injury	n	%*
Neck/ Cervical spine	28	21.5
Upper extremity/ shoulders	27	20.8
Lower extremity	26	20.0
Lower back/ Lumbosacral spine	14	10.8
Upper back/ Thoracic spine	13	10.0
Head	11	8.5
Unspecified	2	1.5
Thorax	2	1.5
Face	2	1.5
Total	**125**	

Note:

1. Percentages for individual diagnoses are based on the total number of claimants followed up at 104-week post-injury (N=130).
2. As there can be multiple diagnoses for each person, the total percentage may not add to 100%.

With reference to the type of injuries listed in the latest available physical diagnoses, the main categories were pain (38), nerve damage/ impingement (21), other/ unspecified (18) and fracture/ bony injury (18). Effectively the total number of injuries recorded was again 125 for the 130 claimants followed up at 104 weeks post injury. A considerable number (14%) of diagnoses were not specified and a further 29% actually specified pain which is a symptom rather than a diagnosis. Table 10 reports the physical injury type at 104 weeks post injury. As the highest prevalence injury "type" is pain, this categorisation cannot be seen as diagnoses.

Table A6. Physical Injury Type at 104-week Post-injury for 130 claimants

Physical Injury Type	n	%*
Pain	38	29.2
Nerve damage/ impingement	21	16.2
Other/ unspecified	18	13.8
Fracture/ bony injury	18	13.8
Ligament/ tendon rupture	11	8.5
Sprain/ strain	6	4.6
Head injury/ concussion	4	3.1
Bruising/ abrasion/ haematoma/ superficial injury	4	3.1
WAD (unspecified)	3	2.3
Dislocation	2	1.5
Total	**125**	

Note:

1. Percentages for individual diagnoses are based on the total number of claimants followed up at 104-week post-injury (N=130).
2. As there can be multiple diagnoses for each person, the total percentage does not add to 100%.

Sub-group Analysis 1: Comparing Minor Injury and Non-Minor Physical Injury Cases

This analysis shows that non-minor physical injuries are more commonly sustained to the upper extremity/shoulder, lower extremities and neck/cervical spine. In fact, at 104 weeks post injury, seven minor injury claims were still active, six of which were spinal injury. Table A7.

Table A7. Minor Versus Non-minor - Physical Injuries by Body Part at 104-week Post-injury

Physical Injury Body Part	Non-minor (n=118)		Minor (n=12)	
	n	%*	n	%*
Upper extremity/ shoulders	26	22.0	1	8.3
Lower extremity	26	22.0	0	0
Neck/ Cervical spine	24	20.3	4	33.3
Lower back/ Lumbosacral spine	18	15.3	2	16.7
Head	11	9.3	0	0
Upper back/ Thoracic spine	7	5.9	0	0
Unspecified	2	1.7	0	0
Face	2	1.7	0	0
Thorax	2	1.7	0	0
Total	**118**		**7**	

Note:

1. Percentages for individual diagnoses are based on the number of claimants per minor injury group at 104-week post-injury, n=12 for minor and n=118 for non-minor.
2. As there can be multiple diagnoses for each person, the total percentage does not add to 100%.

Table A8. Minor Versus Non-minor - Physical Injuries by Type at 104-week Post-injury

Physical Injury Type	Non-minor (n=118)		Minor (n=12)	
	n	%*	N	%*
Pain	37	31.4	1	8.3
Nerve damage/ impingement	20	16.9	1	8.3
Other/ unspecified	16	13.6	2	16.7
Fracture/ bony injury	18	15.3	0	0
Ligament/ tendon rupture	9	7.6	2	16.7
Sprain/ strain	5	4.2	1	8.3
Head injury/ concussion	4	3.4	0	0
Bruising/ abrasion/ haematoma/ superficial injury	4	3.4	0	0
WAD (unspecified)	3	2.5	0	0
Dislocation	2	1.7	0	0
Total	**118**		**7**	

Note:

1. Percentages for individual diagnoses are based on the number of claimants per minor injury group at 104-week post-injury, n=12 for minor and n=118 for non-minor.
2. As there can be multiple diagnoses for each person, the total percentage does not add to 100%.

A3 Injury Type - Psychological

At 104 weeks post-injury, 32 out of the 130 claimants (24%) had at least one updated psychological diagnosis. The total number of psychological diagnoses recorded was 54 for the 130 claimants. Post-traumatic stress disorder (22) was most commonly reported, followed by others (9), along with major depressive episode (8) and anxiousness (8). The latest psychological diagnoses had a median date of 28th November 2019, with the earliest dated 5th July 2019, and latest dated 17th February 2020. Note that there may be delay in insurers receiving medical diagnoses from health professionals. Table 13 shows the most recent types of psychological injury recorded at the 104-week review. Most of these are diagnoses.

Table A9. Psychological Injury at 104-week Post-injury for 130 claimants

Psychological Injury	N	%*
Post-traumatic Stress Disorder	22	16.9
Others	9	6.9
Major Depressive Episode	8	6.2
Anxious	8	6.2
Adjustment Disorder	3	2.3
Insomnia	2	1.5
Generalised Anxiety Disorder	1	0.8
Stress	1	0.8
Total	**54**	

Note:

1. Percentages for individual diagnoses are based on the total number of claimants followed up at 24-month post-injury (N=130).
2. There can be multiple diagnoses for each person, so that the total percentage does not add to 100%.
3. Due to the change in recording at the 52-week time point, the psychological diagnosis recorded may not be mutually exclusive of those at the 13-week post-claim and 26-week post-injury time points

The most prevalent psychological injury is post-traumatic stress disorder (18%) and others (8%). It should be noted that one participant with post-traumatic stress disorder was categorised as having a minor injury. Table A10.

Table A10. Minor versus Non-minor - Psychological Injury

Psychological Injury Type	Non-minor (n=118)		Minor (n=12)	
	n	%*	n	%*
Post-traumatic Stress Disorder	21	17.8	1	100
Others	9	7.6	0	0
Major Depressive Episode	8	6.8	0	0
Anxious	8	6.8	0	0
Adjustment Disorder	3	2.5	0	0
Insomnia	2	1.7	0	0
Generalised Anxiety Disorder	1	0.8	0	0
Stress	1	0.8	0	0
Total	**53**		**1**	

Note:

1. Percentages for individual diagnoses are based on the number of claimants per minor injury group at 104-week post-injury, n=12 for minor and n=118 for non-minor.
2. As the numbers only include those with psychological injuries, the total percentage does not add to 100%.

Non-minor injury cases were progressively more likely to have a psychological injury compared to a minor injury over the audit periods until 52 weeks. Table A11.

Table A11. Comparing Psychological Injury between Minor Injury and Non-minor Cases over Time

With Any Psychological Diagnosis	Non-minor (N=118)		Minor (N=12)	
	n	%	n	%
First COF	11	9.3	4	33.3
Latest COF at 13-week	15	12.7	4	33.3
Latest COF at 26-week	26	22.0	5	41.7
Latest COF at 52-week	48	40.7	7	58.3
Latest COF at 78-week	29	24.6	1	8.3
Latest COF at 104-week	31	26.3	1	8.3

Note:
1. Percentages for individual diagnoses are based on the number of claimants per minor injury group at 104-week post-injury, n=12 for minor and n=118 for non-minor.
2. The numbers only include those with psychological injuries, including psychological diagnoses and symptoms.
3. Due to the change in recording at the 52-week time point, the physical diagnosis recorded may not be mutually exclusive of those at the 13-week post-claim and 26-week post-injury time points.

Figure A2 shows the percentages of minor and non-minor claimants with psychological injuries over time. The psychological injuries for minor claimants recorded at 104 weeks have remained stable as compared with the 78 week time point, having peaked at 52 weeks.

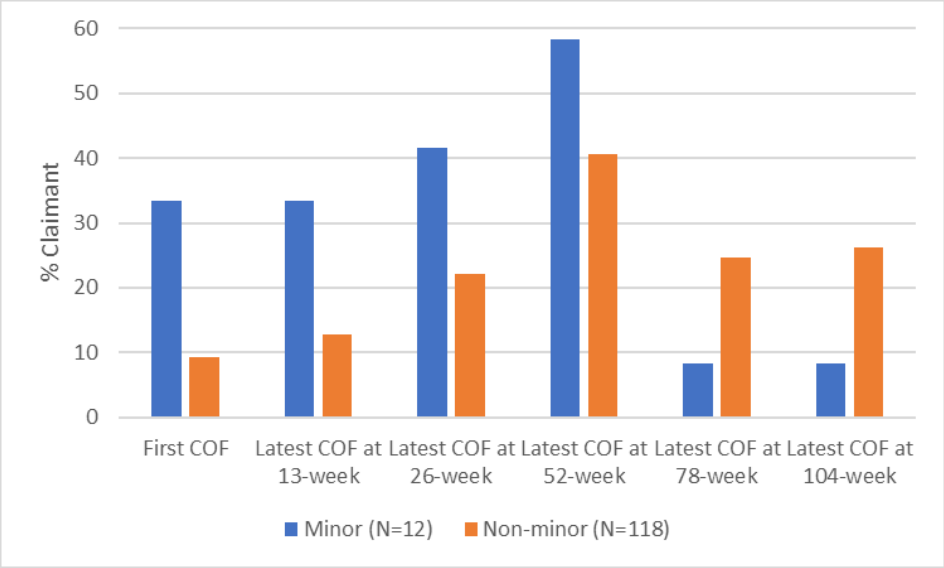


Figure A2. Presence of Psychological Injury between Minor (n=12) and Non-minor (n=118) over time

A4 Assessment of Risk of Poor recovery

Re-screening results for risk of poor recovery were not found for any claimants at 104 weeks post injury.

Table A12. Summary of Screening Outcomes for 130 Claimants

Risk Recovery Screening Outcome	13-week Post-claim		26-week Post-injury		52-week Post-injury		78-week Post-injury		104-week Post-injury		**Latest Screening**	
	n	%	n	%	n	%	n	%	n	%	**n**	**%**
1. Low/ Good	31	23.8	2	1.5	3	2.3	4	3.1	0	0	**36**	**27.7**
2. Medium	43	33.1	3	2.3	7	5.4	4	3.1	0	0	**51**	**39.2**
3. High/ Poor	19	14.6	3	2.3	3	2.3	2	1.5	0	0	**22**	**16.9**
4. Not recorded	37	28.5	122	93.8	117	90.0	120	92.3	130	100	**21**	**16.2**

Note: Percentages for risk recovery screening outcomes are based on the total number of claimants followed up at 24-month post-injury (N=130).

Table A13. Minor versus Non-Minor - Summary of Screening Outcomes for 130 Claimants

Risk Recovery Screening Outcome	13-week Post-claim		26-week Post-injury		52-week Post-injury		78-week Post-injury		104-week Post-injury		**Latest Screening**	
	n	%	n	%	n	%	n	%	n	%	**n**	**%**
Minor (N=12)												
1. Low/ Good	2	16.7	1	8.3	0	0	0	0	0	0	**3**	**25.0**
2. Medium	3	25	0	0	0	0	1	8.3	0	0	**4**	**33.3**
3. High/ Poor	3	25	0	0	0	0	0	0	0	0	**2**	**16.7**
4. Not recorded	4	33.3	11	91.7	12	100	11	91.7	12	100	**3**	**25.0**
Non-minor (N=118)												
1. Low/ Good	29	24.6	1	0.8	3	2.5	4	3.4	0	0	**33**	**28.0**
2. Medium	40	33.9	3	2.5	7	5.9	3	2.5	0	0	**47**	**39.8**
3. High/ Poor	16	13.6	3	2.5	3	2.5	2	1.7	0	0	**20**	**16.9**
4. Not recorded	33	28.0	111	94.1	105	89.0	109	92.4	118	100	**18**	**15.3**

Note: Percentages are based on the number of claimants per minor injury group at 104-week post-injury, n=12 for minor and N=118 for non-minor.

A5 Treatment and Imaging

It was found that about half of the claimants (64, 49%) had had treatment paid for 104 weeks after their injury. Similar to previous findings, the most prevalent types of treatment were general practitioner (43) services, followed by medical specialist (32), Physiotherapist (31) and psychology (25).

