



A fresh approach to an old problem

STANDING COMMITTEE ON LAW AND JUSTICE

ELEVENTH REVIEW OF THE MOTOR ACCIDENTS AUTHORITY

IMIQ Submission Part 2:

**Operational aspects of improved claim practice
and scheme regulation**

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Wednesday 9th November 2011

To the Committee

Thank you for receiving the Injury Management IQ (IMIQ) submission to this Review and for inviting me to provide evidence at the Hearing. As an independent consultant researching claim practice standards across the whole Personal Injury industry, I was unaware of this particular review until media reports drew my attention to it. At the time I did not expect my late submission to be included so I appreciate your proactive response.

I now submit Part 2 of the IMIQ submission following the Hearing. The purpose of this document is to provide further clarification of the IMIQ approach to claim practice and scheme design with a more operational and technical view of what is involved in unravelling the detrimental effects of current practice and paving the way for true sustainability. The information is provided under the following structure:

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Availability to provide ongoing assistance

As an independent consultant I have provided this review with a wealth of objective information based on my experience in health care and claim work practice design. This expertise is not available elsewhere because the need for it is not being recognised and developed within the industry. As such I am willing to undertake a support role to the outcome of this Review and welcome discussion with an appropriate representative in due course.

Yours sincerely,

Frances O'Connor
Director
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Questions on notice to IMIQ

I did not take any questions on notice on the day of the Review Hearing but received three questions from the Committee on Monday 31st October 2011:

1. **Could IMIQ give an outline of the capital and running cost of implementing their proposed Claims Management Program to an organisation such as the Lifetime Care and Support Authority?**
2. **Can IMIQ identify savings to the current administration?**
3. **Can IMIQ point to improved patient/client outcomes?**

My response to the Committee on each of these questions is the same. The sheer diversity of costs attributable to unsatisfactory claim practice, and therefore the cost and savings in improving it, dictates the need for urgent formal analysis for conclusive answers. On my website I refer to these costs collectively as 'the ripple effect'. The biggest obstacle to clearly identifying the extent of the ripple effect is the lack of visibility of how injuries are assessed, why decisions are made and the effect on client outcomes.

This document provides valuable independent insight into the operational elements of the solution. It also begins to clarify how the solution relates to key themes discussed during the Review. But the lack of objective scheme analysis to date prevents anyone within or outside the scheme from providing the comprehensive answers these three questions require. Only thorough formal analysis will create a wholistic view of the full potential and a clear road map to fair and sustainable practice.

The need for objectivity



A limited perception of the potential for better distribution of scheme funds is demonstrated by the statement on "scheme efficiency" in The Motor Accidents Authority Annual Report 2009/2010 (page 58):

*The Scheme is considered efficient if the highest possible amount of each dollar paid in premiums is returned to injured people as compensation payments. This can be achieved by reducing the transaction costs of administering the Scheme where appropriate. These represent a per policy cost **independent of claims costs**. ...In the filing period commencing 1 July 2010, the projected return to claimants is 66.5 per cent of total premiums.*

This could imply that reducing inappropriate claim costs is not considered a relevant and/or possible means of increasing availability of funds for compensation or controlling premiums

and profits. The IMIQ information already provided then expanded on in this document illustrates that it is entirely possible, logical and necessary to measure, analyse and improve claim practice for this purpose.

The cost of poor claim practice extends beyond a scheme as does the potential for savings

Apart from the costs and potential for savings **within** personal injury schemes, scheme redesign must ensure the cost of poor claim practice is prevented from leaking into the broader community. My years of informal research of claim practice through first-hand experience has revealed that a trail of health, social and economic fall-out extends well beyond scheme funding. When claim practice fails to result in accurate assessment of injury or illness and its impact on a person's ability to earn an income, it not only increases litigation but undoubtedly impacts Medicare, social welfare schemes and the business community, as well as creating many personal costs for claimants. Many of the issues raised during the Review can be traced back to the lack of visibility of, and accountability for claim practice in scheme design. If this root cause is not addressed, the preventable costs of the scheme will continue to extend well beyond its' funding and administration.

