Minister for Education and Training
Minister for Industrial Relations
Minister for the Central Coast
Minister Assisting the Minister for Finance

Refs: 07/512, A56193

- 8 OCT 2007

The Hon Christine Robertson MLC
Committee Chair
Legislative Council
Standing Committee on Law and Justice
Parliament House
Macquarie Street
SYDNEY NSW 2000

Dear Ms Robertson, Christine

I refer to your letter of 28 August 2007 regarding the eighth review of the Motor Accidents Authority (MAA) and Motor Accidents Council by the Standing Committee on Law and Justice, and attaching the Committee's questions on notice.

I am pleased to enclose the Motor Accidents Authority's responses to the Committee's questions. As requested, also enclosed is a disk containing the slides presented during the public hearing.

I am also forwarding the responses provided by the independent medical assessors to the Committee's questions on notice.

Any enquiries about this matter may be directed to Ms Boh Yeng, Senior Policy Officer, MAA on (02) 8267 1932 or by e-mail: byeng@maa.nsw.gov.au.

I trust that this information will be of assistance to the Committee.

Yours sincerely,

John Della Bosca MLC

Level 30 Governor Macquarie Tower, 1 Farrer Place, Sydney NSW 2000, Australia
Tel: (02) 9228-4777 Fax: (02) 9228-4392 E-Mail: office@smos.nsw.gov.au

EIGHTH REVIEW OF THE MAA AND MAC
Public Hearing, Monday 27 August 2007

MAA and MAC witnesses

QUESTIONS ON NOTICE

Insurer profits

The 04/05 Annual Report (p82) forecast that insurers will make $264 million in profit (18.9% of premium written) for 2003. But in the 05/06 Annual Report (p89) the forecast has been lowered to $135 million (9.7%) for 2003. Can you explain the nature of these forecasts and the meaning of this difference?

RESPONSE:

As per the scheme actuaries, the changes in the estimates of profitability are due entirely to increases in their estimates of ultimate claim costs. In particular they noted the following changes to components of the estimate of ultimate claim costs:

- **Actual claim payments during the year ending 30 June 2006 were more than projected using data as at 30 June 2005.**
- **Actual reported incurred costs (*claims paid + estimates*), was more than projected during year ending 30 June 2006.**
- **The rate of future superimposed inflation of average claims costs assumed for the projections was increased from 3 per cent per annum to 4 per cent per annum. This was based on claims experience up to 30 June 2006.**
- **The rate of future earnings-related inflation of average claims costs were increased from 4 per cent per annum to 5 per cent per annum.**

Accident Notification Forms

If a rise in the $500 limit could achieve an appreciable decrease in the number of ANFs that convert to full claims what positive effects would this have on the overall performance of the Scheme?

RESPONSE:

Accident Notification Forms that convert to full claims either have treatment expenses in excess of the current threshold amount or are entitled to other heads of damage in addition to treatment costs. It

would be anticipated that an increase in the Accident Notification Form threshold could see some Accident Notification Forms which would currently get converted to full claims finalised as Accident Notification Forms. This could benefit scheme performance as more injured people may be able to finalise their matter with the insurer through the simplified Accident Notification Form process.

Legal costs

The Bar Association's submission (p8) notes that legal costs were indexed five years after the commencement of the *MAC Act* and that it is now two years since that occurred. When will the next indexation occur?

RESPONSE:

An amendment allowing for consumer price indexation adjustments (up to the June 2007 quarter) of the rates and allowances fixed by the *Motor Accidents Compensation Regulation 2005* is currently underway.

Whole Person Impairment

The Government Response to the Committee's 7th Review (p4) noted that the Whole Person Impairment Awareness Project, which commenced in February 2005, is designed to improve understanding of the method for assessing WPI by parties to disputes and their representatives as well as medical assessors and claims assessors.

(a) Can you provide an update of this project?

RESPONSE

The Whole Person Impairment Awareness Project continues in its aim to improve understanding of assessment of whole person impairment amongst Compulsory Third Party stakeholders.

The Whole Person Impairment email enquiry service is active and we have had many interesting queries recently. Replies to queries are being posted within a five-day timeframe unless additional information required, in which case the person making the enquiry has been fully apprised of events. An update of a selection of queries will be published in the next Motor Accidents Assessment Service Bulletin.

The Medical Assessment Service has updated the Whole Person Impairment Case Studies in line with the 2005 and 2007 Guidelines. These case studies will be available to view on the Motor Accidents

Authority website shortly. The case studies have been designed to enable users to easily identify the body regions that they wish to study. A comprehensive medical terminology and glossary of diagnosis will accompany the case studies.

New Permanent Impairment Guidelines will be released on the 1 October 2007. A cross reference table has been developed to enable users to quickly identify the changes between the 2005 and 2007 Guidelines. This table and an accompanying article will be available on the Motor Accidents Authority website and will be published in the next edition of the Motor Accidents Authority Service Bulletin.

The Motor Accidents Authority will be conducting education sessions for stakeholders in regards to the new Guidelines in late September 2007.

(b) Can you describe how this project is attempting to improve understanding of the method of assessing WPI?

RESPONSE:

Motor Accidents Assessment Service has developed brochures and fact sheets to explain the role of Medical Assessment Service and assessment process in relation to Whole Person Impairment and treatment disputes. Feedback has been sought from stakeholders and the fact sheets are currently being edited.

Motor Accidents Assessment Service developed worksheets to assist stakeholders in determining Whole Person Impairment. These worksheets will be reviewed in light of feedback from stakeholders, and will be available on the Motor Accidents Authority website. Medical Assessment Service will invite stakeholders to trial the revised worksheets.

Using the email enquiry service and publishing the queries, with replies, in Motor Accidents Assessment Service Bulletins and on the Motor Accidents Authority website, is anticipated to assist as a learning and development opportunity for stakeholders, together with the revised case studies.

The development of an online whole person impairment index is being researched. This would enable stakeholders to readily refer to the appropriate chapter in American Medical Association Guides to the Evaluation of Permanent Impairment (4th Edition) and Motor Accidents Authority Guidelines as appropriate to the body region(s) in dispute.

(c) Will Medical Assessors and Claims Assessors receive additional training in this area?

RESPONSE:

Training in Motor Accidents Authority Whole Person Impairment was held in August 2007. This training was open to any interested person. Several Claims Assessment Resolution Service Assessors attended the training.

It is a requirement of any Medical Assessment Service Impairment Assessor to have attended training in the Motor Accidents Authority Core module and relevant body system modules.

Medical Assessment Service holds bi-monthly Forums for Medical Assessment Service Assessors. These forums usually comprise of invited guest speakers and/or Medical Assessment Service Assessors presenting cases of interest and issues. The forums facilitate peer discussion amongst Assessors and allow complex issues to be addressed.

The Annual Medical Assessment Service Assessor Conference addresses many complex issues that arise in conducting Medical Assessment Service assessments, such as causation, apportionment, procedural fairness and assessing whole person impairment.

Medical Assessment Service staff and Assessors have presented at Claims Assessment Resolution Service Assessor Conferences to assist these assessors with their understanding of impairment assessment.

Medical Assessment Service assessors recruited for period 2007-2010 are required to complete and pass exams in Whole Person Impairment, prior to undertaking any assessments.

Motor Accidents Assessment Service and Motor Accidents Authority will be delivering education and training sessions regarding the new impairment guidelines due to commence on 1 October 2007.

Claims Assessment Resolution Service Assessors have been provided with training in respect of assessing Whole Person Impairment. Each assessor is given (on appointment) a copy of the Motor Accidents Authority's guidelines and a copy of the American Medical Association Guides. At the annual Claims Assessment Resolution Service Conference in 2005 a whole day was devoted to highlighting the important features of the most used chapters of the guidelines (spine, upper and lower limb, psychiatric impairment). Through articles in the Motor Accidents Assessment Service bulletin and

regular items in the Claims Assessment Resolution Service e-news bulletin, Claims Assessment Resolution Service Assessors are regularly taken to interesting and relevant cases touching upon the guidelines.

Premiums for motorcyclists

The submission of the NSW Motorcycle Council raises several concerns and queries about the premiums paid by motorcycle riders in NSW. The Council argues that premiums for motorcyclists are too high and that there is a lack of information about the methodology for calculating motorcycle premiums.

(a) What is the total amount of money collected per year from motorcycle premiums for each year of the new Scheme?

RESPONSE:

Year Premium Collected	Amount ($'000)
1999/00	23,325
2000/01	24,969
2001/02	27,431
2002/03	28,845
2003/04	31,073
2004/05	32,207
2005/06	35,260
2006/07	25,789

Scheme years run from Oct to Sep. Data for 2006/07 is up to June 2007

(b) What is the total amount of money paid out per year in claims *against* motorcycle CTP holders for each year of the new Scheme?

RESPONSE:

Year Claims Paid	Amount ($'000)
1999/00	10,420
2000/01	18,183
2001/02	12,798
2002/03	6,533
2003/04	3,406
2004/05	2,152
2005/06	285
2006/07	9

Scheme years run from Oct to Sep. Data for 2006/07 is up to June 2007

Note: Claims paid in any particular year, may arise on policies on risk in much earlier years, hence the above data cannot be used to determine underwriting profit for the given years. The Motor Accidents Authority is happy to meet with the Motor Cycle Council to discuss the Compulsory Third Party premiums setting process.

(c) The Council also expresses confusion about the 'MCIS' levy – Can you explain what this levy is and if it is made up of different components what are they and what proportion to each represent?

RESPONSE:

Before 1 October 2006, a person injured in a motor vehicle accident could make a claim only if the victim could prove that the driver of the other vehicle caused the accident. The New South Wales government introduced the Lifetime Care and Support Scheme, where from 1 October 2006 for children and from 1 October 2007 for adults, everyone catastrophically injured in a motor vehicle accident, regardless of fault is a Lifetime Care and Support participant.

Since 1 October 2006, the total Green Slip price payable has been split into:

- **Insurer premium,**
- **Goods and Services Tax on the insurer premium,**
- **Medical Care and Injury Services levy.**

The Medical Care and Injury Services levy is made up of the Motor Accidents Authority and Lifetime Care and Support levy, which are Goods and Services Tax free.

Motor Accidents Authority levy:

The Motor Accidents Authority levy includes bulk billing for New South Wales ambulance and hospital services, Motor Accidents Authority administration costs and Roads and Traffic Authority fees. All components of the Motor Accidents Authority levy were previously included in the insurer premium but were not identified separately. The Motor Accidents Authority levy is calculated as a percentage of the insurer premium and the percentage is the same for all policies. Currently, it is 10 per cent of the insurer premium.

Lifetime Care and Support levy:

The Lifetime Care and Support levy covers the costs of providing life time care and support for everyone catastrophically injured in a motor vehicle accident, regardless of fault. The Lifetime Care and Support levy is also calculated as a percentage of the insurer premium but the percentages are different for each vehicle class / rating region. Part of the Lifetime Care and Support levy amount is a transfer of what would previously have been included in insurer premiums for the cost of the treatment and care component for those catastrophically injured claimants making a Compulsory Third Party claim against the insurer.

(d) The Council presents anecdotal evidence that CTP quotes for motorcycles from the same company can vary wildly from year to year and that it appears that the insurers 'take turns' at providing the lowest Greenslip price each year. Can you comment on this observation?

RESPONSE:

Insurers do not take turns to provide lowest Green Slip price each year. Green Slip prices for motor vehicles including motorcycles are determined by:

1. **Insurers' base premiums comprising their risk premium and expenses. The insurer premium includes the cost of the 1 October 2006 special children's benefit i.e. treatment and care expenses on a no fault basis for children who are not Lifetime Care and Support participants.**

2. **Revised relativities based on the residual claims experience of the various vehicle classes/ and geographic regions. These relativities exclude care and treatment costs for currently compensable catastrophically injured claimants.**

3. **Changes to insurers' rating structures. For example, insurers may introduce new rating factors or remove existing ones and or provide premiums at many intervals between maximum discount (25 per cent for over 55s, 15 per cent for under 55s) and maximum loading (approximately 50 per cent of the base rate).**

4. **Changes in the individual motorist's conditions which result in movement from one rating category to another e.g. the vehicle**

may jump to the next age category when it is 10 years old, drivers under 25 may be added.