Table A14. Summary of Treatment Paid for by Insurers for 130 claimants

Treatment Paid for by Insurers	13-week post-claim		26-week post-injury		52-week post-injury		78-week post-injury		104-week post-injury	
	n	%*	n	%*	n	%*	n	%*	n	%*
GP	67	51.5	59	45.4	66	50.8	52	40	43	33.1
Medical specialist	40	30.8	38	29.2	51	39.2	44	33.8	32	24.6

Physiotherapist	60	46.2	70	53.8	65	50	45	34.6	31	23.8
Psychologist	19	14.6	30	23.1	5	3.8	30	23.1	25	19.2
Pharmaceutical	42	32.3	25	19.2	17	13.1	21	16.2	15	11.5
Surgeon/ Surgical procedure	19	14.6	14	10.8	24	18.5	15	11.5	14	10.8
Exercise physiologist	2	1.5	11	8.5	40	30.8	9	6.9	11	8.5
Orthotist/Prosthetist/Aids or Appliances	29	22.3	14	10.8	22	16.9	7	5.4	7	5.4
Psychiatrist	0	0	1	0.8	4	3.1	2	1.5	6	4.6
Chiropractor/Osteopath	3	2.3	3	2.3	6	4.6	3	2.3	4	3.1
Other	5	3.8	1	0.8	1	0.8	0	0	3	2.3
Masseur/ Acupuncturist/ TCM	3	2.3	4	3.1	1	0.8	3	2.3	2	1.5
Hospital medical officer	8	6.2	4	3.1	6	4.6	0	0	1	0.8
Hospital overnight stay	6	4.6	5	3.8	3	2.3	0	0	1	0.8
Hospital rehabilitation	4	3.1	3	2.3	3	2.3	2	1.5	1	0.8
Occupational therapist	5	3.8	4	3.1	0	0	0	0	0	0
Dentist/ Orthodontist	2	1.5	2	1.5	0	0	0	0	0	0
Total	**314**		**288**		**314**		**233**		**196**	

Note:
1. Percentages for treatments are based on the total number of claimants followed up at 24-month post-injury (N=130).
2. As there can be multiple treatments for each person, the total percentage will therefore not add to 100%.

At 104 weeks, the majority of imaging was referred by medical specialists (71%) followed by general practitioners (21%). The imaging data is summarised in Table 19. for both minor and non-minor injuries.

Table A15. Summary of Imaging Paid for by Insurers for 130 claimants

	13-week post-claim		26-week post-injury		52-week post-injury		78-week post-injury		104-week post-injury	
	n	%*	n	%*	n	%*	n	%*	n	%*
Imaging Type										
1. X-ray	12	21.8	9	27.3	7	17.1	11	34.4	2	14.3
2. CT scan	2	3.6	4	12.1	5	12.2	2	6.3	2	14.3
3. MRI	16	29.1	10	30.3	12	29.3	11	34.4	1	7.1
4. 1+2	7	12.7	2	6.1	0	0	2	6.3	1	7.1
5. 2+3	1	1.8	1	3.0	2	4.9	2	6.3	3	21.4
6. 1+3	9	16.4	2	6.1	2	4.9	1	3.1	1	7.1
7. 1+2+3	0	0	0	0	3	7.3	0	0	1	7.1
8. Ultrasound	5	9.1	5	15.2	7	17.1	2	6.3	3	21.4
9. Bone scan	2	3.6	0	0	0	0	0	0	0	0
10. Other	1	1.8	0	0	3	7.3	1	3.1	0	0
Purpose of Imaging										
Assist diagnosis	22	40.0	9	27.3	5	12.2	5	15.6	2	14.3
Direct treatment	2	3.6	1	3.0	10	24.4	4	12.5	2	14.3
Investigative	5	9.1	12	36.4	10	24.4	14	43.8	6	42.9
Not specified /Can't tell	26	47.3	11	33.3	16	39.0	9	28.1	4	28.6

Referring Professional										
1. General practitioner	24	43.6	14	42.4	10	24.4	9	28.1	3	21.4
2. Medical specialist	11	20.0	7	21.2	25	61.0	23	71.9	10	71.4
3. Physiotherapist	0	0	1	3.0	1	2.4	0	0	0	0
4. 1+2	0	0	0	0	0	0	0	0	0	0
5. 2+3	0	0	1	3.0	1	2.4	0	0	0	0
6. Hospital medical officer	11	20.0	2	6.1	3	7.3	0	0	0	0
7. Not specified /Can't tell	8	14.5	8	24.2	1	2.4	0	0	1	7.1
8. Other	1	1.8	0	0	0	0	0	0	0	0
Total	**55**		**33**		**41**		**32**		**14**	

Note:
1. Only 130 claimants whose claims remained open at 78-week post injury were followed up at 104-week post-injury.
2. Percentages are based on the total number of the 130 claimants with any imaging for each specific time point per minor injury decision.

As would be expected the range of treatment type provided for non-minor injury claimants was far greater than for the minor injury claimants. Table A16.

Table A16. Minor versus Non-Minor -Treatment Paid for by Insurers

Treatment Paid for by Insurer	13-week Post-claim		26-week Post-injury		52-week Post-injury		78-week Post-injury		104-week Post-injury	
	n	%*	n	%*	n	%*	n	%*	n	%*
Minor (N=12)										
1. GP	11	91.7	9	75.0	6	50.0	3	25.0	1	8.3
2. Physiotherapist	10	83.3	8	66.7	6	50.0	2	16.7	0	0
3. Medical specialist	0	0	1	8.3	2	16.7	2	16.7	1	8.3
4. Pharmaceutical	5	41.7	4	33.3	1	8.3	2	16.7	0	0
5. Orthotist/Prosthetist /Aids or Appliances	3	25.0	1	8.3	0	0	0	0	0	0
6. Surgeon/ Surgical procedure	0	0	0	0	0	0	0	0	0	0
7. Psychologist	4	33.3	3	25.0	0	0	1	8.3	1	8.3
11. Other	0	0	0	0	0	0	0	0	1	8.3
13. Chiropractor/Osteopath	0	0	0	0	0	0	0	0	0	0
14. Masseur/ Acupuncturist/ TCM	1	8.3	1	8.3	0	0	0	0	0	0
15. Exercise physiologist	0	0	4	33.3	3	25.0	0	0	0	0
18. Psychiatrist	0	0	0	0	0	0	0	0	0	0
Non-minor (N=118)										
1. GP	57	48.3	50	42.4	60	50.8	49	41.5	42	35.6
2. Physiotherapist	50	42.4	62	52.5	60	50.8	43	36.4	31	26.3
3. Medical specialist	40	33.9	37	31.4	49	41.5	42	35.6	31	26.3
4. Pharmaceutical	37	31.4	21	17.8	16	13.6	19	16.1	15	12.7
5. Orthotist/Prosthetist /Aids or Appliances	26	22.0	13	11.0	22	18.6	7	5.9	7	5.9
6. Surgeon/ Surgical procedure	19	16.1	14	11.9	24	20.3	15	12.7	14	11.9
7. Psychologist	15	12.7	27	22.9	33	28.0	30	25.4	21	17.8

8. Hospital medical officer	8	6.8	4	3.4	6	5.1	0	0	1	0.8
9. Hospital overnight stay	6	5.1	5	4.2	3	2.5	0	0	1	0.8
10. Occupational therapist	5	4.2	4	3.4	0	0	0	0	0	0
11. Other	5	4.2	1	0.8	1	0.8	0	0	2	1.7
12. Hospital rehabilitation	4	3.4	3	2.5	3	2.5	2	1.7	1	0.8
13. Chiropractor/Osteopath	3	2.5	3	2.5	6	5.1	3	2.5	4	3.4
14. Masseur/ Acupuncturist/ TCM	2	1.7	3	2.5	1	0.8	3	2.5	2	1.7
15. Exercise physiologist	2	1.7	7	5.9	8	6.8	9	7.6	11	9.3
16. Dentist/ Orthodontist	2	1.7	2	1.7	0	0	0	0	0	0
17. Nurse/Wound dressings	0	0	0	0	0	0	0	0	0	0
18. Psychiatrist	0	0	1	0.8	4	3.4	2	1.7	6	5.1

Note:

1. Percentages for individual treatment are based on the number of claimants per minor injury group at 104-week post-injury, n=12 for minor and N=118 for non-minor.
2. As there can be multiple treatments for each person, so the total percentage may not add to 100%.

Table A17. Minor versus Non-Minor -Imaging Paid for by Insurer

	Minor (N=12)					**Non-minor (N=118)**				
	13-week	26-week	52-week	78-week	104-week	13-week	26-week	52-week	78-week	104-week
	%	%	%	%	%	%	%	%	%	%
Imaging Type	(n=6)	(n=3)	(n=1)	(n=0)	(n=0)	(n=49)	(n=30)	(n=40)	(n=32)	(n=14)
1. X-ray	16.7	0	0	0	0	22.4	30.0	17.5	34.4	14.3
2. CT scan	0	33.3	0	0	0	4.1	10.0	12.5	6.3	14.3
3. MRI	66.7	66.7	0	0	0	24.5	26.7	30.0	34.4	7.1
4. 1+2	0	0	0	0	0	14.3	6.7	0	6.3	7.1
5. 2+3	0	0	0	0	0	2.0	3.3	5.0	6.3	21.4
6. 1+3	0	0	0	0	0	18.4	6.7	5.0	3.1	7.1
7. 1+2+3	0	0	0	0	0	0	0	7.5	0	7.1
8. Ultrasound	16.7	0	100	0	0	8.2	16.7	15.0	6.3	21.4
9. Bone scan	0	0	0	0	0	4.1	0	0	0	0
10. Other	0	0	0	0	0	2.0	0	7.5	3.1	0
Purpose of Imaging										
Assist diagnosis	33.3	33.3	0	0	0	40.8	26.7	12.5	15.6	14.3
Direct treatment	0	0	100	0	0	4.1	3.3	22.5	12.5	14.3
Investigative	16.7	33.3	0	0	0	8.2	36.7	25.0	43.8	42.9
Not specified/can't tell	50.0	33.3	0	0	0	46.9	33.3	40.0	28.1	28.6
Referring Professional										
1. General practitioner	0	0	0	0	0	0	0	0	0	0
2. Medical specialist	83.3	66.7	100	0	0	38.8	40.0	22.5	28.1	21.4
3. Physiotherapist	0	0	0	0	0	22.4	23.3	62.5	71.9	71.4

4. 1+2	0	0	0	0	0	0	3.3	2.5	0	0
5. 2+3	0	0	0	0	0	0	0	0	0	0
6. Hospital medical officer	0	0	0	0	0	0	3.3	2.5	0	0
7. Not specified/can't tell	0	0	0	0	0	22.4	6.7	7.5	0	0
8. Other	16.7	33.3	0	0	0	14.3	23.3	2.5	0	7.1

Note: Percentages are based on the number of screening per minor injury group at each specific timepoint.

A6 Allied Health Recovery Request

At 104 weeks post-injury, the total number of AHRR for the 130 claimants is 431, over half of the claimants (91, 70%) had one or more approved AHRR on file. Thirteen claimants had one AHRR, 14 people had two AHRR, 14 had three AHRR, 12 had four AHRR and the remaining 38 claimants had five or more AHRR on file. Table A18.

Of the 38 cases with five or more AHRR on file for a single claimant, 14 (37%) were managed by Suncorp, 13 (34%) by NRMA, eight (21%) by Allianz, and three (8%) by QBE.

The latest AHRR had a median date of 2nd November 2019, with the earliest dated 18th August 2019, and latest dated 7th February 2020.

Table A18. Summary of Allied Health Recovery Requests for 130 claimants

Total no. of AHRR	**13-week post-injury**		**26-week post-injury**		**52-week post-injury**		**78-week post-injury**		**104-week post-injury**	
	n	%	n	%	n	%	n	%	n	%
0	64	49.2	50	38.5	44	33.8	41	31.5	39	30.0
1	28	21.5	20	15.4	11	8.5	14	10.8	13	10.0
2	27	20.8	26	20.0	17	13.1	13	10.0	14	10.8
3	8	6.2	12	9.2	20	15.4	16	12.3	14	10.8
4	3	2.3	9	6.9	11	8.5	12	9.2	12	9.2
5+	0	0.0	13	10.0	27	20.8	34	26.2	38	29.2

Note: Percentages are based on the total number of claimants followed up at 78 weeks (N=130). The percentages under the 13 weeks post-claim column adds up to 100.