The next steps

A realistic approach must now be taken to quantifying the ripple effect of costs stemming from longstanding poor practice, and therefore the savings made possible with a well-designed approach. Formal independent and interdisciplinary analysis must uncover:

1. the full cost of poor claim practice to the scheme and beyond, and
2. the full potential for savings with claim practice that identifies and prevents those unnecessary costs*.

This wholistic view of the effect and potential of claim practice is needed to create a new way of thinking **about** personal injury schemes to then prompt new thinking **within** them. Only independent objective expertise will ensure the essential rigor, innovation and credibility in the scheme redesign that must occur.

**Practice designed for Knowledge Development uses claim information to identify poor results and prevent them in the future. It creates valuable business intelligence for insurer and regulator to continually improve performance with evidence-based practice.*

Information on key themes arising from the Hearings

1. Inefficient information exchange

How the IMIQ approach relates to this issue causing frustration and disempowerment for claimants and service providers

At the Hearing I was advised by Committee members that one of the themes arising during the Review was that of disempowerment of claimants and others due to inefficient information exchange by insurers / claim managers. This issue and all its implications is not solely related to process inefficiency or the use of paper files versus electronic files. It relates every bit as much to the knowledge development capability (business intelligence) of the insurer. That is, having controls and supports above and beyond the knowledge and skills of an individual claim assessor (who, it must be remembered, receives a continuous flow of information for a large portfolio of disparate claims being managed concurrently).

Irrespective of the method, ease and speed of information **transmission** made possible by IT, claim information received must undergo critical thinking before a response can be actioned. This requires the ability to understand the significance (risk) of that information to the progress of the claim before a decision is made and communicated. In other words, expediting communication of decisions is inextricably linked to clarity and accuracy in making them (by increasing front line understanding of complex and diverse information).

The lack of industry progress in this area stems from a one-dimensional view of business improvement – ‘process efficiency’ to achieve administration savings (reduced claim staff)*. Year in and year out ‘Business Transformation’ projects attempt to improve efficiency. But failure to understand that efficiency of information flow is interdependent with accurate decision making results in a focus on micro-processes in isolation of the claim outcomes required. In short, random tinkering with system processes increases complexity and task-orientation to create even more distractions from critical thinking than paper files ever had.

Wherever decisions are required, the speed of information exchange cannot be improved without equal focus on improving critical thinking. Effective practice involves controls for both quality and efficiency. So, this issue, its implications and solutions must be viewed holistically as the need to integrate:

- a. Decision support (risk identification and management)
with
- b. Process efficiency

**The perceived administration savings of IT systems is briefly explained further on page 15 under Operational requirements of knowledge development in claim practice.*

Increasing access to claim information in the future with online log in and updates

There was interest during the Hearing in the potential to increase accessibility of claim information through new forms of consumer IT (i.e. remote view and input). Web-based claim management systems already have the capability for integration of information from external sources. But to successfully apply this concept in claim management a knowledge development model must define how information from those sources is to be organised and analysed by the system rules engine as it is received. Without this critical design, received information would remain separate to the rest of the claim until the claim assessor gets to it and decides what to do about it (just like an email) – yet another task in their workflow queue. So it is the ability to immediately integrate information with the rest of the claim that creates the efficient information exchange made possible by new IT.

Knowledge development modelling is expertise personal injury schemes lack. Even where advanced IT systems are already used, fundamental in-house claim processes have not been developed (such as automated risk identification with continuous claim triage). So irrespective of IT capability, the industry will not be able to provide more sophisticated interaction for external claim stakeholders without undertaking significant groundwork. This includes business-to-business portals for input and response to treatment updates or approval requests, and many other necessary interactions with an external party in the claim process.

2. Privacy and the use of claim information


Concerns were raised during the Hearings about privacy in terms of the amount, transfer and use of claim information.

A question was raised about the impact of the IMIQ approach on the amount and privacy of claimant information. I have not reviewed or heard the specific concerns raised about privacy in claim management. However, I am very supportive of the need to increase accountability and security for information collection, storage and use in claim management.

Clearly the need for sensitive information is unavoidable; first and foremost the nature of a claim pertains to bodily injury, but secondly, legislation compensating for the impact of an injury on the person's life dictates the amount and type of information required to accurately assess that. These factors require a high degree of personal and sensitive information from the claimant. So a review of privacy issues must first look at the type and extent of information determined by the scope of compensation and objectives of claim management.