5. **The amount included in the Lifetime Care and Support levy to cover people who were not previously covered by the fault-based scheme but will now be Lifetime Care and Support participants.**

(e) It appears that the Council's concerns could be alleviated through the provision of clear and accurate information – would it be possible for the MAA to meet with the Council to clarify some of these issues?

RESPONSE:

The Motor Accidents Authority is quite happy to meet with the Motor Cycle Council to discuss any issues of interest. In the past the Motor Accidents Authority has met with industry groups such as the Bus and Coach Association (NSW), to go over the premium setting process and also answer any questions related the operation of the scheme.

Complaint handling

The Government response to the Committee's 7th Report (p4) notes that an information package regarding making complaints about CTP insurers will be available on the MAA website by the end of the year. What information was used to inform the development of this package – for example, was feedback from previous complainants sought?

RESPONSE:

The following information has been used to inform the development of the Motor Accidents Authority's information package on making complaints to be posted on the Authority's website:

1. **Australian Standards:**
    - **AS ISO 10002 2006 on Customer Satisfaction – Guidelines for Complaints Handling in Organisations,**
    - **AS 4269 1995 on Complaints Handling.**

2. **Recommendations of the Internal Audit Bureau of New South Wales from their audit review of the Motor Accidents Authority Insurer Licensing and Performance Branch's complaint handling procedures.**

3. Consultation within the Motor Accidents Authority with Motor Accidents Assessment Service, Scheme Performance, Information Technology and Policy, as well as all Senior Motor Accidents Authority Officers.

4. Reference materials and publications of external agencies:

(a) Office of the New South Wales Ombudsman (Fact Sheets, booklets and brochures):

- **Effective complaints handling guidelines,**
- **Handling complaints,**
- **Dealing with difficult complainants,**
- **Understanding complaints management,**
- **Workshop – Towards best practice in complaints management.**

(b) Commonwealth Ombudsman's Office of Canberra – A good practice for effective complaints handling,

(c) Centrelink – Principles and procedures for handling complaints,

(d) Health Insurance Commission's Charter of Care,

(e) Australian Competition and Consumer Commission – Know how to complain.

5. Further consultation is proposed internally within the Motor Accidents Authority, then external consultation with the Compulsory Third Party Industry and NSW Bar Association, NSW Law Society and Insurance Council.

Late withdrawal of admission of liability by insurers

During the last review the MAA advised that it had remedied the problem of late withdrawals of liability by insurers, through changes to policies and procedures for determining liability, which were introduced on 1 January 2005.[1]

(a) Have these changes proved successful over time?

RESPONSE:

---

[1] MAA 7 Report, p49

The Motor Accidents Authority considers that the more rigorous decision making processes adopted by insurers since January 2005 have proved to be successful in reducing the problem of late withdrawals of liability by insurers.

(b) Have there been any late withdrawals of liability since January 2005 and if so what has been the MAA's response?

RESPONSE:

Since January 2005, there have been approximately 24,000 determinations of liability across the Compulsory Third Party industry. Insurers have changed an admission of liability to a denial of liability on approximately 40 claims representing less than 0.2 per cent of all liability determinations. Since January 2005 to date, there have been no complaints to the Motor Accidents Authority from claimants or their legal representatives relating to a claim where the insurer has made a late withdrawal of liability. The Motor Accidents Authority has also been advised by insurers that there have been no court decisions to estop (prevent) an insurer from changing its admission of liability to a denial of liability.

Insurance gap between CTP and public liability insurance

The insurance gap between CTP insurance and public liability insurance has been examined by the Committee in its last four reviews.

(a) The Government response to the Committee's 7th Report (p10) notes that the MAA website now has information regarding the possibility of the gap. Does the MAA have any plans to further publicise the existence of the gap?

Response:

The Motor Accidents Authority has no immediate plans to further publicise this issue.

(b) The Government response also notes that the MAA has previously raised the issue with the Insurance Council of Australia and that the issue is under consideration by the insurance industry. Can you provide more detail about the MAAs interaction with the ICA on this issue? Are you anticipating further consultation with the ICA on this issue?

RESPONSE:

The matter has been raised by the Authority and discussed at executive level with each of the motor accidents scheme licensed insurers and representatives of the Insurance Council.

The Motor Accidents Authority has no immediate plans for further insurer consultation on this issue.

Blameless or inevitable accidents

In its 7th Report (p117) the Committee noted the introduction of a no-fault benefit for blameless or inevitable accidents (such as those caused by a driver suffering a heart attack), which is due to come into force on 1 October 2007.

> (a) What preparations has the MAA made in anticipation of this amendment coming into effect? For example, what measures have been taken to inform the public?

RESPONSE:

In anticipation of the commencement of the Blameless accidents provisions of the *Motor Accidents Compensation Act 1999* on 1 October 2007, the Motor Accidents Authority has revised the motor accidents personal injury claim form (claim form) to include information on the expanded scope of the scheme. The revision of the claim form was undertaken in consultation with licensed insurers and the legal profession. The claim form will be the form approved by the Authority for claims lodged on or after 1 October 2007.

> (b) The Bar Association expressed concern in its submission (p12) that the way the legislation is drafted leaves it open for a driver in certain circumstances to recover damages as a consequence of a blameless accident (*examples are provided in the submission*). What are your views on the concerns raised by the Bar Association?

RESPONSE:

The Motor Accidents Authority considers the intention of the amendment was made clear in the Minister's second reading of the legislation:

"The primary purpose of this bill, as I previously indicated, is to extend the scope of the New South Wales motor accidents scheme by amending the Motor Accidents Compensation Act 1999 to provide a special benefit for children at-fault in a motor vehicle accident and to provide CTP scheme entitlements to people injured in blameless accidents. The blanket application of legal rules and principles can on occasions have unfortunate and even undesirable consequences. The principle of fault is a case in point. For example, when a person injured in a motor accident is unable to access CTP assistance because no-one is found to

have been at-fault in causing their injury, or when children are penalised for behaving as children do. The enhancements to the motor accidents scheme proposed by the bill will provide greater support and security to injured people and their families.

Part 1.2 of the bill provides a right of recovery to people injured in motor vehicle accidents occurring in New South Wales where no-one is at-fault. That is an "inevitable" or "blameless" motor accident. For the purpose of making this new claim for death or injury, the motor accident is deemed to have been caused by the fault of the owner or driver of the motor vehicle. The injury must also be caused by a motor vehicle accident of a kind recognised by the Act. A person who is injured in a blameless accident will be entitled to CTP scheme benefits. The one exception is that the driver of the motor vehicle causing the accident will not be entitled to make a claim under these provisions. However, if that driver is catastrophically injured an application for entry to the Lifetime Care and Support Scheme may be made."
[Legislative Council Hansard 4 April 2006]

Road Safety – Young Drivers

In its submission Youthsafe raises the issue of road safety among young drivers, particularly young male drivers.

(a) Can you outline the initiatives or research the MAA is currently undertaking in the area of road safety for young drivers?

RESPONSE:

The Motor Accidents Authority has a major funding commitment to activities aimed at improving youth road safety in New South Wales.

The *Arrive alive* program is the Motor Accidents Authority's road safety program targeting youth aged 17-25 years. As communicating effectively with young people can be very challenging, the Motor Accidents Authority has supported a wide and innovative range of activities to engage young people and influence their attitudes and behaviour. Current programs of note include:

- *Arrive alive* Grant Scheme

The Motor Accidents Authority continues to promote the active involvement of young people in road safety initiatives in their local communities through the *Arrive Alive* Grants Scheme.

The *Arrive alive* Grant Scheme encourages young people to apply for grants, through a support organisation, to develop, implement and evaluate youth road safety education projects that address identified local needs. An advisory committee of young people and road safety stakeholders assist the Motor Accidents Authority in the grant selection process.

- Sponsorships

The Motor Accidents Authority has also targeted young people through areas of interest including sport, music and the arts as part of the *Arrive alive* program.

With regard to sport, the Motor Accidents Authority has developed partnerships with National Rugby League rugby league clubs including Manly Sea Eagles, West Tigers, St George Illawarra Dragons, Penrith Panthers, Newcastle Knights and the schoolboy league competition, as well as men and women's soccer and men's basketball. Players deliver road safety presentations to young people, generally in schools, and particularly aimed at students in Years 10 to 12.

With regard to music the Motor Accidents Authority has provided funding for Youth Week, a state-wide range of activities held in March each year. Sponsorship of Youth Week has included a Youth Rock Band Competition and grants to local councils, predominantly in rural areas, for the provision of *Arrive alive* shuttle bus services to and from Youth Week events.

The Motor Accidents Authority has provided sponsorship of the Eastern University Games. The Games reach University students with road safety advice including choosing a designated driver, non-use of mobile phones when driving, and how to avoid driver fatigue. The Motor Accidents Authority also sponsored the *Arrive alive* shuttle to safely transport Games participants.

All *Arrive alive* program activities focus on alerting young people to the issues associated with being a young road user (eg inexperience, attitudes and risk-taking behaviour) and providing information about how to handle these issues.

The Motor Accidents Authority's youth road safety website: www.arrivealive.com.au uses music, art, sport and competitions to

engage young people's interest and promote road safety messages in an appealing and innovative way. On average the *Arrive Alive* website receives up to 20,000 visits each month.

(b) What future initiatives or research are planned?

RESPONSE:

The Motor Accidents Authority is currently looking at ways to enhance current activities and investigating opportunities for new initiatives, including support for the revised Graduated Licensing Scheme.

(c) The MAA 05/06 Annual Report (p26) notes that the period 2000-2004 saw some improvement in injury rates among 17-25 year olds. Has this trend continued since 2004 and if so what do you attribute this trend to?

RESPONSE:

While young people (17-25 years) continue to be over-represented in road crashes, there has been some improvement in their injury rates during the period of 2000-2005.

Young people are over-represented in motor vehicle crashes for a range of factors including a combination of inexperience and risk-taking behaviour. This behaviour would appear to be a product of higher levels of risk tolerance in young people shown across a range of activities of which driving is just one, and poorer ability to assess risk.

For this reason Government initiatives have focussed upon increasing level of experience of new drivers through the Graduated Licensing Scheme and addressing risk-taking through additional limitations upon young drivers.

While 2006 was a poor year in relation to P-plate involvement in road fatalities, generally the Graduated Licensing Scheme and other road safety initiatives are delivering improvement in road safety for young people. For example, while still over-represented in road crashes, the injury rate for young people 17-25 years reduced from 970 per 100,000 population (7,941 injured) in 2001 to 784 per 100,000 population (6,487 injured) in 2005.

MAC

When does the term for the current members of the MAC lapse?

RESPONSE:

The current appointed Motor Accidents Council members' term lapse in March 2009. The Chairman and Deputy Chairperson of the Board of Directors of the Motor Accidents Authority and the General Manager remain as members of the Council pursuant to section 208(1)(a), (b) and (i) of the *Motor Accidents Compensation Act 1999*.

Medical Assessment Service

Lifecycle of a dispute

Can you provide an overview of the entire lifecycle for a medical dispute assessment, including the various statutory timeframes by which certain elements of the process need to be completed?

Is there scope for further reducing the overall lifecycle for assessments?

