Motor Accident Guidelines

Version 6
Effective from
18 December 2020

NSW GOVERNMENT

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General introduction to the Motor Accident Guidelines

Parts of the Guidelines

The Guidelines are divided into the following parts:

Part 1: Premium determination

Part 2: Market practice

Part 3: Business plans

Part 4: Claims

Part 5: Minor injury (Soft tissue & minor psychological or psychiatric injuries)

Part 6: Permanent impairment

Part 7: Dispute resolution

Part 8: Authorised Health Practitioners

Part 9: CTP Care

Glossary

Publication note

These Guidelines are published by the State Insurance Regulatory Authority (the Authority).

Part of the NSW Department of Customer Service, the Authority is constituted under the *State Insurance and Care Governance Act 2015* and is responsible for regulating workers compensation insurance, motor accident compulsory third-party (CTP) insurance and home building compensation insurance in NSW.

Replacement and transition

To avoid doubt, the Motor Accident Guidelines published on 17 April 2020 are replaced in whole by these Guidelines.

These Guidelines:

- apply to all claims and applications made before or after the commencement of these Guidelines
- do not invalidate a step previously taken under the Motor Accident Guidelines published on 17 April 2020.

Legislative framework

The *Motor Accident Injuries Act 2017* (the Act) establishes a scheme of CTP insurance and the provision of benefits and support relating to the death of, or injury to, people injured as a consequence of motor accidents in New South Wales (NSW) on or after 1 December 2017.

Injury or death to a person as a result of a motor accident occurring before 1 December 2017 is governed by either the *Motor Accidents Act 1988* or the *Motor Accidents*

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Compensation Act 1999 and the relevant Regulation and Guidelines made under the *Motor Accidents Compensation Act 1999.*

The objects of the Act, as described in section 1.3 are to:

- encourage early and appropriate treatment and care to achieve optimum recovery of persons from injuries sustained in motor accidents and to maximise their return to work or other activities
- provide early and ongoing financial support for persons injured in motor accidents
- continue to make third-party bodily insurance compulsory for all owners of motor vehicles registered in NSW
- keep premiums for third-party policies affordable by ensuring that profits achieved by insurers do not exceed the amount that is sufficient to underwrite the relevant risk and by limiting benefits payable for minor injuries
- promote competition and innovation in the setting of premiums for third-party policies, and provide the Authority with a role to ensure the sustainability and affordability of the compulsory third-party insurance scheme and fair market practices
- deter fraud in connection with CTP insurance
- encourage the early resolution of motor accident claims and the quick, cost-effective and just resolution of disputes
- ensure the collection and use of data to facilitate the effective management of the CTP insurance scheme.

The Motor Accident Injuries Regulation 2017 (the Regulation) contains provisions that supplement the implementation and operation of the Act in a number of key areas.

Guideline-making powers

These Guidelines are made under section 10.2 of the Act, which enables the Authority to issue Motor Accident Guidelines with respect to any matter that is authorised or required by the Act.

Each individual Part of the Guidelines is authorised or required by a specific section or sections of the Act, which is detailed in that Part.

Interpretation of the Guidelines

These Guidelines should be read in conjunction with relevant provisions of the Act and the Regulation, and in a manner that supports the objects of the Act as described in section 1.3 of the Act.

A reference in these Guidelines to a number of days is a reference to a number of calendar days, unless otherwise specified.

Commencement of the Guidelines

The Guidelines come into effect on 18 December 2020 and apply to motor accidents occurring on or after 1 December 2017. The Guidelines relating to premium determination apply to premium rate filings for all third-party policies commencing on or after 15 January 2021.

The Guidelines apply until the Authority amends, revokes or replaces them in whole or in part.

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Existing Guidelines continue to have effect in relation to the scheme established under the *Motor Accidents Compensation Act 1999* (NSW), which applies to motor accidents from 5 October 1999 to 30 November 2017. Those Guidelines continue to apply to the existing scheme until they are amended, revoked or replaced (in whole or in part).

Purpose of the Guidelines

The Guidelines support the delivery of the objects of the Act and the Regulation by establishing clear processes and procedures, scheme objectives and compliance requirements. In particular, the Guidelines describe and clarify expectations that apply to respective stakeholders in the scheme. The Authority expects stakeholders to comply with relevant parts of the Guidelines that apply to them.

Application of the Guidelines

Relevant parts of the Guidelines apply to key customers of the scheme, including:

- vehicle owners and policyholders
- injured persons and claimants.