A second but equally important aspect of privacy is the method by which claim information is collected, stored, transferred and used by an insurer, regulator and service providers. It is my view that the personal injury industry fails to appreciate the inherent **value** of claim information, hence the absence of a comprehensive organised approach. This oversight creates a far greater risk to privacy than a carefully designed approach.

A history of paper files and limited use of information has never guaranteed isolation and security of claim information. Even where paper files are used, data transfers have always occurred between insurer and regulator because insurers are required to report claim data to regulators on a monthly basis in all schemes. But claim information can also be routinely or frequently faxed, emailed, photocopied, mailed, lost, left around open-plan offices 24 hours a day, sent to service providers, misfiled, accidentally sent to wrong recipients, and stored in over-filled cardboard folders with pages of detailed medical reports, forms and file notes falling out. It has always been fairly easy for sensitive information to be misplaced.

 For all these reasons, while electronic collection, storage and transfer of information necessitate excellent IT security, there is no valid reason to avoid or delay using the full capability of IT to improve scheme outcomes.

Effective use of claim data benefits claimants and does not mean more information is collected

In relation to the privacy concerns raised, two important points must be clarified about the IMIQ approach:

1. Knowledge development does not require increases in the amount or type of claim information to be collected, but that the most critical information ***already collected*** is used effectively.
2. Knowledge development creates both long-term benefits (for an insurer, future claimants, premium payers and the scheme as a whole), as well as ***immediate benefit for an individual claimant*** (by prompting the claim assessor).

To be clear, I am not advocating the collection of claim information simply to undertake longer-term research that may or may not ever be integrated back into the claim process. Knowledge development is very much about creating ***improved front line practice for every claim***. This is the ***only*** means of achieving the long-term goals of sustainability because scheme costs, and therefore premiums, largely relate to the cost incurred claim by claim.

Captured information must benefit the claimant immediately

As mentioned in part one of the IMIQ submission, if risk factors on a claim are not known or identified by the claim assessor the claimant can be significantly disadvantaged. Manual injury management file reviews in any scheme reveal enormous numbers of missed risks and failure to manage risks. These misses impact both the claimant and the scheme. The objective is to use claim information to reduce the impact of knowledge deficits of individual claim assessors. This is the only way to improve the consistency of high quality outcomes.

3. Relevant comparisons for the ethical use of information to improve practice and outcomes

Workers Compensation Scheme progress

Insurers in the NSW Workers Compensation scheme are required to submit extensive claim data every month to Workcover NSW (standard practice between insurer and regulator in all schemes). This information is based on the National Data Set for Compensation-based Statistics (NDS) and is collated and analysed by Safe Work Australia along with data from all other workers compensation jurisdictions in Australia. This same data set is used in the NSW CTP scheme for monthly reporting by insurers to the MAA.

The latest version of the NDS aligns it with the World Health Organisation’s International Classification of Diseases (ICD-10) and is being implemented across workers compensation schemes. This has been a slow process due to the limitations of insurer IT capabilities – the old legacy systems prevented easy update of data capture but these systems are now being made obsolete as insurers invest in new generation claim management systems. Currently 9 out of 12 jurisdictions have updated their claim data set to this international level (NSW, WA and ACT private are yet to complete implementation).

| Jurisdictions | TOOCS3/3.1 | TOOCS2.1 |
|---------------|------------|----------|
| SEACARE | x | |
| VIC | x | |
| QLD | x | |
| SA | x | |
| NT | x | |
| ACT GOVT | x | |
| C'WEALTH | x | |
| NZ | x | |
| TAS | x | |
| ACT PRIVATE | | x |
| NSW | | x |
| WA | | x |

Source: Safe Work Australia

While the use of this data to analyse the impact of claim practice in workers compensation remains very poor, this example demonstrates that reporting claim data for large scale analysis has been occurring for many years. In any scheme in which this information is already collected there is an opportunity to monitor claim outcomes more closely to improve accountability for practice standards and decisions.

The Healthcare Industry

Health Informatics (e-Health) is recognised as an essential part of improving patient care

Health Informatics is a specialist discipline playing a vital role in the effective use of information to improve practice, funding and outcomes in health care. The insurance industry lags well behind in recognising that information has this inherent value. Unlike healthcare, there has been no progress in harnessing that value to create business intelligence. There is little awareness of the need for this expertise and a tendency not to apply the advancements made in other industries.