RESPONSE:

The lifecycle of a Medical Assessment Service dispute can be broken down into three distinct stages;

- **Stage 1: date application received to first allocation review (to decide if the matter is ready to be allocated to an assessor and if so to whom),**
- **Stage 2: first allocation review to first assessors appointment**
- **Stage 3: first assessors appointment to last certificate sent to the parties**

The statutory and guideline timeframes, counted in working days, which apply within each of those three distinct stages, are as follows;

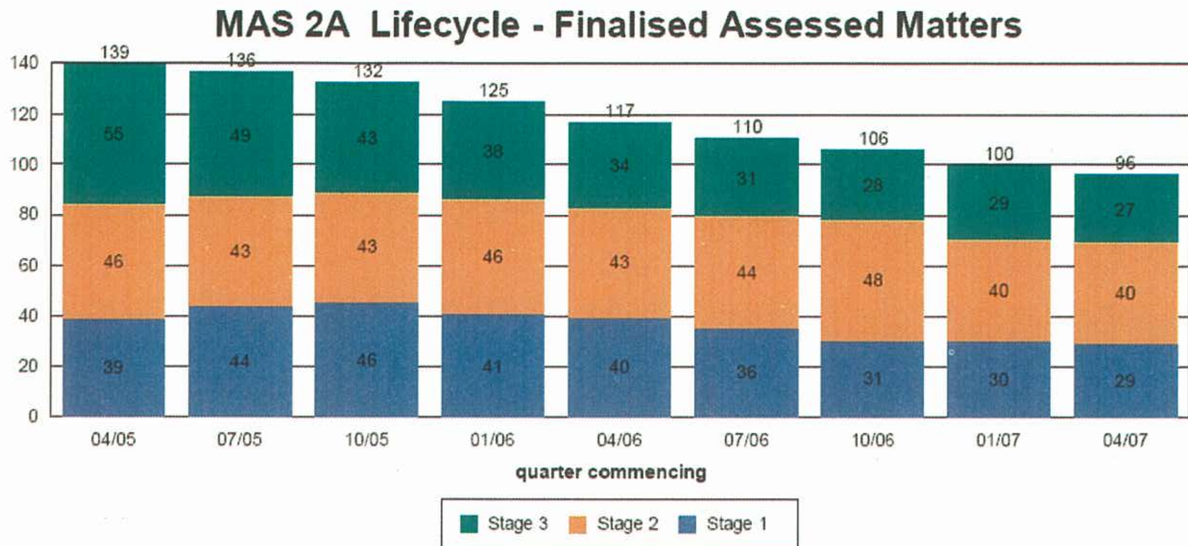
- **Stage 1 – Approximately 30 working days;**
    - **Application processed by Motor Accidents Assessment Service within five days,**
    - **Application acceptance is 'deemed received' by respondent in five days,**
    - **Reply due from respondent within 20 days after receiving Application,**

- Reply processed by Motor Accidents Assessment Service within five days,
- File Review for Allocation completed by Motor Accidents Assessment Service within five days of Reply Due date.

- Stage 2 – No set timeframe but averaging approximately 40 working days;
  - No statutory timeframe set for first Appointment. Motor Accidents Assessment Service endeavours to arrange appointments within approximately 4 weeks time (20 days). Special cases that require rare specialities of assessors, where the claimant has special needs, or in more remote locations, overseas or in gaol may take significantly longer.
- Stage 3 – Approximately 40 working days;
  - Multiple appointments have no set timeframe, but in cases of multiple injuries requiring multiple assessments, or special cases such as where the brain injury protocol is applied, the second or subsequent assessment may need to await completion of the first assessment.
  - Re-scheduled appointments & Non-Attendances requiring cancellation and re-booking of appointments.
  - Certificate & Reasons issued by assessors to Motor Accidents Assessment Service within 15 days.
  - Certificates sent to parties by Motor Accidents Assessment Service within five days of receipt.
  - Combination certificate (in multiple assessment cases) prepared and sent to parties by Motor Accidents Assessment Service within five days of receipt of final assessors certificate.
  - Total approx. 95 days.
- Total Lifecycle – Approximately 110 working days.

The lifecycle of disputes at Medical Assessment Service has been massively reduced in recent times. The average assessment lifecycle peaked in February 2003 at approximately 190 working days, by February 2005 this has been reduced to approximately 150 days and that trend has continued reducing by February 2007 to 100 working days.

The chart below shows the reduction in average lifecycle per quarter for whole person impairment assessment disputes over the past two years, reducing from 139 days to 96 days over the period.



Scope for Further Reducing Medical Assessment Service Assessment Lifecycle

There may be some scope for slightly reducing the lifecycle of Medical Assessment Service assessments again in future, however any reductions are expected to be very modest compared to the significant reductions of previous years. The areas that may contribute to a reduction in the lifecycle include:

- Reply Period – reducing the period for lodging a reply from 20 working days after a respondent says that they received a copy of the application from Motor Accidents Assessment Service, to a shorter period of say 10 or 15 days (two to three weeks) after the date Motor Accidents Assessment Service sent the application to the respondent. This would also provide greater certainty to Reply due dates for Motor Accidents Assessment Service and parties.
- File Review for Allocation – reducing the period for Motor Accidents Assessment Service to conduct the allocation review to within five days of any early Reply that is lodged and is processed by Motor Accidents Assessment Service before it was due, instead of otherwise doing so within 5 days of the Reply Due date if the reply is lodged on its due date.
- Earlier appointments – Requiring that wherever possible all appointments should be booked within 20 working days (4

weeks). Note that this will require a consequential change to reduce re-scheduling and non-attendances.

- **Non-Attendances, very late cancellations and re-schedules – Introduce requirement for payment of non-attendance and late cancellation fees by claimants who fail to attend or cancel an appointment within 48 hours of the appointment. Amount to be for cost recovery of fees paid to assessor or interpreters' only, equal to the amount Medical Assessment Service is required to pay to an assessor or interpreter as a result of the cancellation or non-attendance.**

  Limit the number of times a claimant may re-schedule an appointment before the assessment is conducted on the papers instead. These are important requirements to complement the ability of Medical Assessment Service to arrange earlier assessment appointments, and to counter an increasing trend of non-attendances, very late cancellations and re-scheduled appointments that is already impacting on the Medical Assessment Service assessment lifecycle.

- **Timing of Medical Assessment Service Whole Person Impairment Dispute Lodgements – Of greater concern to Medical Assessment Service than the time it takes for a dispute to be assessed by Medical Assessment Service is the period of time it takes before a whole person impairment dispute is lodged at Medical Assessment Service for assessment. This issue is discussed in detail below regarding delays by parties in resolving medical disputes.**

Recent enhancements

Can you provide details on any recent enhancements to the Scheme that contribute towards making the medical assessment and MAS dispute resolution process more claimant friendly?

RESPONSE:

There have been many enhancements to the scheme that have contributed to making the medical assessment and Medical Assessment Service Dispute process more claimant-friendly.

Forms: The Medical Assessment Service Application and Reply forms have been reviewed on a regular basis. Feedback has been sought from our stakeholders to ensure the forms are as clear and instructional as can be, within the parameters of the dispute process.

Whole Person Impairment Awareness Project: The development of this project is aimed at assisting stakeholders and participants within the scheme and Medical Assessment Service to understand the assessment of whole person impairment. The creation of the Whole Person Impairment email address allows parties to access impairment information in a quick and easy way.

Assessor Training: Medical Assessment Service has a comprehensive assessor training program. Forums for Assessors have been held since 2005 on a monthly or bi-monthly basis. These forums address many aspects of dispute resolution, and aim at improving Assessor performance. This is reflected in Medical Assessment Service amending its standard templates for report writing to ensure the parties can clearly understand how the Assessor came to his/her decision.

Medical Assessment Service holds an annual conference for our appointed assessors. As with the forums these conferences endeavour to assist Assessors in performing their role as an Assessor. Conferences have addressed such topics as Procedural Fairness. The 2007 conference theme is 'Causation' as medical assessors are often required to determine difficult issues of apportionment between competing accidents and pre existing and subsequent injuries / conditions.

The development of the minor skin and minor dental assessment policy has assisted in the timely resolution of these potential minor disputes at Medical Assessment Service. The aim of this policy is to increase Assessor utility and as a consequence potentially reduce the number of appointments a claimant has to attend.

Case Management Services: Case Management Services aim to process matters lodged at Medical Assessment Service quickly. If the parties to a Medical Assessment Service dispute submit their documents earlier than the due date, the Case Manager will review the file ahead of the legislative timeframes, hence reducing the time it takes for a matter to proceed through Medical Assessment Service.

Claimants are contacted via telephone to remind them of pending appointments with Medical Assessment Service Assessors, this will hopefully reduce the fail to attend rate for Medical Assessment Service appointments and help facilitate the timely resolution of disputes.

The Claims Advisory Service contacts unrepresented claimants and provides procedural assistance them when they have a dispute at Medical Assessment Service.

Binding MAS Certificates

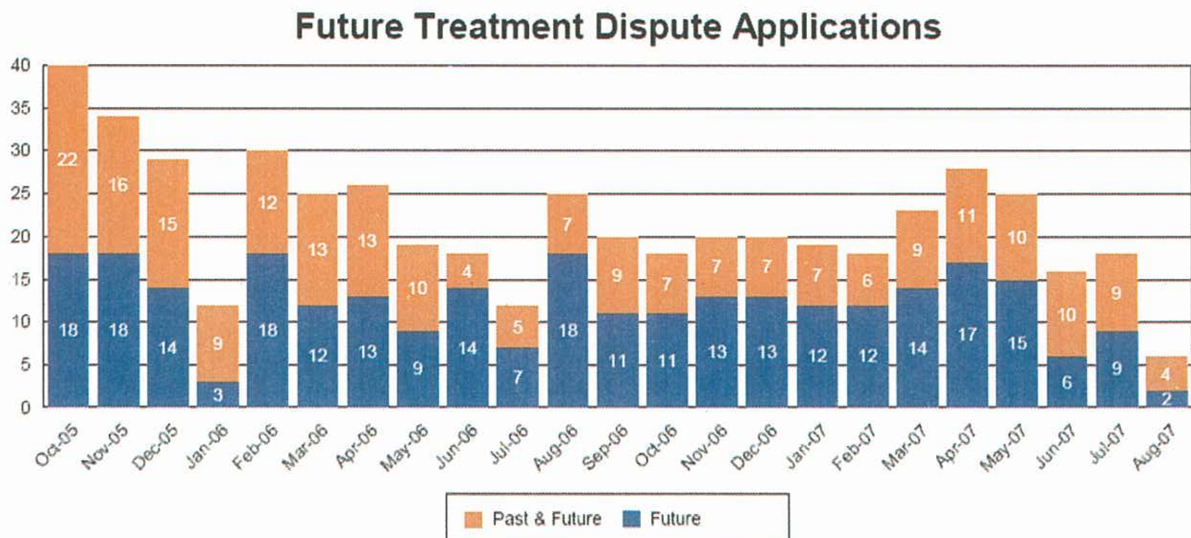
The Committee welcomes the recent (*October 2006*) amendment to section 61 of the *MAC Act* whereby MAS certificates with respect to future treatment are now binding on the parties, CARS and the courts.

(a) Now that future treatment assessment outcomes are binding do you expect to see an increase in these types of disputes being brought to the MAS for resolution?

RESPONSE:

No. There has been no increasing trend in the period since the amendment to section 61 of the *Motor Accidents Compensation Act 1999*. In fact the number of overall treatment disputes at Medical Assessment Service has continued to decline and future treatment disputes have decreased by approximately 20 per cent.

Disputes lodged at Medical Assessment Service about treatment may be either regarding past treatment, future treatment, or they may be a mix of past and future treatment. The chart below focuses on those treatment disputes lodged at Medical Assessment Service that do have a component of the dispute related to future treatment, by counting the number of disputes lodged involving future treatment, plus those with a mix of past and future treatment, and by excluding treatment disputes lodged regarding past treatment only.



As can be seen from the chart above, 12 months prior to October 2006 there were 290 disputes lodged involving future treatment, at an average rate of 24.2 disputes per month. In the 11 months since October 2006 there were 211 disputes lodged involving future

treatment, at an average rate of 19.2 disputes per month, a reduction of approximately five disputes per month or 20 per cent.

A comparison of the party lodging future treatment disputes at Medical Assessment Service is also set out in the chart below, which shows that the profile of the applicant can vary significantly month on month, which needs to be viewed with some caution given the relatively low number of disputes lodged.

The table below shows the monthly figures of future treatment disputes lodged by applicant type for the period October 2005 to August 2007. These figures are reflected in graph format as numbers in table A and as percentages in table B.