Relevant parts of the Guidelines also apply to key scheme stakeholders and service providers, including:

- insurers
- health practitioners
- lawyers and other representatives
- staff of the Authority
- decision-makers
- courts and other dispute resolution bodies.

Under the Act, including section 10.7, it is a condition of an insurer's licence that it complies with relevant provisions of the Guidelines.

Compliance with the Guidelines

The Authority will monitor and review compliance with the Guidelines. Compliance and enforcement will be undertaken in accordance with the Authority's Compliance and Enforcement Policy (July 2017).

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Part 1 of the Motor Accident Guidelines: Premium determination

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Determination of insurance premiums for third-party policies

Introduction

1.1 These Guidelines provide mechanisms for the regulation of insurance premiums matters under Part 2, Division 2.3 and clause 2 of Schedule 4 of the *Motor Accident Injuries Act 2017* (NSW) (the Act). They are issued by the State Insurance Regulatory Authority (the Authority).

Commencement and revocation of previous Guidelines

1.2 These Guidelines are effective for premium rate filings submitted for all third-party policies that the filing insurer proposes to issue with a commencement date on or after 15 January 2021. These Guidelines replace those published on 17 April 2020.

Definitions

1.3 The definitions in the Act apply to these Guidelines.

Guiding principles

1.4 The primary objects (section 1.3) of the Act relating to a premium framework are to:

(a) promote competition and innovation in the setting of premiums

(b) ensure the sustainability and affordability of the scheme and fair market practices

(c) keep premiums affordable by ensuring that the profits realised by insurers do not exceed the amount that is sufficient to underwrite the relevant risk.

1.5 To promote competition and innovation by insurers, the Authority allows risk-based pricing, but this must be done within limits in order to keep premiums affordable. The premium framework recognises that this liability scheme, which is compulsory and privately underwritten, blends risk-based and community-rated approaches to assist with the object of affordability.

1.6 Filed premiums must be adequate and not excessive (under section 2.22(1)(a) of the Act). The Authority will closely scrutinise filed premiums against the objects of the Act and against any range of premiums for transitional policies it has determined under clause 2(3)(c) of Schedule 4 of the Act.

1.7 In aligning with the competition and innovation objects, the Authority recognises that insurers will pursue their own particular business objectives that will be reflected as an integral part of each insurer's pricing strategy. On this basis, technical (actuarial) pricing will not be considered in isolation and an explanation by insurers is encouraged for non-technical pricing considerations, including:

(a) business plans and short, medium and long-term growth strategies

(b) response to pricing by competitors

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(c) market segmentation and distribution strategies

(d) innovation and efficiencies in their business model.

1.8 The Authority will take into account the objects of the Act by considering both qualitative and quantitative explanations when reviewing insurer filings.

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Premium filing process

Filing requirements

1.9 A premium filing under Division 2.3 of the Act must be provided in soft copy and must include:

(a) covering letter

(b) filing report

(c) the Authority's motor accident filing template

(d) any other additional information reasonably required by the Authority.

Covering letter

1.10 The premium filing covering letter must be signed by the NSW CTP product executive or equivalent office holder of the licenced insurer and include:

(a) the proposed commencement date for the premium and the period nominated by the insurer for the Authority to reject the premium (cannot be less than six weeks)

(b) an executive summary of the filing

(c) the overall average premium

(d) any significant changes to the most recent business plan approved by the Authority impacting competitive strategies or market positioning

(e) any significant rating factor changes

(f) any changes in bonus malus levels

(g) implementation plan detailing how the insurer will meet the proposed commencement date

(h) an outline of the policyholder impact analysis.

Filing report

1.11 Every filing report must include:

(a) a summary of the changes proposed and any changes in business strategy

(b) explanation of each filing assumption change made since the previous filing

(c) completed motor accident filing template commentary and analysis of the estimated effects on the portfolio composition as described in 'Portfolio analysis' section below

(d) an analysis of the change in average premium and base premium against the previous filing

(e) signed endorsement of the filing from the NSW CTP Product Executive or equivalent office holder

(f) any other information requested by the Authority.

1.12 Nothing further is required to be included in the filing report if all the following conditions are met:

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(a) the expiry date of the filing lodged is within 12 months from the commencement date of the most recent filing approved by the Authority

(b) the change in average premium excluding GST and the Fund levy reported in Schedule 1C of the Authority's motor accident filing template is less than 4% when compared to the most recent filing approved by the Authority

(c) the change in Base Premium Rate (Class 1 Metro) excluding GST, Fund levy reported in Schedule 1C of the Authority's motor accident filing template is less than 4% when compared to the most recent filing approved by the Authority.