Personal injury schemes operate in parallel with health care - claims arise from an injury or illness, meaning recovery is the primary driver of claim progress, costs and overall outcomes (except for catastrophic claims). This is why the effective use of medical information is critical to improving efficiency and accuracy in the ongoing exchange and decision making between insurer, health service providers, claimants and other stakeholders.

But while the healthcare industry has stepped up to the operational and technical challenges of Health Informatics, personal injury schemes have overlooked this priority area. Consideration must be given to concepts such as funding models (e.g. Casemix), clinical decision support tools and the most fundamental analysis for benchmarking that has long been used to improve outcomes for distinct injury /illness segments in health care.

The World Health Organisation is now well underway in updating the International Classification of Diseases to an online database of injury and illness information. A deliberately long-term view is being taken to ensure the interoperability of data across all of the uses of health information (from funding models to clinical research to decision support and others). Claimants and all stakeholders of personal injury schemes will once again miss out on the benefits of this progress unless insurers and regulators are made accountable for keeping pace with these advancements. They must be able to compare their outcomes for distinct injury and illness segments with that of clinical health care, other schemes and international practice.

Decision support is already a well-established concept in health care

In recognition of the quantity of information clinicians face and therefore the need for guidance at the point of decision making, a report was undertaken in 2002 by the National Electronic Decision Support Taskforce (established by the National Health Information Management Advisory Council). It advised the Health Ministers of "substantial evidence of the effectiveness of decision support in improving the safety, quality and efficiency of health care" (National Electronic Decision Support Taskforce (NEDST). Electronic decision support for Australia's health sector. Canberra: Australian Government Department of Health and Ageing, 2003).

More recently, the May 2010 edition of Pulse+IT magazine* cited a study published in the British Medical Journal in 2005 showing that out of 71 trials of clinical decision support systems (CDSS), 68% resulted in a significant improvement in clinical practice. On the basis of the trials, the design features found to ensure the efficacy of decision support were that it:

- is provided automatically as a part of the workflow (i.e. meaning it is integrated)
- is provided at the time and location of decision-making (i.e. meaning it is integrated)
- provides actionable recommendations
- is computer-based
- provides information immediately otherwise it will not be used (i.e. meaning it is integrated).

*John Johnston. Decision Support – a little history. *Pulse+IT* 2010; 12 - 13

These principles apply equally to improving the assessment and outcomes of personal injury claim management and new IT systems enable it. Yet wherever attempts are made to provide claim assessors with even the most basic reference information, it is from a source that is separate to the claim management process, meaning it is not used because it is not integrated. Personal injury schemes should be learning from this more intelligent and scientific approach in the healthcare industry. Apart from the fact that there is a significant overlap in the **type** of information used, this is one way in which insurers could reinvest profits from these schemes to improve the outcomes achieved.

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Health informatics ... is a discipline at the intersection of information science, computer science, and health care. It deals with the resources, devices, and methods required to optimize the acquisition, storage, retrieval, and use of information in health and biomedicine. Health informatics tools include not only computers but also clinical guidelines, formal medical terminologies, and information and communication systems. It is applied to the areas of nursing, clinical care, dentistry, pharmacy, public health, occupational therapy, and (bio)medical research (from http://en.wikipedia.org/wiki/Health_informatics).

Health information technology (HIT) is, in general, increasingly viewed as the most promising tool for improving the overall quality, safety and efficiency of the health delivery system (Chaudhry et al., 2006). Broad and consistent utilization of HIT will:

Improve health care quality;

- Prevent medical errors;
- Reduce health care costs;
- Increase administrative efficiencies
- Decrease paperwork; and
- Expand access to affordable care.

Interoperable HIT will improve individual patient care, but it will also bring many public health benefits including:

- Early detection of infectious disease outbreaks around the country;
- Improved tracking of chronic disease management; and
- Evaluation of health care based on value enabled by the collection of de-identified price and quality information that can be compared.

Chaudhry, B. Wang, J., & Wu, S. et al., (2006). Systematic review: Impact of health information technology on quality, efficiency, and costs of medical care, *Annals of Internal Medicine*, 144(10), 742–752

(from http://en.wikipedia.org/wiki/Health_information_technology)

Casemix based funding is the key funding model currently used in Australian health care services for reimbursement of the cost of patient care.