Future Treatment Disputes lodged by applicant type

(October 2005 – August 2007)

	Injured person	Insurer	CARS/Court	Total
Oct-05	30	10	0	40
Nov-05	18	16	0	34
Dec-05	22	7	0	29
Jan-06	7	4	1	12
Feb-06	21	8	1	30
Mar-06	19	6	0	25
Apr-06	17	9	0	26
May-06	12	6	1	19
Jun-06	13	5	0	18
Jul-06	6	6	0	12
Aug-06	19	5	1	25
Sep-06	14	6	0	20
Oct-06	14	3	1	18
Nov-06	14	6	0	20
Dec-06	12	7	1	20
Jan-07	9	10	0	19
Feb-07	9	9	0	18
Mar-07	12	11	0	23
Apr-07	14	14	0	28
May-07	14	10	1	25
Jun-07	10	6	0	16
Jul-07	10	8	0	18
Aug-07	3	3	0	6
Total	319	175	7	501

Table A

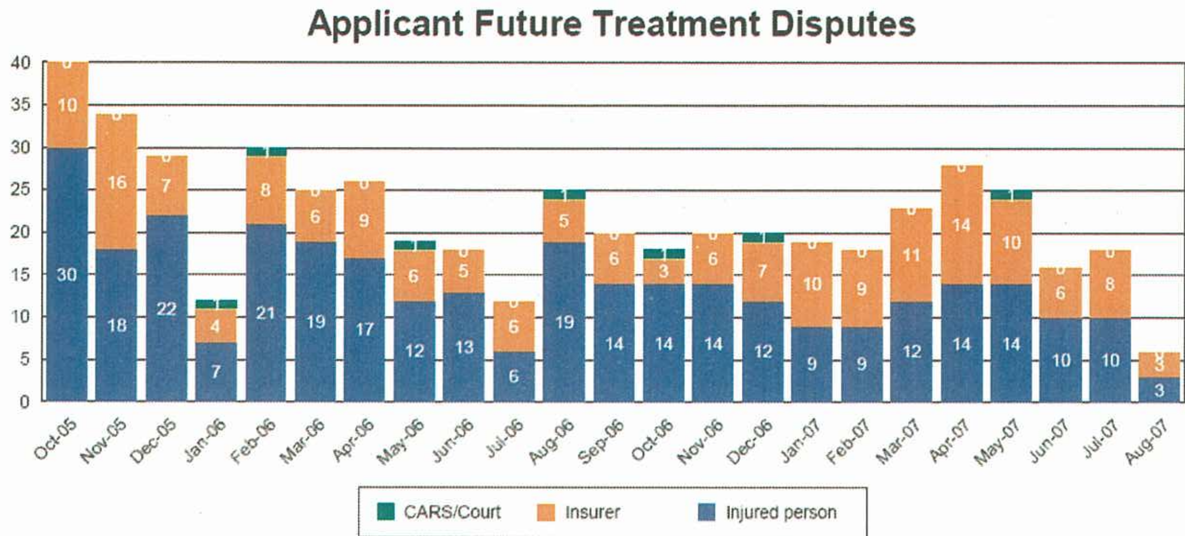
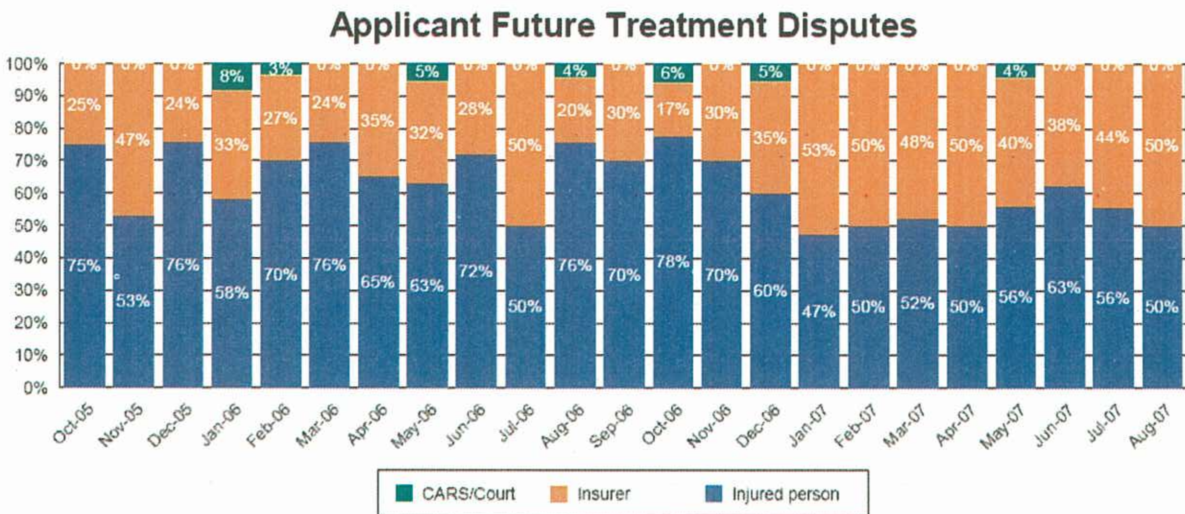


Table B



It is apparent however that in the period before October 2006 future treatment disputes were predominantly lodged by claimants and their representatives (67 per cent on average) rather than by insurers.

In the period since October 2006 future treatment disputes have been more equally lodged by both parties, with those lodged by claimants and their representatives down to 57 per cent on average, although on a reduced total number of future treatment disputes.

(b) If the MAS is to continue to assess past and future earning capacity disputes then shouldn't these assessment outcomes also be made binding? Does the MAA have a position with respect to this?

RESPONSE:

The Motor Authority Assessment Service Reform Agenda aims to address this issue by removing earning capacity disputes from the Medical Assessment Service jurisdiction given that Medical Assessment Service assessments on this issue have only been seen to be of very limited usefulness to the parties.

Multiple disputes

The Committee was advised that over the life of the Scheme on average 13% of claims have a medical dispute. Given the number of medical disputes over the life of the scheme, it appears that *on average* each of these claims has multiple disputes.[2]

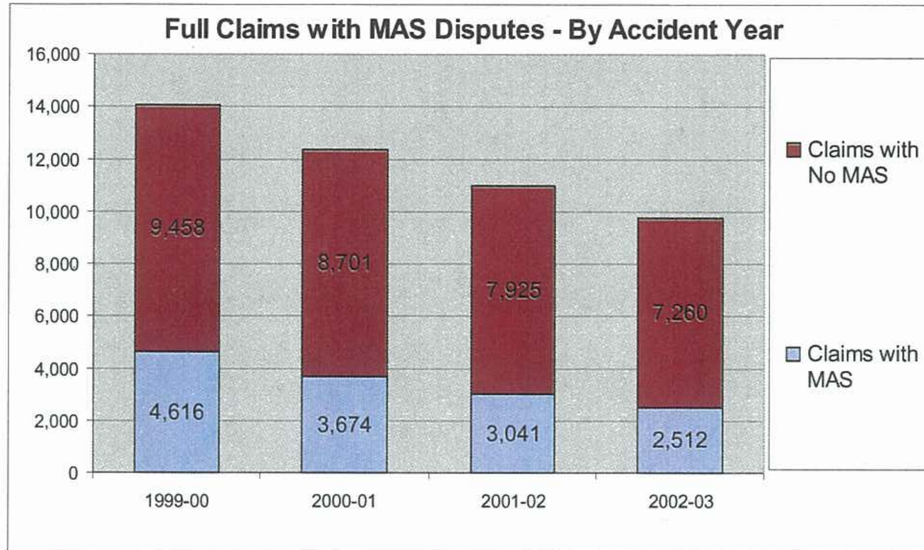
It would perhaps be more accurate to say that in any given accident year only about 30 per cent of all claims are likely to have a medical dispute that will proceed to Medical Assessment Service, but those that do have a claim at the Service will be likely to have more than one medical dispute at the Service.

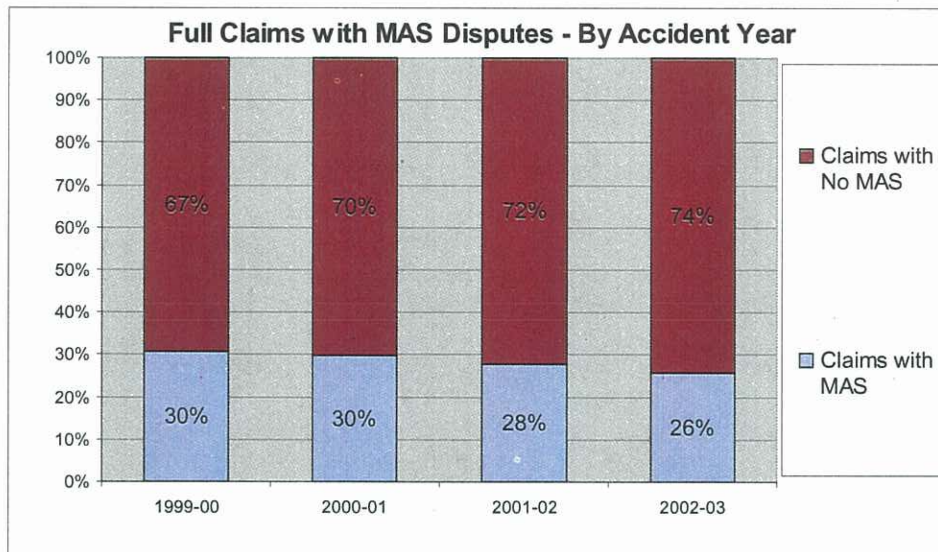
In the seven accident years to date there have been 69,578 full claims lodged to date, and there have been a total of 30,451 disputes at Medical Assessment Service. This however does not mean that every second claim has a medical dispute lodged at Medical Assessment Service. In fact only 16,129 claims have had a medical dispute lodged at Medical Assessment Service so far, and the vast majority of claims will not have any medical dispute proceed to the Service at all.

The first four of the seven accident years up to 2002-2003 can be considered mature and capable of being relatively accurately considered, however the most recent three years since then are clearly not mature and more disputes will be lodged at Medical Assessment Service on those claims over time. The two charts below show that for those most mature years around 30 per cent of claims have had a dispute lodged at Medical Assessment Service and that around 70 per cent have not.

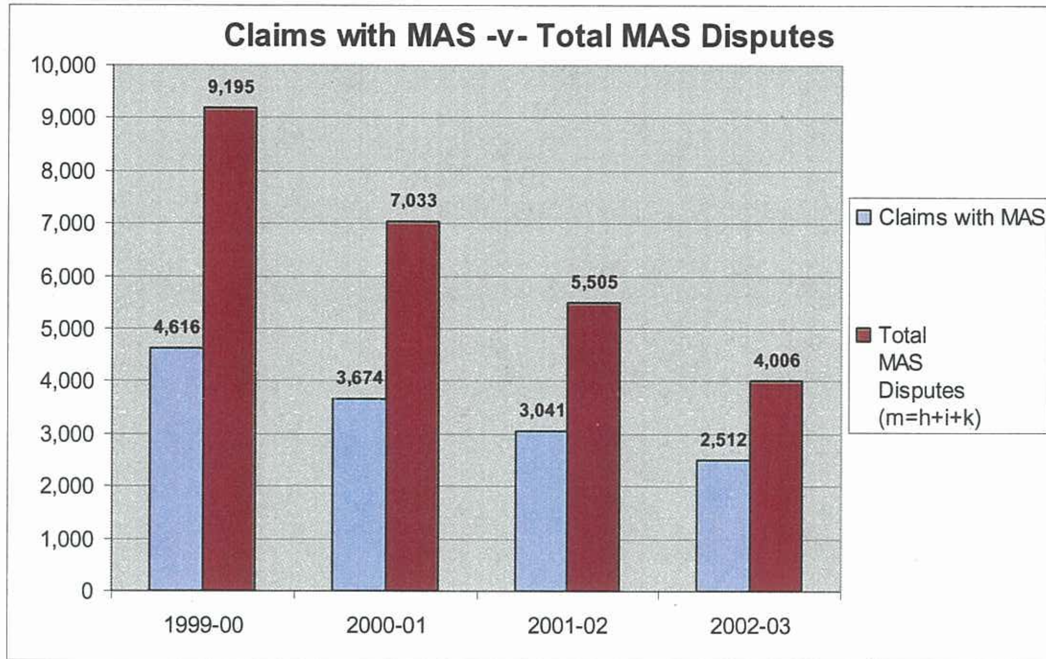
---

[2] For example in 04-05 there were 8993 full claims – 13% of which is 1169 claims. There were 4726 primary assessment applications - which equates to 4.04 disputes per claim. Over the life of the scheme it would be safe to say that on average each claim generates between 2.5 to 3 disputes.





It is correct to say that those claims that do have a dispute at Medical Assessment Service tend to have more than one dispute. In the four most mature accident years the charts below clearly show this, although for the most recent years that discrepancy is less pronounced so far;



(a) Can you offer any insight as to why some claims generate multiple disputes? Is there an underlying issue here that needs to be addressed?