1.13 If any of the above conditions are not met, the filing report must also include:

(a) how the proposed insurance premiums (excluding the Fund levy and GST, and assuming no policyholders are entitled to any input tax credit (ITC)) were determined by the insurer

(b) the factors and assumptions considered in determining the premiums, how those factors were derived, and any variation relative to the Authority's independent actuary's costing assumptions (Schedule 1E, provided by insurers in the form specified in Table 1.3), taking into account the insurer's business mix by class and region and other (claims experience related) factors against those of the industry

(c) an explanation of the non-technical pricing factors where applicable

(d) how the insurer assessed projected future frequency of:

- claims for the industry (inclusive of nominal defendant claims, and by subdivision as set out in Schedule 1E)
- claims for the insurer (by subdivision as set out in Schedule 1E and disclosing the treatment of shared claims and nominal defendant claims).

(e) how the insurer assessed projected future average claim size of:

- claims for the industry (inclusive of nominal defendant claims, and by subdivision as set out in Schedule 1E)
- claims for the insurer (by subdivision as set out in Schedule 1E and including the estimated net effects of shared and nominal defendant claims).

(f) a summary of claim frequency and average claim size (in current values), and resulting cost per policy, by claim component (including nominal defendant), allowing for sharing and net of ITCs, should be included in the filing report. This should reconcile to item 1c in Schedule 1C for claim frequency and indicate the adjustment to claim sizes required to reconcile to item 2b in Schedule 1C.

(g) economic and investment assumptions, including:

- assumed future rates of wage and price inflation
- full yield curve adopted and the single equivalent rate of discount
- assumed future claim payment pattern for the underwriting period covered by the filing specifying whether the basis is current values, inflated or discounted.

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(h) superimposed inflation (SI) assumption, including:

- assumed future rates of SI
- disclosure of the single equivalent rate of SI where different rates have been used for different claim segments and/or different rates of SI have been adopted in future years
- an explanation of the approach taken in setting the SI assumptions.

(i) insurer expenses, including average past actual and expected future rates and amounts of:

- acquisition and policy-handling expenses (excluding commission or other remuneration) associated with third party policies with appropriate explanation provided and a description of the methodology used to allocate overhead expenses
- commission or other remuneration payments (the percentage paid per policy cannot exceed 5% of the insurance premium)
- claims-handling expenses, including an explanation of what is included in this item, and a description of the methodology used to allocate overhead expenses
- net cost of reinsurance.

(j) disclosure of the above past and expected future expenses on a total pool basis as well as on a cost per policy basis for acquisition and policy expenses, and on a per claim basis for claims-handling expenses (for clarity, claims-handling cost per claim expected to arise during the period covered by the filing)

(k) the expense assumptions used and an explanation of how they relate to the above information

(l) proposed profit margin: the percentage of gross insurance premiums intended to be retained as profit, before tax

(m) Adjustments to insurer premium to obtain the class 1 metro base premium by disclosing a full explanation of the calculation of the:

- ratio of the class 1 metro premium to the average premium
- average bonus malus factor: commentary should be included where the filed average bonus malus factor varies from the average implied by the expected future number and mix of insured vehicles by vehicle class and rating region at each bonus malus level (as provided in the portfolio analysis)

(n) details of how the percentage loading applied to the nil ITC premium rates to obtain the ITC premium rates was determined

(o) details of how the short-term loading parameters A, B, X and Y were determined

(p) a comparison with the previous filing of the filed average premium and the actual average premium received by the insurer, together with an explanation of the allowance made for non-annual policies in calculating these average amounts, including:

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- how the assumptions regarding future experience in the current premium filing differ from the corresponding assumptions in the previous filing by the insurer
- the changes in assumptions and the effect of those changes on the proposed premiums, including reconciliation between the previous and proposed new base premium for a Sydney passenger vehicle for which the policyholder is not entitled to any ITC.

(q) any other matter the insurer considered in determining premiums.

1.14 The Authority may request additional information or amendments to the premium filing.

Rejection of premiums by the Authority

1.15 The Authority may reject a premium filed under Division 2.3, section 2.22 of the Act if it is of the opinion that the premium:

(a) is excessive or inadequate in relation to actuarial advice and to other relevant financial information available to the Authority

(b) does not conform to the relevant provisions of these Guidelines, or

(c) will not fall within the range of premiums determined by the Authority under clause 2(3)(c) of Schedule 4 of the Act, 'Savings, transitional and other provisions'.