AHRR details were recorded for 312 out of the 431 AHRRs, this is because at 26 weeks, 52 weeks, 78 weeks and 104 weeks post-injury, only the latest AHRR details were collected.

Table A19 summaries Allied Health Recovery Requests by health professional discipline. The increasing trend for psychological treatment has continued. The most striking finding is the large increase in treatment by psychologists over time.

Table A19. Summary of Allied Health Recovery Requests for 130 claimants

AHRR Treatment	First recovery plan	Latest recovery plan at 13-week post-claim	Latest recovery plan at 26-week post-injury	Latest recovery plan at 52-week post-injury	Latest recovery plan at 78-week post-injury	Latest recovery plan at 104-week post-injury

	%	%	%	%	%	%
	(n=81)	(n=38)	(n=58)	(n=77)	(n=32)	(n=26)
Physiotherapist	77.8	84.2	60.3	58.4	37.5	34.6
Psychologist	13.6	10.5	27.6	26.0	37.5	42.3
AHRR could not be located	0	0	0	0	0	0
Exercise physiologist	6.2	0	10.3	13.0	21.9	19.2
Chiropractor	2.5	0	0	2.6	0	0
Other	0	2.6	1.7	0	3.1	3.8
Masseur/ Acupuncturist/ TCM	0	2.6	0	0	0	0

Note:
1. At 26 weeks, 52 weeks, 78-week and 104-week post-injury, only the latest AHRR details were collected.
2. Percentages are based on the total number of AHRR recorded for each specific timepoint. That is percentages on the first AHRR column adds up to 100.
3. Results only include 130 claimants whose claims remained opened at 52-week post injury were followed up at 78-week post-injury.

Table A20 summarised the Allied Health Recovery Request Goals for 130 claimants over time. The goal to "improve mood" in this cohort peaked at 78 weeks post injury.

AHRR Goal	First AHRR %	Latest AHRR at 13-week post-claim %	Latest AHRR at 26-week post-injury %	Latest AHRR at 52-week post-injury %	Latest AHRR at 78-week post-injury %	Latest AHRR at 104-week post-injury %
	(n=81)	(n=38)	(n=58)	(n=77)	(n=32)	(n=26)
1. Increase pre-injury (normal activity/ employment duty) capacity	14.8	13.2	22.4	15.6	12.5	15.4
2. Increase function/ movement	17.3	13.2	17.2	14.3	18.8	15.4
3. Decrease pain	1.2	0.0	0.0	3.9	3.1	3.8
4. Improve mood	9.9	7.9	17.2	22.1	28.1	19.2
5. 1+2	18.5	21.1	10.3	11.7	18.8	23.1
6. 2+3	11.1	15.8	6.9	3.9	12.5	3.8
7. 1+3	7.4	7.9	6.9	2.6	3.1	3.8
8. 1+2+3	17.3	21.1	17.2	20.8	3.1	11.5
9. Other	1.2	0.0	0.0	1.3	0.0	0.0
10. Not specified	1.2	0.0	1.7	3.9	0.0	3.8

Note:
1. At 26 weeks, 52 weeks, 78-week and 104-week post-injury, only the latest AHRR plan details were collected, hence the total number of AHRR goals (312) differ from the total number of recovery plans for all claimants (431).
2. Percentages are based on the total number of AHRRs recorded for each specific timepoint. Percentages on the first AHRR column therefore add up to 100.

3. Results only include 130 claimants whose claims remained opened at 52-week post injury were followed up at 104-week post-injury.

Table A20. Summary Allied Health Recovery Request Goals for 130 claimants

A7 Recovery Plan

At 104 weeks post-injury, the total number of recovery plans was 124. The latest recovery plan had a median date of 7th November 2019, with the earliest dated 6th September 2019, and latest dated 22nd January 2020.

It is noted that in the following circumstances recovery plans are not required: 1. where the claimant is performing their pre-injury duties; 2. where the claimant is performing their usual activities; 3. where the claimant is part of the Lifetime Care & Support Scheme; 4. where the claim is denied; or 5. where a claimant has returned to their pre-injury duties and activities within 28 calendar days of the claim being made. The results presented below might have included claimants under the above-named criteria.

When comparing the number of recovery plans among people with different pre-injury working status, it appears that those who were working pre-injury had a higher prevalence of having a recovery plan on file. This is consistent with previous reports and is summarised in Table A21.

Table A21. Summary of Recovery Plans at 104-week Post-injury for 130 claimants

Number of Recovery Plan	n	%
Total Overall (n=130)		
0	62	47.7
1	38	29.2
2	14	10.8
3	8	6.2
4	6	4.6
5	2	1.5
Total number of plans	**124**	
Against Pre-injury Working Status		
Not available (n=8)		
0	5	62.5
1	2	25
2	0	0
3	1	12.5
Not working (n=35)		
0	20	57.1
1	8	22.9
2	4	11.4
3	2	5.7
4	1	2.9
Working (n=87)		
0	37	42.5
1	28	32.2
2	10	11.5

3	5	5.7
4	5	5.7
5	2	2.3

Note: Percentages for the variable recovery plan are based on the total number of claimants followed up at 24-month post-injury (N=130).

Recovery plan details were recorded for 115 out of the 124 recovery plans. This is because at 26 weeks, 52 weeks, 78 weeks and 104 weeks post-injury, only the latest recovery plan details were collected. Table A22 below shows that insurer recovery plans included a mixture of goals which varied over time.

Table A22. Summary of Recovery Plan Goals for 130 claimants

Recovery Plan Goal	First recovery plan	Latest recovery plan at 13-week post-claim	Latest recovery plan at 26-week post-injury	Latest recovery plan at 52-week post-injury	Latest recovery plan at 78-week post-injury	Latest recovery plan at 104-week post-injury
	%	%	%	%	%	%
	(n=51)	(n=2)	(n=7)	(n=28)	(n=20)	(n=7)
1. Increase employment capacity	10	0	0	6	2	0
2. Increase self-management/ Independence	0	0	0	2	1	1
3. Increase daily activity	6	1	1	2	0	0
4. 1+2	2	0	0	0	5	0
5. 2+3	5	0	1	2	2	2
6. 1+3	5	1	2	2	6	0
7. 1+2+3	10	0	3	8	1	2
8. Other	1	0	0	1	1	1
9. Not specified	12	0	0	5	2	1

Note:

1. Percentages for each goal are based on the number of recovery plans per time point. The percentages on the first recovery plan column add up to 100.
2. Results only include 130 claimants whose claims remained opened at 78-week post injury were followed up at 104-week post-injury.
3.At 26 weeks, 52 weeks, 78 weeks and 104 weeks post-injury, only the latest recovery plan details were collected, hence the total number of recovery plan goals (115) differ from the total number of recovery plans for all claimants (124).

The table shown below (Table A23) indicates that, as expected, there are a greater number of Allied Health Recovery Requests for people with non-minor injuries. At 104 weeks, 12 minor cases had an AHRR.

Table A23. Minor versus Non-Minor - Summary of Allied Health Recovery Request for 130 Claimants

Total no. of AHRR	**Minor (N=12)**		**Non-minor (N=118)**	
	n	%	n	%
13-week post-injury				
0	3	25	61	51.7
1	3	25	25	21.2
2	4	33.3	23	19.5
3	2	16.7	6	5.1
4	0	0	3	2.5
26-week post-injury				
0	3	25	47	39.8
1	1	8.3	19	16.1
2	3	25	23	19.5
3	3	25	9	7.6
4	1	8.3	8	6.8
5+	1	8.3	12	10.2
52-week post-injury				
0	3	25	41	34.7
1	0	0	11	9.3
2	3	25	14	11.9
3	4	33.3	16	13.6
4	1	8.3	10	8.5
5+	1	8.3	26	22.0
78-week post-injury				
0	3	25	38	32.2
1	0	0	14	11.9
2	3	25	10	8.5
3	4	33.3	12	10.2
4	1	8.3	11	9.3
5+	1	8.3	33	28.0
104-week post-injury				
0	3	25	36	30.5
1	0	0	13	11
2	3	25	11	9.3
3	4	33.3	10	8.5
4	1	8.3	11	9.3
5+	1	8.3	37	31.4

Note: Percentages for number of AHRR are based on the number of claimants per minor injury group at 104-week post-injury, n=12 for minor and N=118 for non-minor.

Table A24 shows that no treatment was occurring in the minor group at 104 weeks post injury, but treatment was continuing for the 26 claimants in the non-minor group.

Table A24. Minor versus Non-Minor - Treatment for Allied Health Recovery Request for 130 Claimants

AHRR Treatment	First AHRR	Latest AHRR at 13-week post-claim	Latest AHRR at 26-week post-injury	Latest AHRR at 52-week post-injury	Latest AHRR at 78-week post-injury	Latest AHRR at 104-week post-injury
	%	%	%	%	%	%
Minor(N=12)	(n=9)	(n=6)	(n=6)	(n=8)	(n=0)	(n=0)
Physiotherapist	7	5	5	5	0	0
Psychologist	1	1	1	1	0	0
AHRR could not be located	0	0	0	0	0	0
Exercise physiologist	1	0	0	2	0	0
Chiropractor/Osteopath	0	0	0	0	0	0
Non-minor(N=118)	(n=72)	(n=32)	(n=52)	(n=69)	(n=32)	(n=26)
Physiotherapist	56	27	30	40	12	9
Psychologist	10	3	15	19	12	11
AHRR could not be located	0	0	0	0	0	0
Exercise physiologist	4	0	6	8	7	5
Chiropractor/Osteopath	2	0	0	2	0	0
Other	0	1	1	0	1	1
Masseur/ Acupuncturist/ TCM	0	1	0	0	0	0

Note: Percentages for AHRR treatments are based on the number of claimants per minor injury group at 104-week post-injury, n=2 for minor and N=118 for non-minor.

Table A25 depicts the AHRR goals of the minor and non-minor groups at 104 weeks. Nine were identified for the minor injury group at both this and the previous time points.

Table A25. Minor versus Non-Minor - Allied Health Recovery Request Goals

AHRR Goal	First AHRR	Latest AHRR at 13-week post-claim	Latest AHRR at 26-week post-injury	Latest AHRR at 52-week post-injury	Latest AHRR at 78-week post-injury	Latest AHRR at 104-week post-injury
	%	%	%	%	%	%
Minor(N=12)	(n=9)	(n=6)	(n=6)	(n=8)	(n=0)	(n=0)
1. Increase pre-injury (normal activity/ employment duty) capacity	1	0	1	0	0	0
2. Increase function/ movement	0	1	1	0	0	0
3. Decrease pain	0	0	0	0	0	0
4. Improve mood	1	0	0	0	0	0

5. 1+2	1	0	0	2	0	0
6. 2+3	2	2	2	1	0	0
7. 1+3	1	1	1	1	0	0
8. 1+2+3	3	2	1	3	0	0
10. Not specified	0	0	0	1	0	0
Non-minor(N=118)	(n=72)	(n=32)	(n=51)	(n=69)	(n=32)	(n=26)
1. Increase pre-injury (normal activity/ employment duty) capacity	11	5	12	12	4	4
2. Increase function/ movement	14	4	9	11	6	4
3. Decrease pain	1	0	0	3	1	1
4. Improve mood	7	3	10	17	9	5
5. 1+2	14	8	6	7	6	6
6. 2+3	7	4	2	2	4	1
7. 1+3	5	2	3	1	1	1
8. 1+2+3	11	6	9	13	1	3
9. Other	1	0	0	1	0	0
10. Not specified	1	0	1	2	0	1

Note: Percentages for individual AHRR goals are based on the number of claimants per minor injury group at 104-week post-injury, n=12 for minor and N=118 for non-minor.

Recovery plans at 104 weeks post injury are more prevalent in the non-minor group. Table A26.

Table A26. Minor versus Non-Minor - Number of Recovery Plans

Total no. of Recovery Plan	Minor (N=12)		Non-minor (N=118)	
	N	%	n	%
0	9	75	53	44.9
1	3	25	35	29.7
2	0	0	14	11.9
3	0	0	8	6.8
4	0	0	6	5.1
5	0	0	2	1.7

Note: Percentages for number of recovery plans are based on the number of claimants per minor injury group at 104-week post-injury, n=12 for minor and N=118 for non-minor.