RESPONSE:

The types of claims that generate medical disputes and therefore have a dispute lodged at Medical Assessment Service tend to be the more complicated claims with more severe injuries, multiple accidents or multiple claims, pre-existing medical conditions, novel or controversial medical issues, or claims where the issue of the entitlement to non-economic loss is uncertain.

Treatment disputes may also be lodged at very different times by one party for individual disputes about individual forms of treatment that arise at different stages of the life of a claim, and these are certainly the types of cases that it is appropriate for Medical Assessment Service to be required to assess as they involve medical disputes about whether a proposed course of treatment should be undertaken.

Permanent Impairment disputes - Given the significant importance of the assessment of disputes about whole person impairment you would also expect a higher disputation rate amongst those claimants who do have a dispute about this issue. In every assessment issued by Medical Assessment Service on this issue one party will not get the decision they were hoping to receive about the threshold and the

issue of entitlement to non-economic loss, and the *Motor Accidents Compensation Act 1999* clearly enables either party to seek a further assessment or a Review of an assessment. In those circumstances it would be reasonable to expect that a great many parties will seek out those further assessment or Review options in an effort to change the outcome of the assessment of Whole Person Impairment, given the importance of that determination.

Lack of negotiation between the parties – There seems to be an increasing reluctance on the part of the parties to try and negotiate with each other regarding any disputes that arise. The Motor Accidents Assessment Service has recommended as part of the stage 2 reforms proposed for 2008 that parties be required to conduct a settlement conference before a claim may be lodged at Claims Assessment Resolution Service for assessment.

Claims Preparation – Many further assessment disputes are lodged as a result of new information (for example on additional injuries) being submitted for assessment that, in many cases, was available at the time of the original assessment but was simply not included by the parties when the application for assessment was made.

Lack of Understanding of Whole Person Impairment and Assessment – Many disputes continue to list a series of 'symptoms' as being the injuries for assessment, rather than listing the actual injuries that are claimed to give rise to an assessable degree of permanent impairment.

Genuine late development of injuries – Many of the cases involving multiple disputes arise simply because there has been a late development in relation to the injury which is relevant to the assessment of the issues in dispute.

(b) If you handle an assessment related to a claimant are you then allocated any further dispute assessments concerning that claimant (assuming the subsequent matter still falls within your area of medical expertise)? Is this beneficial?

RESPONSE:

Please refer to the Medical Assessment Service Assessors' responses.

(c) If you have handled such multiple claims, from your experience, can you provide any insight as to what it is about certain claims that generate multiple disputes? Is it because they relate to medical issues that are difficult to assess?

RESPONSE:

Please refer to the Medical Assessment Service Assessors' responses.

Delays

The Bar Association's submission (Supplementary, p3) acknowledges that the issue of delays in MAS assessments has been significantly improved, but expresses concern that there are still delays in the resolution of medical *disputes*. Can you comment on the extent of delays in resolving medical disputes and describe any steps that are being taken to reduce such delays.

RESPONSE:

The time taken by Medical Assessment Service to assess medical disputes that are lodged at the Service has reduced significantly, however, the time parties take to lodge disputes at the Service, particularly about whole person impairment disputes, is still of some concern.

The dispute about whole person impairment is essentially a dispute about whether a claimant is entitled to be compensated for non-economic loss, which is of major significance to any claim that has this issue in dispute. A claim with this issue still in dispute cannot be settled by negotiation, or be assessed by Claims Assessment Resolution Service or a Court.

It is important that these disputes be resolved, either by agreement of the parties on the issue, or by a binding assessment at Medical Assessment Service, as early as possible in the life of a claim, to allow the parties the opportunity to attempt to resolve the claim as justly and expeditiously as possible, and preferably before they feel compelled to apply to have the claim assessed at Claims Assessment Resolution Service or determined in Court.

In many cases disputes already at Claims Assessment Resolution Service or the Court are placed on hold to enable the parties to undertake assessments at Medical Assessment Service on this issue.

It is generally felt that the majority of claimant's injuries are capable of assessment within around 12-18 months and the overwhelming majority within two years. It is important to note that a Medical Assessment Service assessor may decline to assess the degree of whole

person impairment if the injuries are not yet felt to be stabilised, however this occurs very rarely in around only 1 per cent of claims.

Unfortunately, the time taken for parties to lodge Whole Person Impairment disputes at Medical Assessment Service has not decreased. For example:

- Only 30 per cent of all disputes are lodged within 18 months,
- Less than half of all disputes are lodged within two years,
- 40 per cent of all disputes are lodged more than 2½ years post-accident (and therefore are not likely to be assessed by Medical Assessment Service until more than three years post-accident),
- 20 per cent of all disputes are lodged more than three years post-accident.

There are a number of initiatives which Motor Accidents Assessment Service is pursing as part of the second stage of reforms proposed for 2008 that may encourage the earlier lodgement of these disputes at Medical Assessment Service by the parties:

<u>Assessors declining to assess</u>

Changing the provisions of the Act to ensure that the only reason a Medical Assessment Service assessor may decline to assess Whole Person Impairment is that the assessor is not satisfied that the 'impairment caused by the injury has become permanent', rather than that 'injury is not stabilised'. This will bring the Medical Assessment Service assessors' duty better in line with the requirements of American Medical Association Guides to the Evaluation of Permanent Impairment (4th Edition) and the Motor Accidents Authority Permanent Impairment Guidelines.

It is also intended to avoid situations where the claimant's impairment is clearly permanent, assessable under the Guides, and capable of negotiation and settlement, even though their condition may not be 'stable' (e.g. lower limb amputation clearly exceeding the threshold but receiving ongoing treatment for the foreseeable future.).

<u>Insurers to give reasons for rejecting entitlement to Non-Economic Loss</u>

Including a requirement in the Claims Handling Guidelines for an insurer to notify the claimant in writing that they are denying entitlement to non-economic loss, providing detailed reasons

sufficient to enable the claimant to make an informed decision about whether to accept the insurers' position or to seek to pursue the dispute at Medical Assessment Service.

The response by an insurer to a claimant's claim to be entitled to Non-Economic Loss should simply indicate whether the insurer considers the claimant is entitled to claim Non-Economic Loss, or is unable to determine whether the injured person's degree of permanent impairment is greater than 10 per cent and indicating that the insurer will refer the matter to Medical Assessment Service for assessment, or considers that a claimant is not entitled to claim Non-Economic Loss because the injured person's degree of permanent impairment is not greater than 10 per cent.

It is not intended that the notification be an exhaustive document structured like a Medical Assessment Service Assessor's Statement of Reasons with pages of history and analysis aiming to identify to the exact percentage point the claimant's actual degree of impairment.

It is intended that the notification be as simple as possible, to clearly identify the reasons why the entitlement to Non-Economic Loss is disputed, including information such as:

- list of the injuries considered,
- list of the injuries not considered and reasons why not (e.g. not related, resolved),
- for those injuries considered, references to the relevant provisions of Motor Accidents Authority and American Medical Association Guides to the Evaluation of Permanent Impairment (4th Edition) Guides to identify the method of calculation of Whole Person Impairment for each injury and for the whole person impairment to show why it is felt the degree of whole person impairment is unable to be determined or is not greater than 10 per cent.

Medical Assessment Service will require that a copy of the insurer's reasons for rejecting the claimant's entitlement to Non-Economic Loss be lodged as a pre-requisite to accepting an application for assessment of a Whole Person Impairment dispute.

This initiative would bring the requirements of Insurers in line with existing requirements that apply in relation to disputes about treatment.

Medical Assessment Service Whole Person Impairment Dispute assessed before Claims Assessment Resolution Service Lodgement

This initiative is to require the initial (section 60 of the *Motor Accidents Compensation Act 1999*) Medical Assessment Service Whole Person Impairment Assessment to be completed before lodgement of a General Assessment at Claims Assessment Resolution Service. Clearly if there is no dispute about entitlement to Non-Economic Loss, with the parties agreed that the claimant either is or is not entitled to Non-Economic Loss, then an application at Claims Assessment Resolution Service for a General Assessment will be accepted.

This initiative has been introduced in two stages to allow parties ample opportunity to become better accustomed to lodging disputes at Motor Assessment Service about Whole Person Impairment well in advance of proposed lodgement at Claims Assessment Resolution Service, and preferably at about 12-18 months post-accident in most cases.

Since the May 2006 reforms the Claims Assessment Resolution Service Guideline discretion to dismiss an application at Claims Assessment Resolution Service at clause 11.8.1 is generally exercised only if a Medical Assessment Service section 60 Whole Person Impairment dispute is required and has not been "lodged" at Medical Assessment Service before, or at least at the same time as, the application for Claims Assessment Resolution Service general assessment and with the parties having been given at least two warnings of the intention to dismiss.

If the proposed second stage of the reforms is implemented, the Claims Assessment Resolution Service Guideline discretion to dismiss at clause 11.8.1 would be exercised if a Medical Assessment Service section 60 Whole Person Impairment assessment is required and has not been "completed" with a conclusive certificate issued before the application for a Claims Assessment Resolution Service general assessment is lodged. There would be an exception to this requirement where a Medical Assessment Service assessor declined to assess the matter.

This provision would only require the initial Whole Person Impairment assessment to be completed before the application for a general assessment by the Claims Assessment Resolution Service could be lodged. It would not apply to any subsequent application for either a further assessment or a review of the initial assessment,

which could still be made following the lodgement of the dispute at the Claims Assessment Resolution Service.

Through implementing these initiatives Medical Assessment Service would aim to see the timing of the lodgement of Whole Person Impairment disputes brought forward to a much earlier time in the claim lifecycle, to enable earlier opportunities for the resolution of claims.

Review panel decisions

From the Annual Report (p102) we note that for the year 05-06, 122 review panel decisions were finalised and 72 (60%) of those decisions reversed the outcome of the assessment.

(a) What are the most frequent reasons why assessment outcomes are reversed?

RESPONSE:

The reasons why outcomes were reversed in 2005/6 were most frequently because of:

- **Decision on injuries 'caused' by the accident being incorrect or inadequately explained (in 37 of the 72 cases),**
- **Incorrect application of Whole Person Impairment Guides (in 13 of the 72 cases),**
- **New information provided to the Panel that was not available to the original assessor (in 11 of the 72 cases).**

The reasons are set out in more detail in the table below:

REASON PANEL REVOKED CERTIFICATE (may be more than 1 per dispute)	No of cases	% of cases
Decision on injuries 'caused' incorrect or inadequately explained	37	51%
Incorrect application of WPI Guides	13	18%
New information provided to panel that was not available to original assessor	11	15%
Apportionment decision incorrect or inadequately explained	6	8%
Incorrect or incomplete reference to documents	6	8%
Calculation error in % WPI)	5	7%
Treatment decision incorrect or inadequately explained	5	7%
Incorrect method of apportionment	4	6%
Earning capacity decision incorrect or inadequately explained	3	4%
Stabilisation decision incorrect or inadequately explained	2	3%
Contradictory statements by assessor	2	3%
Failed to assess all injuries referred	2	3%
Other	2	3%
TOTAL	98	(will be more than 100%)
(NB In some cases more than one reason applied. Total no of cases = 72, with 98 reasons)		

(b) If the outcomes show that mistakes are being made by Medical Assessors, what steps are being done to reduce mistakes?

RESPONSE:

In all cases that are reviewed the review panel's decision is sent to the assessor whose assessment was reviewed.

If the assessor disagrees with or seeks clarification of the panel decision this opportunity is made available as a training/learning opportunity after the review panel assessment process has been completed.

A summary of the issues and outcomes of ALL review panel decisions are provided on the Medical Assessment Service Assessor extranet

for all assessors to view, with cases of particular interest highlighted by a link to the full panel decision which is also made available for those cases.

Review cases of interest are regularly summarised in the Medical Assessment Service assessor's e-newsletter, as well as in the quarterly Motor Accidents Assessment Service Bulletin and at assessor training forums and review panel workshops.

All assessors are provided with confidential feedback by Medical Assessment Service on their annual review statistics (i.e. no of applications lodged, accepted, and revoked by a panel) and how this compares with the average for all assessors, and for the other assessors of the same speciality group.