1.16 The Authority will conduct a review of all filings lodged in accordance with Division 2.3 of the Act and these Guidelines. The Authority may also obtain actuarial advice or other relevant financial advice.

1.17 The Authority's review will consider:

(a) whether a filing is considered incomplete. The Authority will determine completeness by reviewing the documentation, schedules and motor accident filing template required by these Guidelines. The Authority must be satisfied that there is materially sufficient explanation of the assumptions and filed premiums to enable a review of the quantitative and qualitative elements of the filing, and

- if classified as incomplete, the Authority may request further information from the insurer in accordance with section 2.20(7) of the Act, which will mean that time does not run in relation to the period allowed for rejecting the premium until the insurer complies with the Authority's request, or
- the Authority may request its withdrawal and, if not withdrawn, will exercise its discretion to reject the filing.

(b) whether the premium has been determined in accordance with the process set out in these Guidelines. This will include the requirement to provide additional information regarding the premiums filed and to justify premiums that have been filed.

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Special provisions for premiums during the transitional period

1.18 The Authority has determined the likely cost of claims arising after the start of the transition period to be consistent with the initial costing by the Authority's independent actuary, subject to any subsequent costing variations.

1.19 In determining the Authority's opinion on whether the premium is adequate and not excessive under section 2.22(1)(a) of the Act, the Authority will consider the comparison between the assumptions in the insurer's filing and those in the independent actuary's costing published by the Authority.

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Premium components and factors

Motor accident schedule of premium relativities

1.20 Insurers must classify vehicles based on the motor accident schedule of premium relativities. The Authority will publish two sets of premium relativities:

(a) customer premium relativities, which are to be used to calculate customer premiums

(b) insurer premium relativities, which are used in Table 1.2, Schedule 1C to arrive at insurers' base premium.

1.21 These premium relativities will be published to licensed insurers each year or other period as determined by the Authority. Insurers must apply the relevant premium relativities that are applicable to the vehicle class and region.

Base premium

1.22 The base premium for each vehicle classification and region must be:

(a) calculated as the class 1 metro vehicle base premium for which the policyholder is not entitled to any input tax credit (ITC)

(b) multiplied by the relativity for the particular vehicle class and region published in the motor accident schedule of insurer premium relativities current at the date the third-party policy begins

(c) divided by 100.

1.23 The nominated base premium is used to define the allowable range of premiums in terms of the limits for bonus malus, the relative premiums for vehicle classifications and regions, and the loading that allows for policyholder entitlement to an ITC. It is equal to:

$$\mathrm{IB}_{\text{class 1 metro}} = \frac{\mathrm{AP} \times \mathrm{n} \times 100}{\sum_{\mathrm{i}} \text{insurer premium relativity}_{\mathrm{i}} \times (1 + \mathrm{bm}_{\mathrm{i}})}$$

Where:

- $IB_{class1metro}$ = The insurer's base premium for class 1 metro including GST but excluding the Fund levy, calculated as if no policyholders are entitled to any ITC. The Fund levy is the combined total of the Motor Accidents Operational (MAF) Fund levy, Lifetime Care & Support (LTCS) Fund levy and Motor Accident Injuries Treatment & Care (MAITC) Fund levy
- AP = The insurer's average premium including GST but excluding the Fund levy, calculated as if no policyholders are entitled to any ITC, as shown in the filing assumptions summary sheet (Table 1.2, Schedule 1C)
- $insurer\ premium\ relativity_i$ = The premium relativity applicable to the i-th policy, as anticipated to be underwritten over the period of the premium filing based on the motor accident schedule of insurer premium relativities
- bm_i = The bonus malus rate (%) applicable to the i-th policy, as anticipated to be underwritten over the period of the premium filing
- n = The number of policies anticipated to be underwritten over the period of the premium filing.

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Ratio of insurer's average premium to class 1 metro (item 13 in Table 1.2)

1.24 This factor expresses the ratio of the insurer's average premium based on the insurer's projected portfolio mix (annual policy equivalent, taking into account the insurer's vehicle class and region mix of business), relative to the base premium of a class 1 metro vehicle. This is calculated by:

(a) determining the percentage of the insurer's projected portfolio (based on the number of vehicles) that will be written in each vehicle class and region

(b) multiplying each of the above proportions by the motor accident schedule of premium relativities published by the Authority for the corresponding vehicle class and region

(c) adding up all of the values calculated in (b) above

(d) dividing (c) above by 100.