Table A27. Minor versus Non-Minor - Recovery Plan Goals

Recovery Plan Goal	First recovery plan %	Latest recovery plan at 13-week post-claim %	Latest recovery plan at 26-week post-injury %	Latest recovery plan at 52-week post-injury %	Latest recovery plan at 78-week post-injury %	Latest recovery plan at 104-week post-injury %
Minor (N=12)	(n=3)	(n=0)	(n=0)	(n=1)	(n=0)	(n=0)

1. Increase employment capacity	33.3	0	0	100	0	0
2. Increase self-management/Independence	0	0	0	0	0	0
3. Increase daily activity	33.3	0	0	0	0	0
4. 1+2	0	0	0	0	0	0
5. 2+3	0	0	0	0	0	0
6. 1+3	0	0	0	0	0	0
7. 1+2+3	33.3	0	0	0	0	0
8. Other	0	0	0	0	0	0
9. Not specified	0	0	0	0	0	0
Non-minor (N=118)	(n=48)	(n=2)	(n=7)	(n=27)	(n=20)	(n=7)
1. Increase employment capacity	18.8	0	0	18.5	10.0	0.0
2. Increase self-management/Independence	0	0	0	7.4	5.0	14.3
3. Increase daily activity	10.4	50	14.3	7.4	0	0
4. 1+2	4.2	0	0	0	25.0	0
5. 2+3	10.4	0	14.3	7.4	10.0	28.6
6. 1+3	10.4	50	28.6	7.4	30.0	0
7. 1+2+3	18.8	0	42.9	29.6	5.0	28.6
8. Other	2.1	0	0	3.7	5.0	14.3
9. Not specified	25.0	0	0	18.5	10.0	14.3

Note:
1. Percentages for each goal are based on the number of recovery plan for the specific minor injury group per time point. The percentages on the first recovery plan column for minor cases add up to 100.
2. Results only include 130 claimants whose claims remained opened at 78-week post injury were followed up at 104-week post-injury.

A8 External Rehabilitation Providers, Domestic Assistance and Vocational Program

At 104 weeks post injury, no active external rehabilitation service was identified for those who sustained a minor injury, while around one-fourth (27) of non-minor cases are still engaged in external rehabilitation services. A total of 45% of claimants (59) had completed an initial rehabilitation assessment with an external rehabilitation provider. Table A28.

Table A28. Number of Active External Rehabilitation Service at 104-week Post-injury for 118 Non-minor claimants

Any Rehab Initial Assessment Performed	n	%
Yes	59	45.4
No	71	54.6
Active External Rehabilitation Service	n	%
Yes	27	22.9
No	91	77.1

Note: Percentages are based on the total number of non-minor claimants at 104 weeks post-injury (n=118).

The majority (51%) of the initial assessments were generic in nature and were aimed to identify the rehabilitation needs of the claimants. If an external rehabilitation provider determined that the claimants had on-going needs for rehabilitation services, a rehabilitation plan was developed and submitted to the insurer for approval. One or more rehabilitation plans were found for a total

number of 48 people (37%). Table A29 shows that at 104 weeks only 11 non-minor claimants had had an initial rehabilitation assessment.

The latest rehabilitation plans had a median of 31st October 2019, with the earliest dated 5th September 2019, and the latest dated 11th January 2020.

Table A29. Minor Versus Non-minor - Type of Initial Rehabilitation Assessment

Rehab Initial Assessment	52-week Post-injury		78-week Post-injury		104-week Post-injury		**Overall**	
	n	%	n	%	n	%	**n**	**%**
Initial need assessment (General)	33	60.0	4	33.3	3	27.3	**40**	**51.3**
Workplace assessment (employment)	8	14.5	4	33.3	4	36.4	**16**	**20.5**
ADL assessment (home)	10	18.2	4	33.3	4	36.4	**18**	**23.1**
Not sure	4	7.3	0	0	0	0	**4**	**5.1**
Total	**55**		**12**		**11**		**78**	

Note: Percentages for the types of initial rehab are based on the number of initial rehab assessment per minor injury group per timepoint, or total number of initial rehab assessment at 104-week.

Table A30 summarises the number of approved rehabilitation plans provided by external rehabilitation providers. As expected, non-minor claimants had a greater number of approved rehabilitation plans.

Table A30. Minor Verse Non-minor - Total Number of Approved Rehabilitation Plans

Total number of Rehabilitation Plan	52-week Post-injury		78-week Post-injury		104-week Post-injury	
Minor (n=12)	n	%	n	%	n	%
0	10	83.3	10	83.3	10	83.3
1	2	16.7	2	16.7	2	16.7
Non-minor (n=118)						
0	77	65.3	75	63.6	72	61
1	16	13.6	14	11.9	16	13.6
2	11	9.3	10	8.5	10	8.5
3	8	6.8	10	8.5	9	7.6
4	5	4.2	3	2.5	5	4.2
5+	1	0.8	6	5.1	6	5.1
All 130 Claimants (n=130)						
0	87	66.9	85	65.4	82	63.1
1	18	13.8	16	12.3	18	13.8
2	11	8.5	10	7.7	10	7.7
3	8	6.2	10	7.7	9	6.9
4	5	3.8	3	2.3	5	3.8
5+	1	0.8	6	4.6	6	4.6

Note: Percentages for the number of initial rehab assessments are based on the number of claimants per minor injury group at 104-week post-injury, n=12 for minor and n=118 for non-minor, or total number of claimants included at 104-week (n=130).

Table A31 confirms that no domestic assistance was requested by any of those 12 minor injury claimants at any timepoint. Four claimants who sustained non-minor injuries had domestic assistance approved post 78 weeks after injury, two of those had more than one domestic assistance approved, the median date for the first domestic assistance approval was 25th September 2019, with an earliest date of 5th September 2019 and latest date of 1st November 2019. The second domestic assistance had a mean date 3rd October 2019, with the earliest dated 4th September 2019, the latest on 1st November 2019.

Table A31. Summary of Approved Domestic Assistance for 118 Non-minor claimants

Domestic Assistance Type	13-week post-claim		26-week post-injury		52-week post-injury		78-week post-injury		104-week post-injury	
	n	%	n	%	n	%	n	%	n	%
1. Personal care	3	18.8	2	13.3	0	0	0	0	1	16.7
2. Indoor home duty	10	62.5	10	66.7	9	52.9	7	70	4	66.7
3. Outdoor home duty	3	18.8	3	20	6	35.3	3	30	1	16.7
4. Shopping and appointment	0	0	0	0	1	5.9	0	0	0	0
5. Others	0	0	0	0	1	5.9	0	0	0	0

Note:
1. Percentages are based on the total number of domestic assistances for each specific timepoint. The percentages under the 13 weeks post-claim column adds up to 100.
2. Note that some claimants may have had more than one domestic assistance request approved.

A9 Outcomes - Return to Work and Usual Activity

Table A32 provides a summary of capacity for work.

Table A32. Summary of Capacity for Work for 130 claimants

Level of Capacity for Work	First COW		Latest COW at 13-week Post-injury		Latest COW at 26-week Post-injury		Latest COW at 52-week Post-injury		Latest COW at 78-week Post-injury		Latest COW at 104-week Post-injury	
	n	%	n	%	N	%	n	%	n	%	N	%
Not working (n=35)												
Has no capacity for any work	13	37.1	2	5.7	2	5.7	4	11.4	4	11.4	1	2.9
Has capacity for some type of work	3	8.6	3	8.6	3	8.6	2	5.7	1	2.9	2	5.7
Fit for pre-injury work	4	11.4	0	0	0	0	2	5.7	1	2.9	0	0
Not completed/not recorded	15	42.9	30	85.7	30	85.7	27	77.1	29	82.9	32	91.4
Working (n=87)												
Has no capacity for any work	66	75.9	38	43.7	35	40.2	28	32.2	13	14.9	16	18.4
Has capacity for some type of work	17	19.5	24	27.6	30	34.5	32	36.8	17	19.5	14	16.1

Fit for pre-injury work	3	3.4	1	1.1	3	3.4	10	11.5	6	6.9	3	3.4
Not completed/not recorded	1	1.1	24	27.6	19	21.8	17	19.5	51	58.6	54	62.1
Working status not available (n=8)												
Has no capacity for any work	4	50.0	0	0	1	12.5	4	50	0.0	0	0	0
Has capacity for some type of work	1	12.5	0	0	0	0	0	0	2	25.0	2	25.0
Fit for pre-injury work	0	0	1	12.5	1	12.5	1	12.5	1	12.5	0	0
Not completed/not recorded	3	37.5	7	87.5	6	75.0	3	37.5	5	62.5	6	75.0

Note: Percentages for claimants are based on the number of claimants per capacity of work category for each specific timepoint. The percentages under the 13 weeks post-claim column add up to 100 for each of the three categories.

Table A32 and Figure 3 show a summary of the assessments of work capacity.

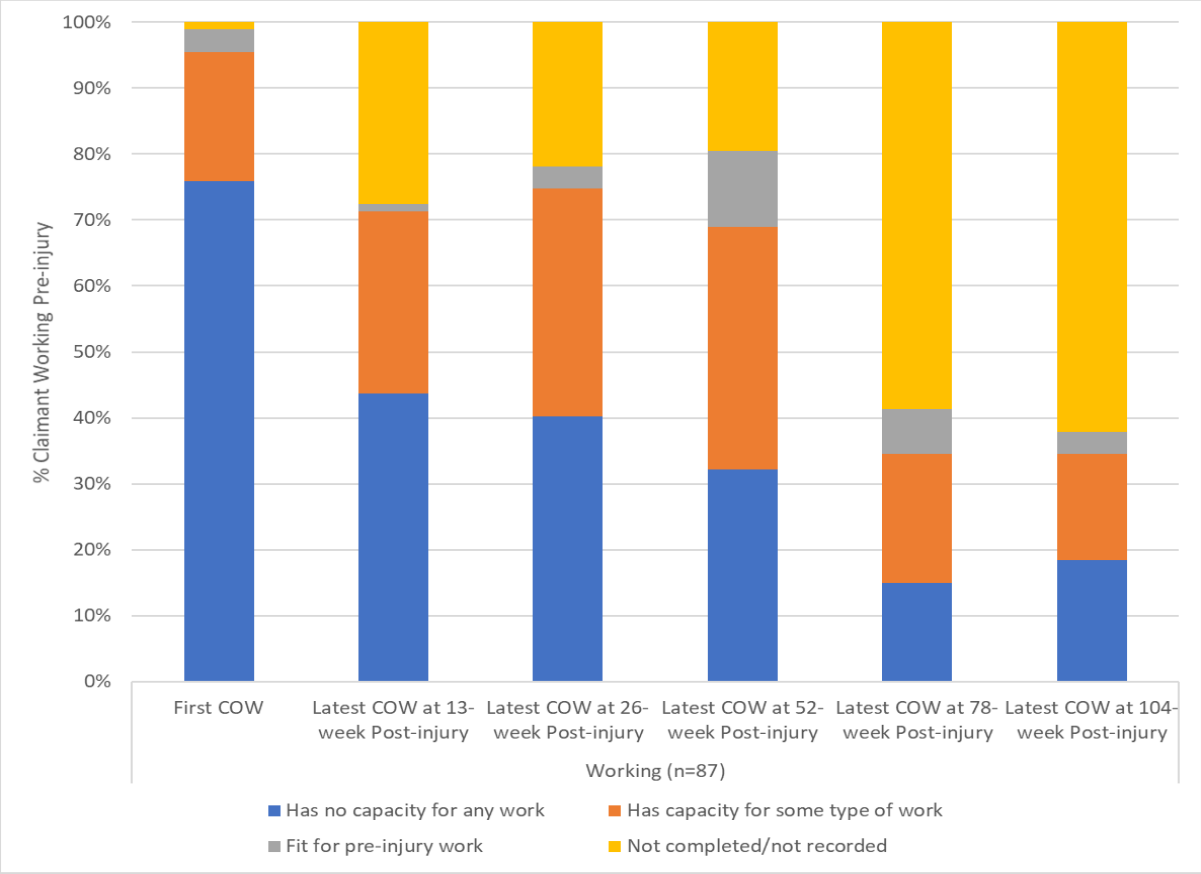


Figure A3. Distribution of Capacity for Work for 87 claimants working pre-injury

Table A33 highlights that for most of the open claims at 104 weeks, there was no assessment of capacity for work.