(c) The Bar Association's submission (supplementary, p6) asserts that some mistakes have been made by Medical Assessors referring to the wrong AMA Guides (ie AMA5 rather than AMA4). Are you aware of such cases and if so, does it suggest that there is confusion regarding the different types of guidelines used across different types of personal injury? What can be done to ensure such mistakes do not occur?

RESPONSE:

The Motor Accidents Authority is only aware of three such cases that have been reviewed for this reason. One related to an assessment in 2005, one in 2006 and the other in early 2007. This is three cases that have been brought to our attention out of the many thousands of assessments conducted during the 2005 – 2007 period.

This does not suggest that there is a high level of confusion, but rather that a mistake has been made in a few isolated cases. All assessors are provided with specific training on the American Medical Association and Motor Accidents Authority Guides before conducting any assessments for Medical Assessment Service. The template issued by Medical Assessment Service for assessors' written decisions also clearly states the guides to be used and this must be signed by the assessor.

The mistakes that have been made in this respect have been brought to the attention of the assessors involved and the whole assessor body in an effort to ensure the likelihood of them occurring in future is reduced.

Medical dispute assessment outcomes

The MAA's 05/06 Annual Report (pp98-100) lists the medical dispute assessment outcomes with respect to the categories of treatment, permanent impairment, stabilisation and earning capacity. For many of these outcomes there are distinct trends with respect to whether the outcome favours the insurer or the claimant. We have several questions in relation to this data.

Whole person impairment (p100)

(a) Whole Person Impairment disputes make up 80% of MAS assessments. For the year 05-06, in 80% of assessments for WPI the outcome is 'permanent and not over 10%', which is similar to previous years. Why do such a significant proportion of WPI assessments result in this outcome?

RESPONSE:

Medical Assessment Service is a dispute resolution service and can only produce/ comment on data regarding the matters referred to the service by the parties. Many matters are never referred to Medical Assessment Service as the parties have negotiated an outcome, such as the insurer has conceded the injured person will exceed the 10 per cent whole person impairment threshold. Medical Assessment Service does not expect to see matters referred when the claimant has clearly exceed the threshold.

Medical Assessment Service expects to see matters where there is a threshold question and the parties have been unable to resolve the dispute.

As time passes from the date of a motor accident, a claimant's injuries tend to improve and resolve, hence resulting in a minimal impairment. The figures above reflect this trend.

There is still a lack of understanding of what and how permanent impairment is assessed, this may reflect on why so many matters referred to Medical Assessment Service are determined to be less than 10 per cent whole person impairment. The Whole Persons Impairment project is aimed at providing the tools and resources to assist the parties in resolving these disputes and to encourage appropriate referrals to Medical Assessment Service.

Stabilisation (p100)

(b) In relation to stabilisation, for the year 05-06, in 92% of assessments the outcome is that all injuries are considered stable, which is similar to previous years. If the usual pattern is that such a significant proportion of injuries are considered stable, why are there so many disputes about stabilisation?

RESPONSE:

Under our current practice, stabilisation is assessed with all permanent impairment disputes, hence the large volume of disputes. There are very few stand alone stabilisation disputes lodged with Medical Assessment Service.

The current reform agenda is proposing to abolish the stand alone dispute regarding stabilisation.

Changes brought about by other initiatives in the reform agenda will remove the need for Medical Assessment Service to assess stabilisation, as this will no longer be the trigger for an insurer to make an offer.

> Earning capacity (p100)
>
> (c) In relation to earning capacity, for the year 05-06, the outcome is 'impairment to past earning capacity' in 88% of assessments and 'impairment to future earning capacity' in 62% of assessments. Again, these figures are similar to previous years. Can any of you comment on this trend?

RESPONSE:

The dispute is about potential 'capacity' not the actual impairment of function or ability to conduct their usual work.

If an assessor considers that the injuries may have ANY impact on the claimant's ability to work in ANY job, they must find an impairment – not only in respect of the job they do now.

Even people who have returned to their pre-accident job without any trouble may still be found to have an impairment to earning capacity if they would be unable to do a more physically demanding job as a result of their injuries.

As time passes since the motor accident injuries tend to resolve, hence the findings as above, that a smaller percentage of injured people are found to have an impairment to future earning capacity.

The fact that someone may have a loss of 'capacity' may not necessarily mean they have suffered any loss or are awarded any compensation for economic loss.

The current reform agenda is proposing to abolish the dispute regarding earning capacity. Under current legislation these disputes are non binding and have seen to be of little use to the parties.

> Related treatment (p99)
>
> (d) For the year 05-06, the treatment in dispute was found to be 'related' to the injury caused by the motor accident in 51% of assessments. In this case there is

no clear distinction as to whether the disputes are decided in favour of the claimant or the insurer, which is unlike the previous figures we have discussed, why is this? Are these types of dispute more difficult to determine?

RESPONSE:

Either party may make an application to have a causation treatment dispute assessed. The Medical Assessment Service Assessors determination is made in order to assist the parties resolve the dispute.

For example an insurer may lodge an application and the dispute be determined that the treatment they are disputing is causally related to the motor accident, in this case the finding could be interpreted to favour the injured person, it can also be seen that the finding assists the insurer in managing the rehabilitation needs of the injured person, thus progressing the claim and reaching an early resolution, and vice versa for an outcome of not causally related.

The Medical Assessment Service Assessor does not consider who will benefit from their decision, it is simply a determination based on the evidence provided by the parties and a physical examination (on most occasions).

Reasonable and necessary treatment (p99)
(e) For the year 05-06, in 22% of cases the assessment outcome is that the treatment is 'fully reasonable and necessary'. Could any of you provide comment on this?

RESPONSE:

As stated below, a finding of 'Fully reasonable and necessary' will only be made by an Assessor if they find the entirety of the dispute as listed by the parties to be 'reasonable and necessary'.

This means that in all the treatment disputes referred to Assessors in 2005/2006, only 22 per cent of the complete disputes were found to be reasonable and necessary. There are numerous disputes where only part of the treatment as listed by the parties was found to be reasonable and necessary.

(f) The Annual Report (p99) also notes that: *The finding of treatment not reasonable and necessary continued to increase to 45% of assessments, however, this may be somewhat misleading. As assessors must make their determinations on the dispute as described by the parties, unless the treatment described by the parties is exactly what the assessor determines is R&N, the assessor must find against the described treatment. The assessor will usually then list*

the level/frequency etc of the listed treatment that is/was R&N, and this may be quite similar to that sought in the application.'

(i) Can you give an example from your experience to illustrate an occurrence such as this?

RESPONSE:

An example may be a party lodges an application at Medical Assessment Service in regards to the following dispute-"whether physiotherapy proposed by Dr X once a week from March 2007 until October 2007 is reasonable and necessary in relation to the subject motor vehicle accident". The Assessor makes a determination that eight months of weekly physiotherapy, (based on evidence based best practice) is not reasonable and necessary, however three months would be.

The Assessor will issue a certificate stating the dispute, as listed by the parties, "whether physiotherapy proposed by Dr X once a week from March 2007 until October 2007 is reasonable and necessary in relation to the subject motor vehicle accident" is not reasonable and necessary, however within the attached Statement of Reason, the Assessor will note that weekly physiotherapy for three months would be appropriate.

(ii) In the situation described in the Annual Report, is the insurer then obliged to pay for the level/frequency of the treatment as listed by the assessor? If not, what happens?

RESPONSE:

The Assessors' decision is binding on the certificate they issue. That is whether the dispute as listed by the parties, is found to be reasonable and necessary or not reasonable and necessary.

The Assessors' comments on what actually would be reasonable and necessary will assist the parties to negotiate a resolution of the dispute.

If parties cannot resolve the dispute, either party can make an application to Medical Assessment Service to have to have the dispute assessed again.

(iii) Again with reference to that described situation – what is the difference between that and a finding that the 'treatment was partly reasonable and necessary', which occurred in 33% of assessments?

RESPONSE:

The majority of treatment disputes lodged at Medical Assessment Service are for multiple disputes, such as physiotherapy, domestic assistance, medication, radiological investigations. The Assessor to whom the disputes are referred may find that only some of the disputes referred are reasonable and necessary, such as the physiotherapy and radiological investigations are, however the medication and domestic assistance is not. Therefore the Assessor would be issuing both 'reasonable and necessary' and 'not reasonable and necessary' certificates.

The overall outcome of the dispute would be "treatment was partly reasonable and necessary".

REPORT OF PROCEEDINGS BEFORE

STANDING COMMITTEE ON LAW AND JUSTICE

INQUIRY INTO THE MOTOR ACCIDENTS AUTHORITY AND MOTOR ACCIDENTS COUNCIL

Uncorrected Transcript

At Sydney on Monday 27 August 2007

The Hon. DAVID CLARKE: Mr Grellman, you spoke about the activities of the Motor Accident Authority council. How many times has it met in the past twelve months?

Mr GRELLMAN: It is scheduled to meet every other month, so it should have met six times in the past twelve months. But I would need to check to confirm that.

The Hon. DAVID CLARKE: Could you take that on notice and get back to us?

Mr GRELLMAN: I will, Mr Clarke.

RESPONSE:

Between August 2006 and August 2007 six meetings were held. They were held on 7 September 2006, 7 November 2006, 15 February 2007, 13 March 2007, 8 May 2007 and 10 July 2007.

The Hon. GREG DONNELLY: The Bar Association in its submission says, "The principal mechanisms whereby parties can challenge an absence of procedural fairness in the CARS assessment process is by admission of an appeal to the Supreme Court", and it notes that most applications lodged are by insurers. Can you either answer or take this question on notice: How many CARS decisions have been challenged in the Supreme Court on the basis of procedural fairness?

RESPONSE:

One.

Mr BOWEN: I do not believe we can answer that question this morning but we can answer it; we do have that answer.

Mr BOWEN: They are overwhelmingly from insurers, but we will certainly characterise those for you.

The Hon. DAVID CLARKE: When you say they are overwhelmingly from insurers, could a major factor in that be because applicants are restricted in their capacity to bring appeals for cost reasons?

Mr BOWEN: If a claimant is dissatisfied with the CARS theory they can just go to the District Court: they are not bound by the CARS decision whereas an insurer is bound by the CARS decision. So, if they are really unhappy with it their only basis is to challenge the procedures in the Supreme Court.

CHAIR: The information you are asking for will be distorted if the claimant can go to the District Court. Are you able to supply information on District Court matters?

RESPONSE:

When a claim is assessed at Claims Assessment Resolution Service a certificate of assessment is issued. Under section 95 of the *Motor Accidents Compensation Act 1999* if liability and quantum have been assessed, either party can reject the certificate of assessment. If liability is not in issue and has not been assessed then only the claimant can reject the assessment. If an assessment is rejected the claimant may (if the claim does not resolve in the interim) commence legal proceedings and this is usually done in the District Court although it is possible that some proceedings could be commenced in the Local Court.

As the acceptance or rejection of an assessment is a matter between the parties, there is no easy mechanism within Claims Assessment Resolution Service to record the acceptance/rejection rate. It is not possible to monitor the rejection rate through for example monitoring the commencement of proceedings in the District Court, as the District Court no longer maintains a specialised Motor Accidents List and in any event that would not necessarily distinguish between proceedings commenced by way of a rehearing from Claims Assessment Resolution Service (as opposed to a 'first time' hearing courtesy of an exemption) and it would not include those assessments that were rejected but which settled before proceedings were commenced or those proceedings commenced in the Local Court.

In November 2004 an exercise was conducted with the assistance of the six licensed Compulsory Third Party insurers. A list of assessments conducted from 1999 - October 2004 was provided to them and they were asked to indicate whether the assessment was rejected or accepted. This did not include of course assessments involving interstate insurers.

The results suggested that of 556 assessments, for which data was provided by the insurers, 87 per cent were accepted and only 75 assessments were rejected.

The Hon. GREG DONNELLY: What kinds of procedural fairness issues have been raised in those challenges? Can you provide us with any information about that?