1.25 The formula for the calculation is:

$$Ratio = \frac{\sum_k a_k \times true\ premium\ relativity_k}{100}$$

Where:

- α_k = The proportion (as a %) of the insurer's projected portfolio (based on vehicle count) for the k-th vehicle class and region
- *true premium relativity*$_k$ = The premium relativity for the k-th vehicle class and region in the motor accident schedule of insurer premium relativities published by the Authority.

Bonus malus factor (item 14 in Table 1.2)

1.26 This factor expresses the average bonus malus applied by an insurer to its projected annual policy equivalent portfolio (after taking into account the insurer's vehicle class and region mix of business). This is calculated by:

(a) determining the total portfolio premium (before GST and levies) to be collected, inclusive of the bonus malus rates to be applied, for the portfolio of risks projected to be written by the insurer. This portfolio of risks should take into account the insurer's mix of business by vehicle class, region and rating factors

(b) determining the total portfolio premium (before GST and levies) to be collected, before the application of any bonus malus rates, for the portfolio of risks projected to be written by the insurer

(c) dividing (a) by (b).

1.27 The formula for the calculation is:

$$bonus\ malus\ factor = \frac{\sum_i base\ premium_i \times (1 + bm_i)}{\sum_i base\ premium_i}$$

Where:

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- *base premium*$_i$ = The applicable base premium ($) for the i-th policy based on its vehicle class and rating region
- bm_i = The bonus malus rate (%) applicable to the i-th policy given the rating factors and bonus malus structure adopted by the insurer.

Bonus malus limits, rating structure and risk rating factors

1.28 Each risk rating factor proposed by an insurer must be objective and evidence-based. A risk rating factor must not be used unless approved by the Authority. Insurers can apply to use objective risk rating factors except race, policy duration, ITC entitlement and postcode.

1.29 The authority encourages insurers to apply to use innovative rating factors that differentiate risk with quantifiable data, including telematics. Alternative pricing mechanisms, including initial premium payments combined with premium refund or extra premium options, are possible for all vehicle classes. Insurers may refund part of the premium paid for a third-party policy during or after the period for which the policy is issued, by reference to digital information recorded about the safe driving of the insured vehicle during that period, or other factors including the distance travelled. If insurers wish to apply these refund provisions to any vehicle class, the basis and methodology must be approved by the Authority.

1.30 Where there is a significant change to an insurer's bonus malus structure or change in the bonus malus applied to a group of policyholders (more than 10% change in the bonus malus percentage applied compared to the current rating structure in force, in absolute terms), an insurer must include in their filing:

(a) analysis showing the technical relativity (or cost) for each group of policyholders within the rating factor for which bonus malus changes are proposed

(b) a comparison of the technical relativity (or cost) against the actual premium relativity or bonus malus percentage (or cost) proposed.

1.31 Where an insurer proposes a rating structure that is significantly different from the technical basis, reasons for the difference must be discussed in the filing report.

1.32 The various levels of the bonus malus filed by a licensed insurer for each vehicle class and rating region must be supported by experience-based evidence or a reasoned assessment of risk and/or strategic commercial reasons, except where an absolute bonus malus has been mandated by the Authority. An insurer must not charge the maximum malus for all vehicles in a particular vehicle classification unless this is supported by such evidence or assessment.

Malus limits

1.33 The maximum malus percentage may be calculated exactly or rounded to the nearest one tenth of 1%. For example, a multiple calculated as 51.2657% may be applied without rounding or rounded to 51.3%.

1.34 Premiums charged by an insurer must be no greater than the multiple shown in Table 1.1 of the insurer's base premium, excluding GST, for the vehicle classification and each region.

Table 1.1: Multiple of the insurer's base premium, excluding GST

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Vehicle classes	Maximum malus
1 (excluding new† non-fleet class 1 vehicles), 3c, 3d, 3e, 5, 6a, 6b, 6c, 8, 9a, 9d, 9e, 9f, 11, 12a, 13 and 18a	(145% x RB + (IB – RB) x 30%)/IB
7	Not more than 100% of the insurer's base premium excluding GST
10d, 10e, 10f, 10g and 10h	(130% x RB + (IB – RB) x 30%)/IB
6d, 6e, 12b, 14, 15a, 15c, 17, 18b, 18c and 21	Not more than 110% of the insurer's base premium excluding GST

† Original (establish) registration for current year and including plus or minus one year

Where:

- *IB* = The insurer's filed base premium for a class 1 metro vehicle for which the policyholder is not entitled to any ITC
- *RB* = The reference base rate at the time of filing.