...Casemix is a system that measures hospital performance, aiming to reward initiatives that increase efficiency in hospitals. It also serves as an information tool that allows policy makers to understand the nature and complexity of health care delivery.

Diagnosis Related Groups (DRGs) is the best-known classification system that is used in this funding model. It classifies acute inpatient episodes into a number of manageable categories based on clinical condition and resource consumption. A single acute episode of inpatient care is allocated to one DRG using coded clinical information derived from the patient's medical record. This information is coded by the Health Information Managers in order to allocate a DRG. Each DRG is allocated a 'weight', which is dependent on the average cost of inputs (e.g. nursing, diagnostic services, procedures) required to achieve the appropriate patient outcome. The facility is reimbursed a predetermined amount for each patient episode.

(from http://en.wikipedia.org/wiki/Case_mix)

4. The potential to introduce competition with claim practice performance comparisons

Consumer expectations for informed choice on any health-related service are increasing and rely on publicly-available performance reporting

In most industries a natural selection process creates competition as new standards are set by newcomers challenging the old ways. Obviously this is an impossible form of competition in insurance because hugely prohibitive finance guarantees an increasingly consolidated market. But in most areas of life consumers rightly expect the freedom to choose products and services according to performance, especially when business stands to profit so greatly. Claim practice has such an impact on premiums and claimants that scheme design must now recognise it as perhaps the only viable means of sustainable competition.

Insurance is only required because of the potential need to claim. So when insurance is compulsory, consumers should at least be given the opportunity to select an insurer on the basis of claim practice performance. That is, their ability to facilitate good recovery and return to work or other outcomes.

This approach mirrors the concept behind the MyHospitals website introduced by the Federal Government. Increasing transparency and accountability in the hospital system has set a precedent for the ethical right of consumers to choose the best organisation to manage their care in the event of an injury or illness. While this was a controversial idea when first proposed, now state governments have also agreed to use this mechanism to improve patient care and generate millions of dollars in savings. Just recently the Sydney Morning Herald reported that the second-largest hospital company in Australia (Healthscope) has initiated self-reporting on their own website to lure patients away from lesser-performing hospitals (*Patient care no longer a secret*, News Review page 6, Weekend Edition November 5 – 6 2011). So clearly there is merit in using this concept for competition in health-related businesses.

This concept should be considered for the future of personal injury schemes. Claim practice is largely hidden from consumers even during their own claim meaning they currently have no way of selecting an insurer on the basis of performance.

A mechanism to stimulate sustained competition can only be achieved by committing to the use of claim information to benefit scheme stakeholders.

5. Catastrophic and non-catastrophic claim management solutions must be differentiated

During the Hearing discussions, there was a general lack of distinction made between the issues pertaining to catastrophic injuries versus non-catastrophic injuries. The reason distinction is so important is the need to improve outcomes across the scheme as a whole. These two major claim segments have many different objectives, management needs and performance measures. In front line practice they require differentiated injury management (distinct claims teams, processes, legislation, etc). They must both be considered in reducing preventable claim costs but addressed separately to ensure both the synergies and differences are clear.

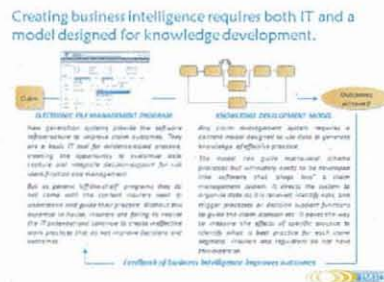
The hidden impact of the cost of non-catastrophic injuries

While the cost of catastrophic injuries is much higher, it must be understood that poorly-managed non-catastrophic injuries create a significant ripple-effect of social, economic and ongoing health implications. In this segment, the type and severity of the injury does not necessarily indicate the true cost to the scheme or the claimant. The quality and effect of treatment received, the effect on income and lifestyle, psychological coping ability, and potential malingering are variables which need to be assessed and managed to reduce unnecessarily long claim durations and costs for these claims.

Across a scheme significant disparity can occur in the results achieved for similar claim profiles. Yet discrepancies are not investigated to improve consistency in scheme outcomes. The same principles apply to the management of catastrophic injuries but the specific risks and management strategies to be monitored will differ.