Table A33. Minor Versus Non-minor - Summary of Claimant Capacity

Level of Capacity for Work	First COW		Latest COW at 13-week Post-injury		Latest COW at 26-week Post-injury		Latest COW at 52-week Post-injury		Latest COW at 78-week Post-injury		Latest COW at 104-week Post-injury	
	n	%	n	%	n	%	n	%	n	%	n	%
Minor (n=12)												
No capacity for any work	7	58.3	3	25.0	4	33.3	4	33.3	0	0	0	0
Capacity for some work	2	16.7	5	41.7	4	33.3	4	33.3	2	16.7	1	8.3
Fit for pre-injury work	0	0	1	8.3	1	8.3	1	8.3	0	0	0	0
Not completed/not recorded	3	25.0	3	25.0	3	25.0	3	25.0	10	83.3	11	91.7
Non-minor (n=118)												
No capacity for any work	76	64.4	37	31.4	34	28.8	32	27.1	18	15.3	17	14.4
Capacity for some work	19	16.1	22	18.6	29	24.6	30	25.4	18	15.3	17	14.4
Fit for pre-injury work	7	5.9	1	0.8	3	2.5	12	10.2	7	5.9	3	2.5
Not completed/not recorded	16	13.6	58	49.2	52	44.1	44	37.3	75	63.6	81	68.6

Note: Percentages for claimants are based on number of claimants per minor injury group.

Table A34 indicates that for both the minor (86%) and non-minor groups (60%), capacity for work is not being recorded on the COW.

Table A34. Minor Verse Non-minor - Summary of Claimant Capacity of Claimants Working Pre-injury

Level of Capacity for Work	First COW		Latest COW at 13-week Post-injury		Latest COW at 26-week Post-injury		Latest COW at 52-week Post-injury		Latest COW at 78-week Post-injury		Latest COW at 104-week Post-injury	
	n	%	n	%	n	%	n	%	n	%	n	%
Minor (n=7)												
No capacity for any work	6	85.7	3	42.9	4	57.1	4	57.1	0	0	0	0
Capacity for some work	1	14.3	4	57.1	3	42.9	3	42.9	2	28.6	1	14.3
Fit for pre-injury work	0	0	0	0	0	0	0	0	0	0	0	0
Not completed/not recorded	0	0	0	0	0	0	0	0	5	71.4	6	85.7
Non-minor (n=80)												
No capacity for any work	60	75.0	35	43.8	31	38.8	24	30.0	13	16.3	16	20.0
Capacity for some work	16	20.0	20	25.0	27	33.8	29	36.3	15	18.8	13	16.3
Fit for pre-injury work	3	3.8	1	1.3	3	3.8	10	12.5	6	7.5	3	3.8
Not completed/not recorded	1	1.3	24	30.0	19	23.8	17	21.3	46	57.5	48	60.0

Note: Percentages for claimants are based on number of claimants working pre-injury per minor injury group.

Table A35 provides a summary of the Return-to-Work Status for the 130 Claimants. In general, over time capacity to work is less likely to be recorded. What is available indicates that there is only a small difference in assessed post injury capacity to work for those claimants working preinjury compared with all claimants.

Table A35. Summary of Return-to-Work Status for 130 Claimants

Return-to-Work Status	Full Capacity for Work %	Some Capacity of Work %	No Capacity for Work %	Not Recorded %
All 130 Claimants (n=130)				
13-week post-claim	13.1	20.8	45.4	20.8
26-week post-injury	16.9	26.2	4.6	52.3
52-week post-injury	36.2	27.7	19.2	16.9
78-week post-injury	8.5	12.3	15.4	63.8
104-week post-injury	1.5	3.8	30.8	63.8
Claimants Working Pre-injury (n=87)				
13-week post-claim	16.1	26.4	50.6	6.9
26-week post-injury	20.7	33.3	5.7	40.2
52-week post-injury	42.5	27.6	21.8	8
78-week post-injury	11.5	16.1	17.2	55.2
104-week post-injury	1.1	4.6	39.1	55.2

Note: Percentages for return-to-work status are based on the total number of claimants followed up at 24-month post-injury (N=130) or number of sub-groups of those claimants working pre-injury (n=87)

Table A36, A37 and Figure 4 present summaries of return to work by minor versus non-minor injury group. Overall capacity to return to work is similar for both groups.

Table A36 Minor Verse Non-minor - Summary of Return-to-Work Status for All 130 Claimants

Return-to-Work Status		Full Capacity for Work %	Some Capacity of Work %	No Capacity for Work %	Not Recorded %
Minor (N=12)	13-week post-claim	16.7	25	33.3	25
	26-week post-injury	25	25	8.3	41.7
	52-week post-injury	25	25	25	25
	78-week post-injury	8.3	8.3	0	83.3
	104-week post-injury	0	0	16.7	83.3
Non-Minor (N=118)	13-week post-claim	12.7	20.3	46.6	20.3
	26-week post-injury	16.1	26.3	4.2	53.4
	52-week post-injury	37.3	28	18.6	16.1
	78-week post-injury	8.5	12.7	16.9	61.9
	104-week post-injury	1.7	4.2	32.2	61.9

Note: Percentages for case closure/ settlement are based on the number of claimants per injury group at 104-week post-injury, n=12 for minor and n=118 for non-minor.

Table A37. Minor Verse Non-minor - Summary of Return-to-Work Status for Claimants Working Pre-injury

	Full Capacity for Work	Some Capacity of Work	No Capacity for Work	Not Recorded

Return-to-Work Status		%	%	%	%
Minor (N=7)	13-week post-claim	14.3	42.9	0	42.9
	26-week post-injury	28.6	42.9	0	28.6
	52-week post-injury	28.6	28.6	42.9	0
	78-week post-injury	14.3	14.3	0	71.4
	104-week post-injury	0	0	28.6	71.4
Non-Minor (N=80)	13-week post-claim	16.3	25	51.3	7.5
	26-week post-injury	20	32.5	6.3	41.3
	52-week post-injury	43.8	27.5	20	8.8
	78-week post-injury	11.3	16.3	18.8	53.8
	104-week post-injury	1.3	5	40	53.8

Note: Percentages for case closure/ settlement are based on the number of claimants working pre-injury per minor injury group at 104-week post-injury, n=7 for minor and n=80 for non-minor.

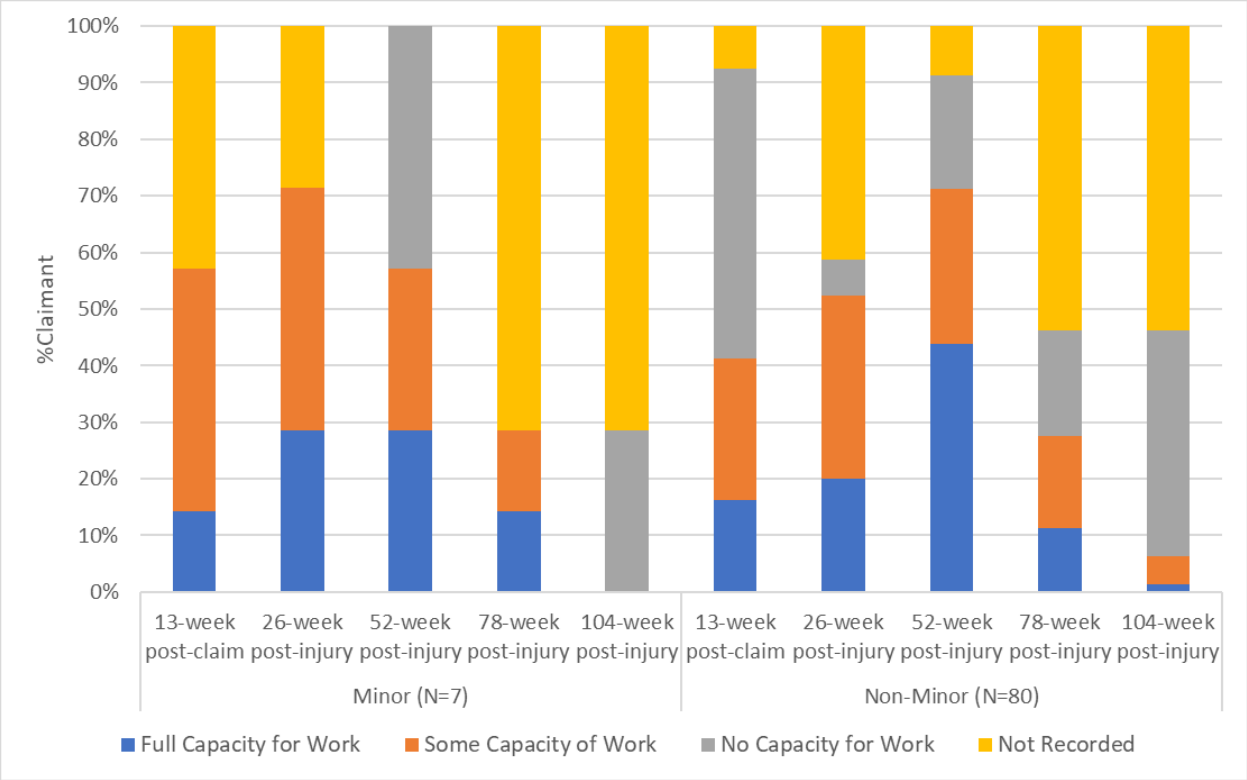


Figure A4. Summary of Return-to-Work Status for Minor and Non-minor Cases Who Were Working Pre-injury

A10 Liability and Treatment Beyond 26 weeks Post-injury

Table A38 and A39 show that there are some cases that were closed/ settled at earlier audit points that have been reopened at later timepoints.

Table A38. Summary of Liability Status, Treatment Status and Case Closure/ Settlement

	13-week post-claim		26-week post-injury		52-week post-injury		78-week post-injury		104-week post-injury	
	n	%	n	%	n	%	n	%	n	%
Liability Beyond 26-week Post-injury										
1. Yes – Accepted	59	45.4	85	65.4	109	83.8	113	86.9	112	86.2
2. No – Rejected	33	25.4	33	25.4	16	12.3	17	13.1	18	13.8
3. Not yet assessed/no outcome determined yet	38	29.2	12	9.2	5	3.8	0	0	0	0
Reason for Treatment Beyond 26-week Post-injury										
1. Non-minor injury	65	50	88	67.7	114	87.7	117	90	117	90
2. Treatment and care will improve recovery of the injured person	0	0	0	0	3	2.3	3	2.3	3	2.3
3. No information identified	13	10	14	10.8	2	1.5	0	0	0	0
4. Liability beyond 26-week post injury rejected	52	40	28	21.5	11	8.5	10	7.7	10	7.7
Treatment Ceased										
1. Yes	0	0	1	0.8	14	10.8	28	21.5	27	20.8
2. No	31	23.8	27	20.8	66	50.8	46	35.4	53	40.8
3. Not known	99	76.2	102	78.5	50	38.5	56	43.1	50	38.5
Case Closure										
1. Yes	1	0.8	11	8.5	0	0	0	0	25	19.2
2. No	106	81.5	84	64.6	120	92.3	130	100	105	80.8
3. Not known	23	17.7	35	26.9	10	7.7	0	0	0	0

Note: Percentages for liability status are based on the total number of claimants followed up at 24-month post-injury (N=130).

Table A39. Minor Versus Non-minor - Summary of Case Closure/ Settlement

Case Closure/ Settlement	13-week post-claim %	26-week post-injury %	52-week post-injury %	78-week post-injury %	104-week post-injury %
Minor (N=12)					
1. Yes	0	16.7	0	0	58.3
2. No	58.3	0	50	100	41.7
3. Not known	41.7	83.3	50	0	0
Non-minor (N=118)					
1. Yes	0.8	7.6	0	0	15.3
2. No	83.9	71.2	96.6	100	84.7
3. Not known	15.3	21.2	3.4	0	0

Note: Percentages for case closure/ settlement are based on the number of claimants per minor injury group at 104-week post-injury, n=12 for minor and n=118 for non-minor.