Bonus limits

1.35 Premiums charged by an insurer for specific vehicle classifications by region must accord with the following:

(a) If the vehicle is a new non-fleet class 1 vehicle, premiums must be 80% of the base premium, excluding GST, for each region. No other bonus malus may be charged.

- *New* = Original (establish) registration for current year and including plus or minus one year.
- *Non-fleet* = A fleet of fewer than 5,000 class 1 and/or class 3c vehicles.

1.36 Otherwise for class 1 vehicles that are not new and class 3c vehicles that are not part of a fleet, if the youngest driver is aged:

(a) under 55, the minimum premium is no less than 80% of the insurer's base premium, excluding GST, for these vehicle classes by region

(b) 55 or over, the minimum premium is no less than 75% of the insurer's base premium, excluding GST, for these vehicle classes by region.

1.37 Otherwise for fleet vehicles, if the:

(a) fleet comprises 5,000 or more class 1 and/or class 3c vehicles owned by a single entity/operator, or a group of related entities/operators, that proposes to insure third-party policies with one licensed insurer, the minimum premium is no less than 60% of the insurer's base premium, excluding GST, for these vehicle classes by region.

1.38 Premiums charged by an insurer for vehicle classes 10d, 10e, 10f, 10g and 10h must be no less than 80% of the insurer's base premium, excluding GST, for the vehicle classes by region.

1.39 Premiums charged by an insurer for vehicle classes 3d, 3e, 5, 6a, 6b, 6c, 8, 9a, 9d, 9e, 9f, 11, 12a, 13 and 18a must be no less than 70% of the insurer's base premium, excluding GST, for the vehicle classes by region.

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1.40 Premiums charged by an insurer for vehicle classes 6d, 6e, 12b, 14, 15a, 15c, 17, 18b, 18c and 21 must be no less than 90% of the insurer's base premium, excluding GST, for each of these vehicle classes by region.

1.41 Premiums charged by an insurer for vehicle class 7 must be no less than 100% of the insurer's base premium, excluding GST.

Premiums where entitlement to an ITC is applicable

1.42 Specific premiums apply when the vehicle owner is entitled to ITC for GST purposes to allow for the tax treatment. The insurer will determine two sets of premium rates:

(a) *nil ITC premium rates,* which apply to policyholders with no entitlement to any ITC for GST included in the premium

(b) *some ITC premium rates,* which apply to policyholders entitled to claim an ITC for at least some of the GST included in the premium. Some ITC premium rates will be the insurer's corresponding nil ITC premium rates increased by a loading.

1.43 Each insurer will determine the percentage loading it considers appropriate. However, the loading, expressed as a percentage of the corresponding nil ITC premium rates, must be within the range of 6.5% to 7.5%.

1.44 The loading will be determined in relation to the effect of policyholders' entitlement to claim an ITC on the insurer's entitlement to claim decreasing adjustments for claims costs attributable to those policyholders.

1.45 The ITC loading must be the same percentage for each vehicle classification and region. However, minor variations in the percentage loading attributable only to the calculation of premiums for non-annual policies or to rounding are acceptable.

Loading of premiums for short-term policies

1.46 For quarterly or six-month policies, short-term insurer premiums may include a surcharge (the short-term policy surcharge), excluding GST, LTCS levy and MAF levy, which is calculated as follows:

- Quarterly premium = (annual premium + X) x (100% + Y%) / 4
- Half-yearly premium = (annual premium + A) x (100% + B%) / 2

Where:

Annual premium excludes GST, LTCS levy and MAF levy X, Y, A and B are amounts that each insurer will determine, subject to:

- X (administrative costs loading for quarterly policies) being no more than $15
- Y (a forgone investment income loading for quarterly policies) being no more than 2.2%
- A (administrative costs loading for half-yearly policies) being no more than $5
- B (forgone investment income loading for half-yearly policies) being no more than 1.5%.

1.47 Each licensed insurer must set one proposed rate for each of the factors X, Y, A and B that will be applied consistently across all short-term CTP policies

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offered by that insurer. The proposed loadings will be included in all filings and must be approved by the Authority. The surcharge does not apply to short-term periods for common due date policies. GST and the pro rata Fund levy for the relevant policy term are then added to calculate the total amount payable by the policyholder for a short-term policy, initially to the nearest one cent.

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Justifying third-party premium assumptions

1.48 Insurers must specify how they have determined proposed premiums and explain the proposed premiums to the satisfaction of the Authority. Insurers are required to complete the Authority's motor accident filing template.