RESPONSE:

There has only been one such case (*Allianz Australia Insurance Ltd v Crazzi*) which raised an issue of procedural fairness in the context of the revisiting / reopening of a Claims Assessment Resolution Service Assessor's decision. The Claims Assessment Resolution Service Assessor had indicated he would allow the parties the opportunity to make submissions in respect of a claim for interest and that his reasons would deal with his decision to not allow an adjournment in the case. The Assessor did neither of those things and issued a certificate and reasons covering the quantum of the claim. When the claimant brought that matter to his attention, the Claims Assessment Resolution Service Assessor considered he had breached procedural fairness rules and therefore that his decision was in fact no decision at all, and that he should reopen the matter and revisit the issue of interest and deal with the adjournment in his reasons. He did this and it was then that a summons was issued. The Claims Assessment Resolution Service Assessor's decision (to revisit his decision to afford procedural fairness to the claimant) in that case was upheld.

Mr BOWEN: We will take that question on notice if you do not mind. It is more than just one.

The Hon. JOHN AJAKA: Just following on from what the Hon. Greg Donnelly has said, in answering those two questions asked by the honourable member could they be divided into two clear categories of the insurer and the applicant so we understand how many there are from each category?

RESPONSE:

Since 1999 there have been only 15 summonses issued in the Supreme Court, of which all were issued by insurers.

In respect of the results, of those challenges, nine resulted in the settlement or discontinuance of the Supreme Court proceedings, one resulted in the Assessor's decision being set aside and five have resulted in the assessor's decision being upheld (although two are on appeal).

In respect of the nature of the challenge, of the 15 summonses issued seven relate to the quantum of an assessment, five (including the two on appeal) relate to the exemption (or not) of the claim from assessment, one related to a procedural decision, one related to a procedural error and only one (*Allianz Australia Insurance Ltd v Crazzi*) has raised an issue of procedural fairness, and the Claims Assessment Resolution Service Assessor's decision in that case was upheld.

Mr BOWEN: We will take that on notice. We have been looking at this. We do not have direct access to the District Court database—it is something we have talked with them about—we have to extract that information back from the insurers. We have done some studies on it on a sample basis. I will see what we can find out on that, on the numbers of matters that go through to the District Court and what the outcome is.

The Hon. DAVID CLARKE: With the Supreme Court could you also indicate the percentage of the insurers' success rate? It would be interesting to know the outcomes.

RESPONSE:

Since 1999 there have been 15 summonses issued in the Supreme Court and to date only one has resulted in the Assessor's decision being set aside, which would be a success rate for the insurers of 7.7 per cent.

Mr BOWEN: It is pretty low because we are quite often a party to these.

CHAIR: Just in graph form for the percentage.

Mr BOWEN: We will just identify it and give you a list of cases if you like, that is the easiest. In fact, the publications are on the record; we will give you a list of the cases.

RESPONSE:

See attachment A.

The Hon. JOHN AJAKA: If I may direct a question on the next issue to Ms Donnelly. You have noted legal and investigative costs at 9.4 per cent. Are those the legal costs paid in relation to claimants only, or is it a combination of those costs for both claimants and the insurers?

Ms DONNELLY: It is an estimate of the proportion of the premium that would need to go to all legal and investigative costs, including medico-legal costs.

The Hon. JOHN AJAKA: Do you have a breakdown of the different percentages of those costs what would comprise the claimants and what would comprise the insurers?

Ms DONNELLY: I do not have one with me. We could follow that up.

RESPONSE:

55 per cent of the legal costs would be paid in relation to claimants and 45 per cent for insurers.

The Hon. GREG DONNELLY: I refer to premiums in New South Wales vis-a-vis other jurisdictions. Can you enlighten the committee on that?

Mr BOWEN: We will take that question on notice and provide an indication of the premiums in the other jurisdictions. All other States have a single premium, or with a few variations. There may be a single plus one premium with a discount for seniors or a slightly different country loading or discount. New South Wales is the only jurisdiction that has full-risk pricing, but we can provide an indication. Perhaps the best one is our average class 1 premium compared to what a motor vehicle driver driving a similar vehicle in each other State would pay. New South Wales is in the middle at the moment. The premiums in the Australian Capital Territory and South Australia are considerably higher, and in Queensland they are about the same or slightly higher for a comparable system. Victoria has a slightly higher premium but a very different system; it is a full no-fault statutory benefit scheme. Western Australia has a lower premium off the back of a massive increase in the number of registrations over the past few years.

RESPONSE:

At the last Heads of Compulsory Third Party meeting in March 2007, the following information was provided for each jurisdiction for Class 1 vehicles (passenger sedans):

	State and Territory							
	Vic	**NSW**	**QLD**	**WA**	**SA**	**TAS**	**ACT**	**NT**
Class 1 Private	**$356**	**$326 - $342**	**$282.20 - $294.20**	**$225.23**	**n/a**	**$332**	**$396**	**$426.30**
Class 1 Business	**$356**	**$346 - $364**	**$302.00 - $315.00**	**$239.09**	**n/a**	**$332**	**$436**	**$426.30**
Number of Vehicles ('000) *(as at Jun-06)*	**3,845**	**4,140**	**3,027**	**1,620**	**1,157**	**414.5**	**225**	**111**

Source: Australian & New Zealand CTP Scheme Comparison Table – March 2007

ATTACHMENT A

Matter name	Financial year commenced	Issue	Result	Assessor
Rutherford	2005	Procedural Error by Case Management Administrative error by CARS for sending s 92 certificate to wrong address	Sought costs of extension of time application against MAA Summons dismissed by consent as insurer did not take the point	N/A – case management
Newman	2004 -05	Exemption decision 83 year old lady – involvement of hospital and argument of medical negligence	Claimant died, summons discontinued by parties and claim assessed	PCA Daley decision not to exempt Broomfield - assessor
Hancock	2005-06	Issue with quantum Assessment decision – assessor allowed interest by reference to the Civil Liability Act not Motor Accidents Compensation Act	Settled	Browne
Richards	2004-05	Issue with quantum Assessment decision – assessor allowed Sullivan v Gordon damages	Court set Assessor's decision aside – final orders not known (Malpass M)	Clarke
Prakash	2005-06	Exemption decision Breach of duty admitted damages denied	Settled	PCA Cassidy
Hewes	2005-06	Procedural decision by CARS Assessor not to refer to MAS	Settled	Holz

Lorusso	2006-07	Exemption decision Challenge on Assessor's recommendation as to suitability and on Cross Examination of witness	Summons dismissed by Court (Sully J)	Ford
Young	2005-06	Exemption decision Assessor did not recommend exemption and would not allow adjournment for MAS	Summons dismissed by Court (Hoeben J)	Flynn
Kelly	2005-06	Exemption decision Assessor's recommendations on suitability	On Appeal (Rothman J)	Broomfield
Khateib	2006-07	Exemption decision Assessor's recommendations on suitability	On Appeal (Rothman J)	Patterson
Toubia v Peters	2005-06	Issue with quantum Section 126	Court upheld assessor's decision (Malpass M) No jurisdictional error – no error on face of record	Wall
El Mohammed	2006-07	Issue with quantum Unknown but suspect section 126	Settled	White
Mihalic	2006-07	Issue with quantum Unknown but suspect section 126 and economic loss	Settled	Ford
Crazzi	2005-06	Procedural fairness Challenge to issue of second and third s 94 Certificate	Summons dismissed by Court (Johnson J)	Flynn
White	2006-07	Exemption decision 20% contributing negligence to 40% - mandatory exemption refused	Proceedings on foot	PCA Cassidy

EIGHTH REVIEW OF THE MAA AND MAC

Public Hearing, Monday 27 August 2007

QUESTIONS ON NOTICE

Medical Assessors

Training

What level of training and/or support do you receive from the MAS in order to perform your role as an assessor?

RESPONSES:

Dr Kathleen McCarthy

There is the initial formal training in modules relevant to the areas of specialty that I do assessments in. This is carried out at the Royal North Shore Hospital at the University of Sydney Clinical School. I undertook training in 2001 in the Core Module, Neurological Module, and Mental and Behavioural Module. Apart from this the Motor Accidents Authority has provided updates and information in the way of the Motor Accidents Assessment Service Bulletin, as well as the extranet website for assessors. Bi-monthly assessor forums are held by the Motor Accidents Authority at which time there is an opportunity for further training in procedural fairness, natural justice as well as more medically-oriented issues and case discussions. The annual Assessor Meeting is a formal one-day event at which there are topics of medical as well as administrative significance directed at improving and maintaining standards and quality in assessment work. Medical Assessment Service provides direct support either by direct response to queries or referral to senior experienced assessors as a resource for further support in the assessor role.

Dr Dwight Dowda

There is the initial formal training in modules relevant to the areas of specialty that I do assessments in. This is carried out at Royal North Shore Hospital at the University of Sydney Clinical School, and I in fact have been delivering training since 2000 in the Core Module, Spine Module, Lower Extremity Module and Upper Extremity Module. Apart from this the Motor Accidents Authority has provided updates and information in the way of the Motor Accidents Assessment Service Bulletin, as well as the extranet website for

assessors. Bi-monthly assessor forums are held by Motor Accidents Authority at which time there is an opportunity for further training in procedural fairness, natural justice as well as more medically oriented issues and case discussions. The annual Assessor Meeting is a formal one day event at which there are topics of medical as well as administrative significance directed at improving and maintaining standards and quality in assessment work. Medical Assessment Service provides direct support either by direct response to queries or referral to senior experienced assessors as a resource for further support in the assessor role.

Dr G Papatheodorakis

Prior to my appointment as a Medical Assessment Service Assessor, I undertook training in 2001 (Royal North Shore Hospital; University of Sydney Clinical School) in the Core Module, Spine Module, Lower Extremity Module and Upper Extremity Module, all of which were relevant in assessing the musculoskeletal system. Since then, I have also completed modules in Dental and Minor Skin Impairments. Medical Assessment Service training and development for assessors is an-ongoing process, including Medical Assessment Service resources/information available through the Assessor Extranet, Annual Medical Assessment Service Assessor Conferences, Quarterly Electronic Newsletters and bi-monthly Medical Assessment Service Assessor forums.

Do you receive specific training in relation to determining whole person impairment?

RESPONSES:

Dr Kathleen McCarthy

Yes. This is essentially described as above, in terms of formal training in use of both Motor Accidents Authority Guidelines and the American Medical Association Guides to the Evaluation of Permanent Impairment 4th Edition. Further training in relation to specific case studies and application of the Guides or Guidelines occurs through the bi-monthly forums, the Motor Accidents Assessment Service Bulletin and updates available through the Motor Accidents Authority's extranet.

Dr Dwight Dowda

Yes. This is essentially described as above, in terms of formal training in use of both Motor Accidents Authority Guidelines and the

American Medical Association Guides to the Evaluation of Permanent Impairment 4th Edition. Ongoing training in relation to specific case studies and application of the Guides or Guidelines occurs through the bi-monthly forums, the Motor Accidents Assessment Service Bulletin and updates available through the Motor Accidents Authority's extranet.

Dr G Papatheodorakis

Yes. Apart from the above noted measures, I have also completed a course provided by the American Board of Independent Medical Examiners in Impairment Assessment utilising the American Medical Association Guides to the Evaluation of Permanent Impairment (4th Edition).

Is the training adequate or is there room for improved training and guidance?

RESPONSES:

Dr Kathleen McCarthy

I consider that the training is relevant and results in improved quality and consistency. The feedback from participants over the years since 2000 has been consistently positive. The Quality Assurance reports from the Medical Assessment Service would be helpful in confirming this aspect.

Dr Dwight Dowda

Since I have been involved in the development and delivery of the formal training in modules of impairment evaluation, it would be inappropriate for me to praise the level of training offered. The feedback from participants over the years since 2000 has been consistently positive.

Dr G Papatheodorakis

I consider that the training is adequate.

Multiple disputes

The Committee was advised that over the life of the Scheme on average 13% of claims have a medical dispute. Given the number of medical disputes over the life of the scheme, it appears that *on average* each of these claims has multiple disputes.[1]

> (a) Can you offer any insight as to why some claims generate multiple disputes? Is there an underlying issue here that needs to be addressed?

RESPONSES:

Dr Kathleen McCarthy

This may be due to the nature of the injuries, and the claimant's or legal advocate's approach to disputing various heads of damage. However, I believe that the capacity to present additional facts, or to have an issue reviewed, is one of the strengths of Medical Assessment Service over the finality of Common Law court proceedings. From a medical perspective there does not appear to me to be any consistent reason why claims might have multiple disputes.