Operational requirements of knowledge development in claim practice

The way out of poor claim practice and its enormous ripple effect is summarised in a high level operational view in the accompanying PowerPoint slides (refer to Part 2: an operational view of 21st Century claim practice and view in Slide Show mode).



The two main elements each require specialist expertise:

1. Claim management software infrastructure
2. Knowledge development modelling

Each element provides distinct but complementary benefits along with implementation issues related to a general lack of industry expertise. A brief overview of some of these issues is provided below.

1. Claim management software infrastructure

Note: This area is not within the scope of IMIQ expertise, but is complementary to IMIQ experience and expertise. The information provided is a brief synopsis of ongoing IMIQ networking with industry consultants assisting insurers in implementing IT. Specific figures of the capital and running costs, and the operational savings that have been reported to IMIQ have not been included – to ensure accuracy and context, this information should be sourced directly but analysed within the context of knowledge development advice from IMIQ.

Web-based claim management systems provide the basic IT platform to house a comprehensive content model that defines effective claim practice. These systems do not provide any business intelligence or decision support content, just the software operating environment. For a very simple metaphor of their function in relation to claim practice, consider the components of a motor vehicle; this aspect of claim management software would be the 'body' and very basic mechanics of a car, whereas a knowledge development model would sit inside it as the engine, electronics and navigational equipment that allows the driver to head towards a specific destination. In other words, without knowledge development models to enable their full potential, claim management systems are just vehicles in which claims sit but which cannot move them forward or provide direction for the optimal outcome. Combining them with knowledge development modelling allows

these systems to play a significant part in creating consistent outcomes for distinct claim types.

Insurers are increasingly investing in these systems across all areas of the personal injury industry. The main motivation for this investment is that the original legacy systems traditionally used to capture and report minimum claim data:

- are extremely costly to operate
- have very limited functionality
- cannot be easily configured to update data capture, and
- are not interoperable with other systems required (for data sharing).

The newer stand-alone claim management systems offer the opportunity to:

- significantly reduce their 'cost of ownership' (IT running costs) by removing the need for multiple systems and streamlining the ongoing IT expertise required
- significantly increase data capture in a useful form for analysis and
- significantly decrease the time and expense to update data capture and processes.

Perceived administration savings

Another motivation for industry investment in electronic files is the belief that they can significantly reduce administration costs, thereby reducing the front line staff required to manage a claim portfolio. However, without expertise in customising content within these systems, the result is even more time-consuming micro-processes which have little value in improving claim outcomes. This means claim management does not become any more efficient, is likely to become more inefficient, and is definitely no more accurate in terms of the problem-solving necessary to close claims and keep case loads down. So it is unlikely that this one-dimensional view reduces operational costs in the long-run.

Application in General Insurance

These systems have been used for approximately 10 years in General Insurance claims because of awareness of their usefulness in performance improvement. In the last 5 years functionality has improved dramatically and significant claim management savings are being realised because of their use to create knowledge of effective practice:

- 8 - 10% reduction in claim costs per annum due to basic analysis
- 5 - 7% reduction in claim costs per annum due to the identification and management of over-servicing by service providers
- 10 – 12% reduction in claim costs per annum due to the integration of basic decision support tools to guide claim assessors in assessment and decision making.

2. Knowledge Development modelling (IMIQ expertise)

Claim information has an inherent value, but that value can only be harnessed by converting it to knowledge of how the optimal outcomes of distinct claim segments can be achieved. A model designs how the information most significant to the outcome is captured and organised as it is received, then used throughout the claim lifecycle to identify risks and prompt or guide the claim assessor with decision support.

Significant industry obstacles to this level of practice include:

1. Lack of awareness of the concept and benefits of a knowledge development approach, evidence-based claim practice, and Health Informatics.
2. Lack of expertise in the fundamentals of knowledge development:
 - a. identifying what claim information is significant to the final outcomes achieved (combining health and other claim profile variables)
 - b. organising claim information to harness its value in improving outcomes and practice standards
 - c. analysing claim information to convert it to knowledge (business intelligence) that improves individual claim management and scheme design
 - d. developing decision support tools and functions to improve assessment and management of individual claims.

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