1.49 The total estimated claims cost (risk premium) adopted in the filing must:

(a) reflect the expected outcomes of the Act

(b) be on a central estimate basis; that is, an estimate of the mean, which must not be intentionally or knowingly conservative or optimistic.

Basis of estimate

1.50 Expense assumptions adopted in the filing must be set with reference to:

(a) maximum rates of expense assumptions specified by the Authority

(b) excluding expenses not directly relevant to the acquisition, policy administration or claims management of the insurer's third-party insurance business

(c) the suitability of the expense type for inclusion in a compulsory insurance product and the efficiency of the insurer's own administration and claims processes

(d) the insurer's best estimate of expenses, taking into account current internal management budgets and internal strategies to control costs.

Level of explanation

1.51 Filed assumptions for must be explained with sufficient information that an analysis of the filing can lead to a conclusion that the results stated in the filing:

(a) have been determined on a central or best estimate basis where required

(b) meet the adequate test under section 2.22(1)(a) of the Act

(c) represent a genuine effort on the part of the insurer to offer competitive premiums and thereby allow the Authority to form an opinion under section 2.22(1)(a) of the Act that the filed premium is adequate and not excessive.

1.52 The level of detail to be provided will depend on the price impact of the assumptions, the extent of the uncertainty surrounding the assumptions, the nature of the analysis and considerations of materiality as viewed by the Authority.

Insurance liability valuation report

1.53 Each licensed insurer must provide the Authority with a copy of its latest full valuation report (when it is completed, including all appendices) relating to its NSW CTP business. If a full valuation of the NSW CTP portfolio is conducted more frequently than annually, the insurer must provide the most recent full

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valuation report available. A comparison and explanation of any differences between the filed assumptions and the following assumptions from an insurer's NSW CTP portfolio insurance liability valuation report assumptions must be provided in filings:

(a) claim frequency assumed for premium liabilities†

(b) average claim size assumed for premium liabilities†

(c) superimposed inflation

(d) economic assumptions

(e) claim-handling expense assumed for premium liabilities†

(f) policy and administration expense assumed for premium liabilities†.

† If premium liabilities are not estimated at a given balance date, then the insurer should use the latest accident year/underwriting year. Claim frequency and average claim size may be considered in aggregate (for example, as a risk premium) if an insurer's adopted methodology for the full valuation does not enable such a breakdown.

1.54 Insurers must explain any developments in experience since the most recent full valuation as part of this comparison.

CTP business plan and management accounts

1.55 Each licensed insurer must provide the Authority annually with a copy of its current NSW CTP business plan and disclose all relevant business and distribution strategies when significant changes are made. Each licensed insurer must provide the Authority with a copy of its NSW CTP management accounts annually. In addition, the insurer must provide a:

(a) comparison of budgeted expenses and actual expenses for the previous filing period

(b) detailed budget of expenses covering the proposed filing period.

1.56 The above expense analysis should show the following expenses separately (to the extent they have been broken down as such in the management accounts):

(a) commission

(b) acquisition and policy administration expenses

(c) claims-handling expenses

(d) any other expense components itemised in the insurer's own management accounts.

Discount rate assumptions

1.57 Insurers must use rates of discount that are no less than the risk-free rates based on the forward rates implied from market information available at the time of preparing the filing, being applied to the average underwriting date of the period filed.

1.58 Insurers must disclose the single weighted average discount rate calculated by applying the payment pattern or expected weighted mean term for the claim liabilities underlying the policies to be underwritten to the insurer's adopted rates of discount.

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Maximum rates of assumptions used in the determination of premiums

1.59 The Authority is not bound by any of the maximum rates of assumptions if it considers that it would be unreasonable to apply them in the particular circumstances of the case. The Authority's intention in setting maximum rates of assumptions is to reflect current market conditions. Alignment to changing market conditions will be considered through periodical reviews. The following assumptions are subject to a maximum rate used in the determination of premiums:

(a) claims-handling expense assumptions must not exceed a rate of 7.5% of risk premium

(b) acquisition and policy-handling expenses, including commission and other remuneration, are subject to a maximum rate of $43.60 per policy (on average across the policies underwritten by an insurer), indexed with movement in CPI

(c) the superimposed inflation assumption must not exceed a rate of 2.5%

(d) the maximum profit margin for determining premiums is 8% of the proposed average gross premium (excluding levies and GST).

1.60 The Authority will review these maximum rates periodically. The motor accident filing template will include all maximum rates of assumption as amended.