A11 Internal Review and Disputes

The total number of internal reviews recorded for the 130 claimants was 74. At 104 weeks post-injury, 35% of the 130 claimants had applied for at least one internal review (see Table A40). The majority of those who applied for internal review (62%) had one internal review on file. Of the total number of internal reviews recorded at 104 weeks post-injury (74), the majority (56, 62%) were for non-minor injury.

Table A40. Minor Verse Non-minor - Total Numbers of Internal Reviews Claimants

Total no. of Internal Review	52-week post-injury		78-week post-injury		104-week post-injury	
	n	%	n	%	n	%
Minor (N=12)						
0	4	33.3	3	25	3	25
1	2	16.7	3	25	3	25
2	3	25	3	25	3	25
3	3	25	3	25	3	25
Non-minor (N=118)						
0	87	73.7	87	73.7	82	69.5
1	23	19.5	23	19.5	25	21.2
2	5	4.2	5	4.2	6	5.1
3	3	2.5	2	1.7	3	2.5
3+	0	0	1	0.8	2	1.7
Total number	**59**		**63**		**74**	

Note: Percentages for individual diagnoses are based on the number of claimants per minor injury group at 104-week post-injury, n=12 for minor and N=118 for non-minor.

At 104-week post-injury, internal disputes were recorded for non-minor claimants only. All internal reviews were treatment-related, with almost half (46%) overturned. This is summarised in Table A41.

Table A41. Summary of Internal Review Decisions at 104-Week Post-injury for Non-minor Claimants

Latest Internal Review Outcome	Non-minor (N=118)	
	n	%
Treatment		
1. Overturned	5	45.5
2. Upheld	5	45.5
3. Decision pending	1	9.1
Related treatment		
Surgeon/ Surgical procedure	6	54.5
Medical specialist	2	18.2
Physiotherapist	2	18.2
Exercise Physiologist	1	9.1

Note: Percentages are based on the number of internal reviews for each specific type of internal review per minor injury group.

Very few cases were referred to the Dispute Resolution Service (n=12). Table A42.

Table A42. Summary of DRS at 104-Week Post-injury for 130 Claimants

Minor Injury Decision DRS Type	DRS Outcome	n
Minor - Physical/Soft tissue		
1. Minor Injury Decision	2. Upheld	1
4. Uncertain	3. Pending	2
4. Uncertain	4. Withdraw due to claimant non-respondent	1
Minor - Psychological		
4. Uncertain	4. Withdraw due to claimant non-respondent	1
Minor - Both physical and psychological		
1. Minor Injury Decision	2. Upheld	1
4. Uncertain	3. Pending	1
Non-minor - Physical		
1. Minor Injury Decision	1. Overturned	2
3. Treatment - Surgical Procedure	1. Overturned	1
3. Treatment - Surgical Procedure	3. Pending	1
Non-minor - Psychological		
2. Causational	2. Upheld	1

As expected, change in the minor injury decision from minor to non-minor cases was observed. A total number of 23 cases were identified, 11 (48%) from NRMA, 10 (44%) from GIO and two (9%) from CIC-Allianz. For three (13%) cases the minor injury decision changed at 104 weeks post-injury, five (22%) at 78 weeks post-injury, four (17%) cases at 52 weeks post-injury, eleven (48%) cases at 26 weeks post-injury. Eleven (48%) claimants were determined to have sustained non-minor physical injuries, ten (44%) with non-minor psychological injuries, and two (9%) claimant with non-minor both physical and psychological injuries.

Of the 23 cases, there were 13 (57%) females and ten (44%) males, with a median age of 38.0. Eighteen (78%) of these claimants who were working pre-injury, ten (56%) were working full time, four (22%) part time and four (22%) on a causal basis. Table A43.

Table A43. Classification changed from Minor to Non-minor- Latest Minor Injury Determination at 104-Week Post-injury

Final Minor Injury Determination	n	%
5. Non-minor – Physical	11	47.8
6. Non-minor – Psychological	10	43.5
7. Non-minor – Both physical and psychological	2	8.7
Total	**23**	

Note: Percentages are based on the total number of claimants whose minor injury decision changed from minor to non-minor (n=23).

A12 Physical and Psychological Diagnosis

At 104 weeks post-injury, injuries to the neck/cervical spine (11, 48%) and lower back/lumbosacral spine (9, 39%) were the most common, followed by upper extremity/shoulders (5, 22%) and lower extremity (5, 22%). With reference to the physical injury body part, pain (14, 61%) was the most common physical injury type, followed by nerve damage/ impingement (10, 44%) and other/unspecified category (4, 17%). The most commonly reported psychological injuries were Post-traumatic Stress Disorder (6, 26%) and other (4, 17%).

Table A44. shows that changes are most likely with reference to the neck or lower back and psychological injury.

Table A44. Minor to Non-minor – Summary of Physical and Psychological Injuries

Physical Injury Body Part	n	%*
Neck/cervical spine	11	47.8
Lower back/lumbosacral spine	9	39.1
Upper extremity/shoulders	5	21.7
Lower extremity	5	21.7
Head	2	8.7
Upper back/thoracic spine	2	8.7
Face	1	4.3
Thorax	1	4.3
Unspecified	1	4.3
Total	**37**	
Physical Injury Type		
Pain	14	60.9
Nerve damage/ impingement	10	43.5
Other/unspecified	4	17.4
Sprain/strain	2	8.7
WAD (unspecified)	2	8.7
Head injury/ concussion	1	4.3
Bruising/ abrasion/ haematoma/ superficial injury	1	4.3
Ligament/ tendon rupture	1	4.3
Fracture	1	4.3
Dislocation	1	4.3
Total	**37**	
Psychological Diagnoses		
Post-Traumatic Stress Disorder	6	26.1
Others	4	17.4
Anxiety	2	8.7
Major Depressive Episode	1	4.3
Adjustment Disorder	1	4.3
Insomnia	1	4.3
Generalised Anxiety Disorder	1	4.3
Total	**16**	

Note: Percentages are based on the total number of claimants whose minor injury decision changed from minor to non-minor (n=23). There can be multiple diagnoses for each person, so the total percentage may not add to 100%.

Table A45 indicates that almost 70% of cases with psychological injury changed from minor to non-minor injury

Table A45. Diagnosis changed from Minor to Non-minor – Psychological on Certificate of Fitness

With Any Psychological Diagnosis	First COF		Latest COF at 13-week post-claim		Latest COF at 26-week post-injury		Latest COF at 52-week post-injury		Latest COF at 78-week post-injury		Latest COF at 104-week post-injury		Overall
	n	%	n	%	n	%	n	%	n	%	n	%	n
Yes	4	17.4	7	30.4	11	47.8	15	65.2	10	43.5	10	43.5	16
No	19	82.6	16	69.6	12	52.2	8	34.8	13	56.5	13	56.5	7

Note: Percentages are based on the total number of claimants whose minor injury decision changed from minor to non-minor (n=23).

A13 Treatment

The most common treatments were physiotherapy and treatment by general practitioners. Forty-four percent of these claimants with minor injury classification changed had five or more AHRR approved.

At 104 weeks post-injury, only 3 (13%) of these claimants are still engaged in active external rehabilitation services. Rehabilitation Plans were only found on file for six (26%) claimants. A recovery plan was not found for 13 out of the 23 claimants.

Table A46. Changed from Minor to Non-minor – Summary of Treatments Paid for by Insurers

Treatment	13-week Post-claim		26-week Post-injury		52-week Post-injury		78-week Post-injury		104-week Post-injury	
	n	%*	n	%*	n	%*	n	%*	n	%*
GP	13	56.5	14	60.9	14	60.9	12	52.2	15	65.2
Physiotherapist	13	56.5	13	56.5	16	69.6	10	43.5	6	26.1
Psychologist	5	21.7	6	26.1	8	34.8	8	34.8	6	26.1
Medical specialist	4	17.4	4	17.4	8	34.8	7	30.4	5	21.7
Exercise physiologist	1	4.3	1	4.3	2	8.7	3	13.0	4	17.4
Pharmaceutical	4	17.4	3	13.0	1	4.3	5	21.7	3	13.0
Surgeon/surgical procedure	2	8.7	1	4.3	1	4.3	2	8.7	2	8.7
Psychiatrist	0	0	0	0	2	8.7	1	4.3	1	4.3
Orthotist/prosthetist/aids or appliances	3	13.0	0	0	0	0	0	0	0	0
Other	2	8.7	0	0	0	0	0	0	0	0
Chiropractor/ Osteopath	1	4.3	1	4.3	1	4.3	0	0	0	0
Hospital medical officer	1	4.3	0	0	0	0	0	0	0	0

Occupational therapist	1	4.3	0	0	0	0	0	0	0	0
Hospital overnight stay	0	0	0	0	1	4.3	0	0	0	0
Total	**50**		**43**		**54**		**48**		**42**	

Note:

1. The percentages are based on number of claimants whose minor injury decision change from minor to non-minor (n=23).
2. There can be multiple treatments for each person, the total percentage will therefore not add to 100%.

Table A47 shows that 44% of cases with the highest number of AHRRs had changed from minor to non-minor injury

Table A47. Classification changed from Minor to Non-minor – Number of Allied Health Recovery Requests

Total no. of AHRR	n	%
0	2	8.7
1	3	13
2	3	13
3	2	8.7
4	3	13
5+	10	43.5
Total AHRR	**100**	

Note: The percentages are based on the number of claimants whose minor injury decision change from minor to non-minor (n=23).

Physiotherapy and Psychological treatment are the most common treatment requests for cases where the decision had changed from minor to non-minor. Table A48.

Table A48. Classification changed from Minor to Nonminor – Allied Health Recovery Requests

AHRR Treatment	First AHRR	Latest AHRR at 13-week post-claim	Latest AHRR at 26-week post-injury	Latest AHRR at 52-week post-injury	Latest AHRR at 78-week post-injury	Latest AHRR at 104-week post-injury
	%	%	%	%	%	%
	(n=18)	(n=10)	(n=13)	(n=17)	(n=9)	(n=7)
Physiotherapist	83.3	80.0	38.5	52.9	11.1	28.6
Psychologist	11.1	20.0	46.2	41.2	66.7	42.9
Exercise physiologist	5.6	0	15.4	5.9	11.1	14.3
AHRR could not be located	0	0	0	0	0	0
Other	0	0	0	0	11.1	14.3

Note:

1. At 26 weeks, 52 weeks, 78 weeks and 104 weeks post-injury, only the latest AHRR details were collected.

2. Percentages are based on the total number of AHRR recorded for each specific timepoint. That is percentages on the first AHRR column adds up to 100.

Table A49 shows that overtime the treatment goals become more complex for those cases that the injury determination changed from Minor to non-minor.

Table A49. Classification changed from Minor to Non-minor – Summary Allied Health Recovery Request Goals

AHRR Goal	First AHRR %	Latest AHRR at 13-week post-claim %	Latest AHRR at 26-week post-injury %	Latest AHRR at 52-week post-injury %	Latest AHRR at 78-week post-injury %	Latest AHRR at 104-week post-injury %
	(n=18)	(n=10)	(n=13)	(n=17)	(n=9)	(n=7)
1. Increase pre-injury capacity	22.2	10.0	15.4	11.8	11.1	0
2. Increase function/movement	27.8	10.0	15.4	11.8	11.1	0
3. Decrease pain	0	0	0	0	0	14.3
4. Improve mood	0	20.0	38.5	41.2	55.6	14.3
5. 1+2	11.1	30.0	7.7	17.6	0	28.6
6. 2+3	0	10.0	0	11.8	22.2	0
7. 1+3	16.7	10.0	15.4	0	0	14.3
8. 1+2+3	16.7	10.0	7.7	0	0	14.3
9. Other	5.6	0	0	0	0	0
10. Not specified	0	0	0	5.9	0	14.3

Note:

1. At 26 weeks, 52 weeks, 78 weeks and 104 weeks post-injury, only the latest AHRR details were collected.
2. Percentages are based on the total number of AHRRs recorded for each specific timepoint. Percentages on the first AHRR column therefore add up to 100.

Almost 57% of cases where the injury determination changed from minor to non-minor had no recovery plan, and 26% had only one.

Table A50. Classification changed from Minor to Non-minor – Number of Recovery Plan

Total no. of Recovery Plan	n	%
0	13	56.5
1	6	26.1
2	1	4.3
3	2	8.7
4	1	4.3
Total	**23**	

Note: The percentages are based on the number of claimants whose minor injury decision change from minor to non-minor (n=23).