Dr Dwight Dowda

This may be due to the nature of the injuries, and also the claimant's advocate's approach to disputing various heads of damage. From a medical perspective there does not appear to me to be any consistent reason why claims might have multiple disputes.

Dr G Papatheodorakis

I cannot offer any insight as to why some claims generate multiple disputes.

(b) If you handle an assessment related to a claimant are you then allocated any further dispute assessments concerning that claimant (assuming the subsequent matter still falls within your area of medical expertise)? Is this beneficial?

RESPONSES:

Dr Kathleen McCarthy

---

[1] For example in 04-05 there were 8993 full claims – 13% of which is 1169 claims. There were 4726 primary assessment applications - which equates to 4.04 disputes per claim. Over the life of the scheme it would be safe to say that on average each claim generates between 2.5 to 3 disputes.

This remains the choice of the parties. Occasionally, I have seen a case for a further dispute, but as I understand, it remains the prerogative of the parties to decide whether a claimant should go back to a particular assessor or not. I have found the continuity offered by seeing a further dispute on a case that I have assessed already once is helpful and probably a more efficient way of dealing with the dispute. The capacity to raise multiple medical claims for assessment arises from the responsibility of the claimant or legal adviser to fully explore all issues. Each individual injury to part of the body can be held as a separate dispute.

Dr Dwight Dowda

This remains the choice of the parties. It is not infrequent that I have seen a case for a further dispute, but as I understand it remains the prerogative of the parties to decide whether a claimant should go back to a particular assessor or not. I have found the continuity offered by seeing a further dispute on a case that I have assessed already once is helpful and probably a more efficient way of dealing with the dispute.

Dr G Papatheodorakis

In my capacity as a Medical Assessment Service Assessor, I have been allocated further dispute assessments concerning a claimant that I have previously assessed. On each occasion, the assessment is comprehensive, and considers all previous and any new information that is made available.

(c) If you have handled such multiple claims, from your experience, can you provide any insight as to what it is about certain claims that generate multiple disputes? Is it because they relate to medical issues that are difficult to assess?

RESPONSES:

Dr Kathleen McCarthy

I cannot answer this. In the case of complex multiple injuries the issues are usually more of what specialty (or assessor) can assess which injury.

Dr Dwight Dowda

I am unable to answer this. I do believe that one cannot discount the setting in which a claimant finds himself or herself. There might be

particularly active legal pressure to pursue different heads of damage. In the case of complex multiple injuries the issues are usually more of what specialty (or assessor) can assess which injury.

Dr G Papatheodorakis

This may relate to issues of causation, deterioration of a condition/injury or when further information emerges that needs further consideration.

Medical dispute assessment outcomes

The MAA's 05/06 Annual Report (pp98-100) lists the medical dispute assessment outcomes with respect to the categories of treatment, permanent impairment, stabilisation and earning capacity. For many of these outcomes there are distinct trends with respect to whether the outcome favours the insurer or the claimant. We have several questions in relation to this data.

Whole person impairment (p100)
(a) Whole Person Impairment disputes make up 80% of MAS assessments. For the year 05-06, in 80% of assessments for WPI the outcome is 'permanent and not over 10%', which is similar to previous years. Why do such a significant proportion of WPI assessments result in this outcome?

RESPONSES:

Dr Kathleen McCarthy

The large majority of injuries sustained in motor vehicle accidents resolve with minimal residual impairment.

Dr Dwight Dowda

The simple answer is that the large majority of injuries sustained in motor vehicle accidents resolve with minimal residual impairment.

Dr G Papatheodorakis

The majority of accident related injuries resolve with minimal residual impairment.

Stabilisation (p100)
(b) In relation to stabilisation, for the year 05-06, in 92% of assessments the outcome is that all injuries are considered stable, which is similar to previous years. If the usual pattern is that such a significant proportion of injuries are considered stable, why are there so many disputes about stabilisation?

RESPONSES:

Dr Kathleen McCarthy

Stabilisation itself is not the main concern in a large proportion of the disputes, but to assess permanent impairment a medical assessor firstly needs to establish that stabilisation is present as set out in the Motor Accidents Authority and the American Medical Association Guides to the Evaluation of Permanent Impairment 4th Edition Guidelines. Thus, it becomes a dispute.

Dr Dwight Dowda

Stabilisation itself is not, as I understand, a large proportion of the disputes, but to assess permanent impairment firstly requires that stabilisation is established, so it by de facto, becomes a dispute.

Dr G Papatheodorakis

Stabilisation of injuries is required prior to assessing permanent impairment.

Earning capacity (p100)

(c) In relation to earning capacity, for the year 05-06, the outcome is 'impairment to past earning capacity' in 88% of assessments and 'impairment to future earning capacity' in 62% of assessments. Again, these figures are similar to previous years. Can any of you comment on this trend?

RESPONSES:

Dr Kathleen McCarthy

Impairment of past earning capacity can include any impairment of earning capacity and since the acute injuries can result in a variable period during which a person may be totally or partially incapable of working due to those injuries, this would account for the higher percentage for "past earning capacity". Since a large number of acute injuries subsequently go on to healing with recovery of function, the lesser percentage of "future earning incapacity" probably reflects this situation. I think that the trend reflects the medical aspects of the type of injury.

Dr Dwight Dowda

Impairment of past earning capacity can include any impairment of earning capacity and since the acute injuries can result in a variable period of time during which a person may be totally or partially incapable of working due to those injuries, this would account for the higher percentage for "past earning capacity". Since a large number of acute injuries subsequently go on to healing with recovery of function, the lesser percentage of "future earning incapacity" probably reflects this situation. It would appear to be a logical trend.

Dr G Papatheodorakis

From a medical perspective, any initial (acute) injuries will usually result in a degree of impairment; and as the injuries resolve, impairment then lessens as function improves.

> Related treatment (p99)
> (d) For the year 05-06, the treatment in dispute was found to be 'related' to the injury caused by the motor accident in 51% of assessments. In this case there is no clear distinction as to whether the disputes are decided in favour of the claimant or the insurer, which is unlike the previous figures we have discussed, why is this? Are these types of dispute more difficult to determine?

RESPONSES:

Dr Kathleen McCarthy

An accident might cause injuries, which receive standard and accepted medical/paramedical treatments. There can also be alternative (and not scientifically supported, based on evidence-based medicine) treatments that are given. In both instances, the relationship of the treatment to the injury might be quite clear. However, there can also be circumstances where a particular treatment undertaken is clearly of no relevance or relationship to the injuries sustained in the subject accident. The medical assessor does not have specific regard to whether the insurer or the claimant requests treatment. However, as more "case precedents' are established, I think that insurers are less likely to dispute a treatment that had been previously determined evidence based.

Dr Dwight Dowda

An accident might cause injuries which receive standard and accepted medical/paramedical treatments. There can also be alternative (and not scientifically supported on the basis of evidence-

based medicine) treatments that are given. In both instances the relationship of the treatment to the injury might be quite clear, while there can also be circumstances where a particular treatment undertaken is clearly of no relevance or relationship to the injuries sustained in the subject accident.

Dr G Papatheodorakis

I am unable to comment on this as I have not assessed a treatment dispute.

Reasonable and necessary treatment (p99)
(e) For the year 05-06, in 22% of cases the assessment outcome is that the treatment is 'fully reasonable and necessary'. Could any of you provide comment on this?

RESPONSES:

Dr Kathleen McCarthy

This phrasing is part of the Guidelines. My comments above regarding evidence-based medicine and the adoption of particular therapies (both traditional and alternative) are of relevance here. I anticipate that disputes of this category will trend lower in number for the reasons given above.

Dr Dwight Dowda

My comments above regarding evidence-based medicine and the adoption of particular therapies (both traditional and alternative) are of relevance here. The undertaking of therapies that have been shown to have no useful benefit in the management of an injury process, particularly if they are protracted over time, is a common problem. While this might involve doctors and their treatments, it also has to take into account the sometimes extensive involvement of a variety of paramedical therapy providers (both mainstream and alternative) under whose care and influence the claimant can fall.

Dr G Papatheodorakis

I am unable to comment on this as I have not assessed a treatment dispute.

(f) The Annual Report (p99) also notes that: *'The finding of treatment not reasonable and necessary continued to increase to 45% of assessments, however, this may be somewhat*

misleading. As assessors must make their determinations on the dispute as described by the parties, unless the treatment described by the parties is exactly what the assessor determines is R&N, the assessor must find against the described treatment. The assessor will usually then list the level/frequency etc of the listed treatment that is/was R&N, and this may be quite similar to that sought in the application.'

(i) Can you give an example from your experience to illustrate an occurrence such as this?

RESPONSES:

Dr Kathleen McCarthy

No.

Dr Dwight Dowda

No I can't.

Dr G Papatheodorakis

I am unable to comment on this as I have not assessed a treatment dispute.

(ii) In the situation described in the Annual Report what is the difference between that and a finding that the 'treatment was partly reasonable and necessary', which occurred in 33% of assessments?

RESPONSES:

Dr Kathleen McCarthy

If the treatment dispute encompassed more than one particular treatment, for example physiotherapy for the neck and the back, for a certain time and for a number of sessions. This may be reasonable and necessary before surgery but not after, or for 10 sessions but not 20 and so on. It might be in the situation cited above that multiple different treatments are being considered, some of which are reasonable and necessary and some of which are not reasonable and necessary.

Dr Dwight Dowda

I cannot explain this finding. A specific treatment can only be reasonable and necessary or not reasonable and necessary. It might be in the situation cited in the above question that multiple different

treatments are being considered, some of which are reasonable and necessary and some of which are not reasonable and necessary.

Dr G Papatheodorakis

I am unable to comment on this.

Review panel decisions

From the Annual Report (p102) we note that for the year 05-06, 122 review panel decisions were finalised and 72 (60%) of those decisions reversed the outcome of the assessment.

(a) What are the most frequent reasons why assessment outcomes are reversed?

RESPONSES:

Dr Kathleen McCarthy

I do not have the data to give this information…it would have to be obtained from the Medical Assessment Service.

Dr Dwight Dowda

I do not have the data to give this information…it would have to be obtained from the Medical Assessment Service.

Dr G Papatheodorakis

I am unable to comment on this. This information is best provided by Medical Assessment Service.

(b) The Bar Association's submission (supplementary, p6) asserts that some mistakes have been made by Medical Assessors referring to the wrong AMA Guides (ie AMA5 rather than AMA4). Are you aware of such cases and if so, does it suggest that there is confusion regarding the different types of guidelines used across different types of personal injury? What can be done to ensure such mistakes do not occur?

RESPONSES:

Dr Kathleen McCarthy

The most common evidence of these types of mistakes I have seen is in medico-legal reports that I have read from non-Motor Accidents Authority assessors. The Motor Accidents Authority's Guidelines are quite clear on their dependence on American Medical Association

Guides to the Evaluation of Permanent Impairment 4th Edition and the requirement to use the 4th Edition in conjunction with the Motor Accidents Authority's Guidelines. The training given to Motor Accidents Authority assessors frequently emphasises the Motor Accidents Authority Guidelines/American Medical Association Guides to the Evaluation of Permanent Impairment 4th Edition connection. While there are Motor Accidents Authority assessors who also have assessment roles in other jurisdictions (notably Workers Compensation in New South Wales) those who are regularly involved in doing either Motor Accidents Authority or Workers Compensation assessments are well familiarised with the relevant guidelines and American Medical Association Guides that must be used.

Dr Dwight Dowda

The most common evidence of these types of mistakes I have seen is in medico-legal reports that I have read from non-Motor Accidents Authority assessors. The Motor Accidents Authority's Guidelines are quite clear on their dependence on American Medical Association Guides to the Evaluation of Permanent Impairment 4th Edition and the requirement to use the 4th Edition in conjunction with the Motor Accidents Authority Guidelines. The training given to Motor Accidents Authority assessors frequently emphasises the Motor Accidents Authority Guidelines/American Medical Association Guides to the Evaluation of Permanent Impairment 4th Edition connection. While there are Motor Accidents Authority assessors who also have assessment roles in other jurisdictions (notably Workers Compensation in New South Wales) those who are regularly involved in doing either Motor Accidents Authority or Workers Compensation assessments are well familiarised with the relevant guidelines and American Medical Association Guides that must be used.

Dr G Papatheodorakis

The cases that I am aware of concern medico-legal assessments from non-Motor Accidents Authority Assessors.