With regard to recovery plan goals for those cases that had changed from minor to non-minor, the focus appears to be on increasing employment capacity, however as these small numbers need to be interpreted with caution. Table A51.

Table A51. Classification changed from Minor to Non-minor – Summary Recovery Plan Goals

Recovery Plan Goal	First AHRR	Latest AHRR at 13-	Latest AHRR at 26-	Latest AHRR at 52-	Latest AHRR at 78-	Latest AHRR at 104-

	%	week post-claim %	week post-injury %	week post-injury %	week post-injury %	week post-injury %
	(n=8)	(n=0)	(n=0)	(n=3)	(n=2)	(n=1)
1. Increase employment capacity	62.5	0	0	66.7	0	0
2. Increase self-management/ Independence	0	0	0	0	50	0
3. Increase daily activity	0	0	0	0	0	0
4. 1+2	0	0	0	0	0	0
5. 2+3	12.5	0	0	0	0	0
6. 1+3	0	0	0	0	50	0
7. 1+2+3	12.5	0	0	0	0	0
8. Other	0	0	0	0	0	100
9. Not specified	12.5	0	0	33.3	0	0

At 104-weeks post-injury, three (13%) claimants were still receiving services from an external rehabilitation provider. However, 74% of cases where the minor injury determination had changed to non-minor did not have a rehabilitation plan. Table A52.

Table A52. Classification changed from Minor to Non-minor – Number of Rehabilitation Plans

Total no. of Rehabilitation Plan	n	%
0	17	73.9
1	3	13
2	2	8.7
3	1	4.3
Total	**23**	

Note: The percentages are based on the number of claimants whose minor injury decision change from minor to non-minor (n=23).

In those cases where the injury determination has changed, capacity for work is more likely to be recorded for those who were working preinjury. Table A53.

Table A53. Classification changed from Minor to Non-minor – Capacity for Work against Pre-injury Working Status

Capacity for Work	First COW		Latest COW at 13-week post-claim		Latest COW at 26-week post-injury		Latest COW at 52-week post-injury		Latest COW at 78-week post-injury		Latest COW at 104-week post-injury	
	n	%	n	%	n	%	n	%	n	%	n	%
Not working (n=5)												
Fit for pre-injury work	0	0	0	0	0	0	1	20	0	0	0	0
Has capacity for some type of work	2	40	2	40	2	40	1	20	1	20	1	20
Has no capacity for any work	1	20	0	0	0	0	0	0	0	0	0	0
Not recorded	2	40	3	60	3	60	3	60	4	80	4	80
Working (n=18)												
Fit for pre-injury work	0	0	0	0	1	5.6	2	11.1	2	11.1	2	11.1
Has capacity for some type of work	8	44.4	7	38.9	5	27.8	3	16.7	4	22.2	4	22.2
Has no capacity for any work	10	55.6	4	22.2	6	33.3	7	38.9	4	22.2	5	27.8
Not recorded	0	0	7	38.9	6	33.3	6	33.3	8	44.4	7	38.9

At 104 weeks post injury, most of those whose injury determination has changed to non-minor have no capacity for work (67%) or it has not been recorded (33%). Table A54.

Table A54. Classification changed from Minor to Non-minor – Return-to-work Status against Pre-injury Working Status

Return-to-Work Status	13-week Post-claim		26-week Post-injury		52-week Post-injury		78-week Post-injury		104-week Post-injury	
	n	%	n	%	n	%	n	%	n	%
Not working (n=5)										
Full Cap	0	0	0	0	2	40	0	0	0	0
Some Cap	3	60	3	60	2	40	1	20	0	0
No Cap	0	0	0	0	0	0	0	0	1	20
Not Recorded	2	40	2	40	1	20	4	80	4	80
Working (n=18)										
Full Cap	5	27.8	5	27.8	7	38.9	4	22.2	0	0
Some Cap	10	55.6	9	50.0	7	38.9	1	5.6	0	0
No Cap	3	16.7	1	5.6	3	16.7	7	38.9	12	66.7
Not Recorded	0	0	3	16.7	1	5.6	6	33.3	6	33.3

A14 Liability and Internal Review

At 104 weeks post-injury, the liability for all 23 claimants whose minor injury decision changed from minor to non-minor were accepted by the insurers. There were no new internal reviews between 78-weeks and 104 weeks post-injury. Three of these claimants who were working pre-injury were still involved with an external rehabilitation provider. Treatments had ceased for four (17%) of those claimants, while 14 (61%) claimants were still receiving treatment post injury, and it is not known if the remaining five (22%) claimants were still receiving treatment or not. Twenty-one (91%) of these claims remained open at 104 weeks post injury.

Table A55. Changed from Minor to Non-minor – Case Closure

Case Closure/ Settlement at 104 weeks	n	%
1. Yes	2	8.7
2. No	21	91.3

Note: Percentages are based on the total amount of claimants whose minor injury decision changed from minor to non-minor (n=23).

Table A56. Changed from Minor to Non-minor – Internal Review and Outcome

Total no. of Internal Review	n	%
0	7	30.4
1	11	47.8
2	4	17.4
3+	1	4.3
Total number	**25**	

Note: Percentages are based on the total amount of claimants whose minor injury decision changed from minor to non-minor (n=23).

A subgroup analysis of psychological injury, diagnosis and treatment was conducted. Note that it is inappropriate to report on these figures as they require further investigation, due to the very small sample size in these sub-group analyses. Tables A57, A58 and A59.

Table A57. Psychological Diagnoses and Psychological Treatment against Minor Injury Decision

	% with psychological diagnosis						% With any psychological diagnoses
Minor Injury Decision	First COW	Latest COW at 13-week post-claim	Latest COW at 26-week post-injury	Latest COW at 52-week post-injury	Latest COW at 78-week post-injury	Latest COW at 104-week post-injury	
Minor - Physical (n=7)	14.3	14.3	28.6	28.6	0	0	**57.1**
Minor - Psychological (n=1)	100	100	0	100	0	0	**100**
Minor - Both physical and psychological (n=4)	50.0	75.0	75.0	100	25.0	25.0	**100**
Non-minor - Physical (n=89)	4.5	5.6	7.9	22.5	11.2	12.4	**31.5**
Non-minor - Psychological (n=17)	41.2	41.2	70.6	100	58.8	58.8	**100**
Non-minor - Both physical and psychological (n=12)	0	25.0	58.3	91.7	75.0	83.3	**91.7**

Note: Percentages are based on the total number of claimants (N=130) per minor injury decision category.

Figure A5 indicates that the pattern of psychological injury increases over time for both minor and non-minor cases, peaking at 52 weeks post injury.

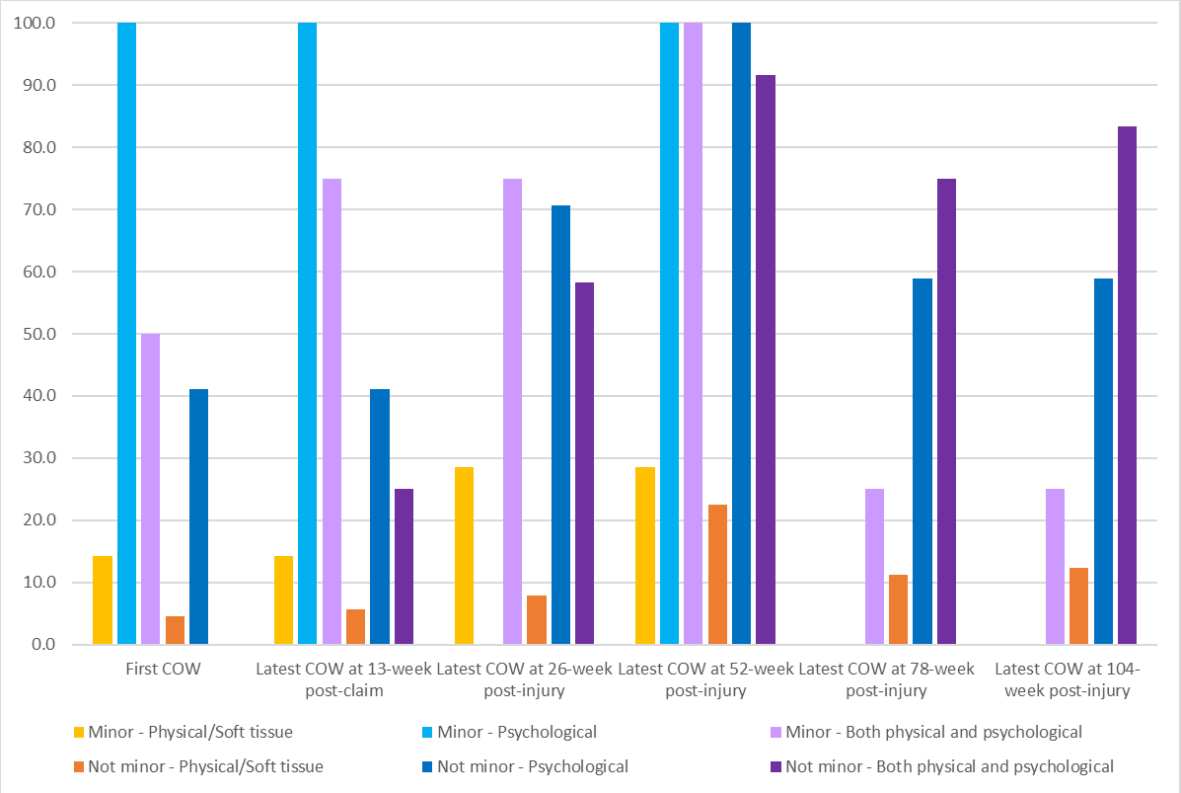


Figure 5. Psychological against Minor Injury Decision

Table A58. Details of Treatment for Psychologist paid for by insurer against Minor Injury Decision

Psychologist	13-week Post-claim		26-week Post-injury		52-week Post-injury		78-week Post-injury		104-week Post-injury	
	n	%	n	%	n	%	n	%	n	%
Minor - Physical (n=7)	2	28.6	0	0	0	0	1	14.3	4	57.1
Minor - Psychological (n=1)	0	0	0	0	0	0	0	0	0	0
Minor - Both physical and psychological (n=4)	2	50.0	3	75.0	0	25.0	0	0	1	25.0
Non-minor - Physical (n=89)	6	6.7	13	14.6	12	13.5	13	14.6	6	6.7
Non-minor - Psychological (n=17)	5	29.4	9	52.9	14	82.4	8	47.1	6	35.3
Non-minor - Both physical and psychological (n=12)	4	33.3	1	8.3	7	58.3	8	66.7	8	66.7

Note: Percentages are based on the total number of claimants (N=130) per minor injury decision category.

Figure A6 depicts that at 104 weeks, psychological treatment is still being paid for, with about 25% being for cases with a minor physical and psychological injury.

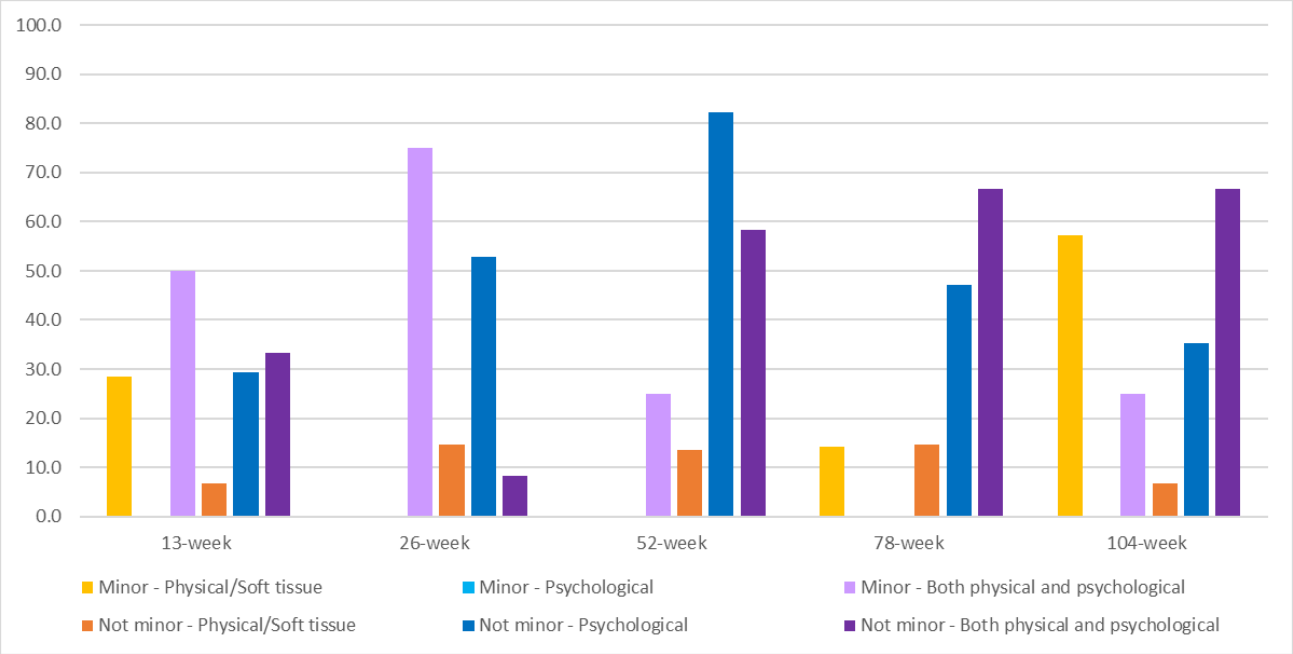


Figure A6. Summary of Treatment for Psychologist paid for by insurer against Minor Injury Decision

Table A59. Details of Treatment for Psychiatrist paid for by insurer against Minor Injury Decision

Psychiatrist	13-week Post-claim		26-week Post-injury		52-week Post-injury		78-week Post-injury		104-week Post-injury	
	n	%	n	%	n	%	n	%	n	%
Minor - Physical (n=7)	0	0	0	0	0	0	0	0	0	0
Minor - Psychological (n=1)	0	0	0	0	0	0	0	0	0	0
Minor - Both physical and psychological (n=4)	0	0	0	0	0	0	0	0	0	0
Non-minor - Physical (n=89)	0	0	0	0	1	1.1	1	1.1	3	3.4
Non-minor - Psychological (n=17)	0	0	1	5.9	3	17.6	1	5.9	2	11.8
Non-minor - Both physical and psychological (n=12)	0	0	0	0	0	0	0	0	0	0

Note: Percentages are based on the total number of claimants (N=130) per minor injury decision category.

Table A60 depicts Allied Health Recovery Requests for Psychology treatment against the minor injury decision.

Table A60. Summary of Allied Health Recovery Requests for Psychology against Minor Injury Decision

Approved psychology AHRR	13-week Post-claim		26-week Post-injury		52-week Post-injury		78-week Post-injury		104-week Post-injury		Any psychological AHRR	
	n	%	n	%	n	%	n	%	n	%	n	%
Minor - Physical (n=7)	1	14.3	0	0	0	0	0	0	0	0	1	14.3
Minor - Psychological (n=1)	0	0	0	0	0	0	0	0	0	0	0	0
Minor - Both physical and psychological (n=4)	1	25	1	25	1	25	0	0	0	0	2	50.0
Non-minor - Physical (n=89)	4	4.5	6	6.7	6	6.7	3	3.4	5	5.6	17	19.1
Non-minor - Psychological (n=17)	6	35.3	6	35.3	7	41.2	7	41.2	3	17.6	13	76.5
Non-minor - Both physical and psychological (n=12)	3	25	3	25	6	50	2	16.7	3	25	8	66.7

Note: Percentages are based on the total number of claimants (N=130) per minor injury decision category.

Those with psychological injuries had a 21% higher rate of external rehabilitation referral, and a 24% higher rate of internal review application compared to those without any psychological injury. Table A61.

Table A61. Summary of External Rehabilitation Service against Psychological Injury

	With any psychological diagnoses			
	Yes (n=65)		No (n=65)	
	n	%	n	%
Number of Rehab Plan				
0	34	52.3	48	73.8
1	11	16.9	7	10.8
2	7	10.8	3	4.6
3	5	7.7	4	6.2
4	4	6.2	1	1.5
5+	5	7.7	2	3.1

Psychological injury does not appear to be associated with Internal Review. Table A62.

Table A62. Summary of Internal Review against Psychological Injury

	With any psychological diagnoses			
	Yes (N=65)		No (N=65)	
	n	%	n	%
Total no. of Internal Review				
0	35	53.8	50	76.9
1	18	27.7	10	15.4
2	6	9.2	3	4.6
3+	6	9.2	2	3.1
Latest Minor Injury Internal Review Decision	(n=22)		(n=6)	
Overturned	8	36.4	1	16.7
Upheld	14	63.6	5	83.3

CTP Scheme Performance

Insurer Claims Experience and Customer Feedback Comparison

State Insurance Regulatory Authority

For the 12 months to 28 February 2021 unless otherwise stated

1. CLAIM ACCEPTANCE RATES

(Dec 2020)* **(Statutory benefit claims)**

Majority of claims are accepted by insurers

10,054 Total Statutory benefit claims

9,852 Total claims accepted

98%

	ACCEPTED CLAIMS	ACCEPTANCE RATE
AAMI	836	96.3%
ALLIANZ	1,814	97.4%
GIO	1,701	97.5%
NRMA	3,039	97.7%
QBE	2,462	99.7%
TOTAL	9,852	98.0%

Late lodgement is the main reason claims are declined

1. Late claim lodged more than 90 days after accident
2. Insufficient information provided to insurer
3. Claim related to a serious driving offence
4. Claim did not involve a motor vehicle accident

2. TIMELINESS OF ACCESSING BENEFITS

People injured are receiving early treatment

95% of persons injured receiving **TREATMENT AND CARE**

54%* of persons injured receiving **WEEKLY PAYMENTS**

Within 4 weeks of claim lodgement

	TREATMENT AND CARE	WEEKLY PAYMENTS
AAMI	94%	56%
ALLIANZ	96%	68%
GIO	93%	48%
NRMA	95%	54%
QBE	94%	44%
TOTAL	95%	54%

*54% of eligible customers are receiving weekly benefit payments within 4 weeks of lodging a claim.

How quickly do insurers accept a claim?

3.3 weeks

AAMI	3.3
ALLIANZ	3.1
GIO	3.2
NRMA	1.9
QBE	5.8

3. INSURER INTERNAL REVIEWS

How often are claims referred to internal review?

2,177 Insurer Internal Reviews

	NUMBER OF INTERNAL REVIEWS	INTERNAL REVIEWS PER 100 CLAIMS^**
AAMI	239	25
ALLIANZ	422	22
GIO	438	23
NRMA	480	15
QBE	598	23
TOTAL	2,177	21

Top 3 reasons for internal review

1. Minor injury decision
2. Treatment and care
3. Amount of weekly payments

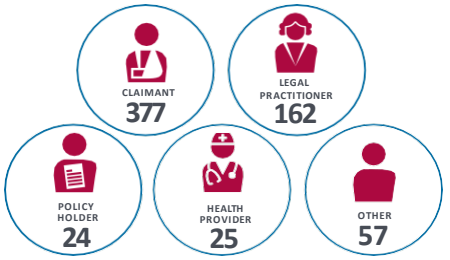
4. COMPLIMENTS & COMPLAINTS

159 COMPLIMENTS

645 COMPLAINTS

	TOTAL COMPLIMENTS	TOTAL COMPLAINTS	COMPLAINTS RECEIVED PER 100,000 GREENSLIPS SOLD^**
AAMI	12	65	12
ALLIANZ	41	72	7
GIO	32	122	13
NRMA	46	213	11
QBE	28	172	12
Youi	0	1	13
TOTAL	159	645	11

Who made the complaint?



What are the top 3 complaints?

1.Process 2.Service 3.Decision

*Claims acceptance rates are for claims lodged to December 2020. Figures will be updated each quarter.

**^The number of internal reviews insurers conduct will depend on how many claims insurers receive. By comparing internal reviews per 100 claims received it allows insurer comparison regardless of market share. Similarly insurers with more customers will receive more complaints. Therefore, by measuring complaints per 100,000 greenslips sold, customers can compare insurers' performance regardless of their market share.

Customer metrics under development. *Data sourced from SIRA, Centre for Road Safety and other sources.

Scheme Measures – Financial Metrics

State Insurance Regulatory Authority

SCHEME TO DATE

(1 December 2017 – 28 February 2021)

PREMIUM MEASURES

	ACTUAL 12 Mths to Jan 2021	ACTUAL Jan 2021	SCHEDULE 1E effective 15 Jan 2021
AVERAGE PREMIUM	$487	$479	$503
NUMBER OF POLICIES*	5,878,959	445,949	N/A

*Current month policy numbers are not included as understated due to time lags in reporting by insurers.

CLAIMS

		EXPECTED to date	% DIFFERENCE
LODGED All claims	37,449	37,721	Less than 1% (0.7%)
LODGED Statutory benefit only (excluding early notification)	33,845	33,897	Less than 1% (.015%)
AT FAULT	5,687	5,783	Not comparable as too many claims yet to be determined
NOT AT FAULT MINOR	14,582	15,244	
NOT AT FAULT NON-MINOR	9,601	10,333	
NOT YET DETERMINED			
• Within the statutory timeframe	3,683	2,537	
• Outside of statutory timeframe***	292	N/A	
FINALISED OR INACTIVE	22,554	N/A	
OPEN OR ACTIVE	11,291	N/A	

CASUALTIES

	ACTUAL 2021	ACTUAL 2020
PEOPLE INJURED (YTD Jan 21 v Jan 20)	1,028	987
FATALITIES (YTD Feb 21 v Feb 20)	53	56

TOTAL PAYMENTS

	ACTUAL ($M) scheme to date	EXPECTED ($M) to date	% DIFFERENCE
TOTAL PAYMENTS	$802.3	$731.0	10%
TREATMENT	$301.5	N/A	
CARE	$15.5	N/A	
WEEKLY INCOME REPLACEMENT*	$344.7	N/A	
LEGAL COST (insurer & claimant)	$26.9	N/A	
INSURER INVESTIGATIONS	$29.9	N/A	
OTHER	$83.8	N/A	

*Includes weekly payments and payments for both past and future economic loss

AVERAGE PAID

	ACTUAL scheme to date	EXPECTED to date	% DIFFERENCE
AT FAULT CLAIMS	$19,047	$17,000	12%
MINOR INJURY CLAIMS	$6,900	$6,900	0%
NON-MINOR INJURY CLAIMS**	Too early	Too early	

**Too early as common law damages not paid yet

OBSERVATIONS

Premium: Status

Average premiums have been reducing over the past year from over $520 in early 2018 to $487 for the 12 months to January 2021. This reflects reductions in filed premiums by insurers as well as a reduction in levies. Schedule 1E has been reduced in January 2021 from $506 to $503.

Current month numbers are not included as undeveloped due to time lags in reporting by insurer.

Claim Numbers: Status

The overall number of claims lodged are in line with current expectations. As there is a large number of claims with fault status yet to be determined, exact comparisons between the number of at-fault or minor or non-minor claims against expectations is not possible. Insurers have up to 3 months post claim lodgement to complete the minor injury assessment

Casualties: Status

The figures show a decline in the number of accidents from last year.

Claim Payments: Status

Total claim payments to date are currently higher than expected, due to faster than expected settlement of higher injury severity claims for damages. There is a high degree of uncertainty in the timing of claim payments as they rely heavily on the timing and size of settlements of damages claims. Damages claims have only started to emerge in any material number from June 2020. Overall, Damages claims are expected to represent over 70% of total claims costs

Average Claim Payments: Status

Average claim payments for Not at-fault Minor claims are in line with expected under Schedule 1E. The experience for At-fault claimants is currently trending higher than Schedule 1E (< $1 premium impact). This experience has a relatively small impact to premiums because the bulk of premiums are used to fund claim payments for people with non-minor injuries and the experience for these claims has yet to emerge.

***This refers to active claims which have been lodged more than 3 months ago

CUSTOMER METRICS UNDER DEVELOPMENT. DATA SOURCED FROM SIRA, CENTRE FOR ROAD SAFETY AND OTHER SOURCES.