1.61 Insurers may take into account allowances for innovation and efficiency that are forecast to improve scheme and policyholder outcomes to justify any assumption exceeding the maximum rates of assumptions currently prescribed by the Authority. To avoid doubt, the Authority may still reject the insurer's premium, notwithstanding compliance with this clause.

Risk equalisation mechanism (REM)

1.62 In determining proposed premiums, the insurer must consider any risk equalisation arrangements that the Regulation may impose under section 2.24(2) of the Act or in accordance with section 2.24(7) of the Act.

Calculating net REM amount

1.63 Insurers must calculate the net REM amount consistently with the Authority's motor accident filing template and Schedule 1D related to the filing period by:

(a) projecting the number of annualised policies to be issued for the filing period by each REM pool and for the total of other classes and regions that are not part of the REM pools

(b) multiplying the projected number of annualised policies for the filing period above by the REM $ amount for each REM pool prescribed by the Risk Equalisation Mechanism Deed

(c) the sum of all the REM amounts for all REM pools from the above clause divided by the projected number of annualised policies for all classes and regions (including those not in REM pool) for the filing period

(d) This result is the net REM amount per policy that is included in item 12a of Schedule 1C of these Guidelines.

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Portfolio analysis

1.64 Insurers must provide a portfolio analysis consistent with the format detailed in the Authority's motor accident filing template. The following information and analysis relating to portfolio mix must be provided:

(a) the expected future number and mix of insured vehicles by vehicle class and rating region at each bonus malus level, including commentary on strategies that are expected to result in any changed mix of business

(b) actual past number and mix of insured vehicles for the previous 12 months (for a period ending no earlier than two months before the rate filing is submitted) by vehicle class and rating region at each bonus malus level that applied for each policy written within that 12-month period

(c) for each REM pool, compare the projected mix of business from the last filing against actual mix, including a detailed explanation of any variation of projected mix from recent experience

(d) the net impact of the REM based on the projected mix

(e) the proposed use of bonus malus, and the basis on which they will be offered to all vehicle owners, including a complete description of the rating structure, each rating factor with relevant qualifying time periods, where applicable, definitions of generic terminology, a summary of the explicit changes in bonus malus since the previous filing and the impact on the insurer's required and expected average premium

(f) for all policyholders to be issued a renewal notice during the proposed filing period (assuming 100% retention), the distribution by numbers of policies experiencing a price increase/decrease (including Fund levy and GST) using incremental bands designated in the Authority's motor accident filing template compared to the actual premium paid for in force policies for each of the following vehicle classes (in Excel format):

- class 1 by rating region
- class 3c by rating region
- class 3d
- class 3e
- class 6a
- class 7 by plate type
- classes 10d, 10e, 10f, 10g and 10h combined
- classes 6d, 6e, 12b, 14, 15a, 15c, 17, 18b, 18c and 21 combined
- all remaining classes combined
- all classes combined in aggregate.

(g) the expected number of policies by underwriting quarter split by vehicle class, region, ITC entitlement, policy duration and at each bonus malus level, with premium income split by insurer premium,

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MAF levy, LTCS levy, MAITC levy, GST and total payable (in Excel format)

(h) the resulting average bonus malus factor for each vehicle class and rating region (in Excel format).

Sensitivity analysis

1.65 Insurers must undertake sensitivity analysis on key assumptions that are subject to significant uncertainty to quantitatively illustrate the impact of uncertainty on proposed premiums. Such sensitivity analysis includes the use of scenarios to test the impact of multiple assumptions simultaneously.

1.66 The extent of the variation assumed on key assumptions for sensitivity testing should reflect an alternate reasonable and plausible situation. Insurers must document the results of the sensitivity analysis in the filing report.

1.67 The Authority may provide guidance on the specific assumptions or scenarios to be tested and included in a filing before its submission.

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Motor accident filing template

1.68 The following documents and the Authority's motor accident filing template are to be attached to every filing report.

Schedule 1A

1.69 Insurers must provide the base premium, including GST but excluding Fund levy, for each vehicle classification and region for policyholders who are not entitled to any ITC (PDF version in filing report and Excel version using the Authority's motor accident filing template).

Schedule 1B

1.70 Insurers must provide a full description of the proposed bonus and malus structure and the actual amounts (after applying any rounding) proposed to be charged for each vehicle classification, region and bonus malus rate, subdivided into separate amounts of:

(a) GST

(b) insurance premium excluding GST

(c) Fund levy

(d) total payable by the policyholder.

1.71 Separate schedules are required for nil ITC premium rates and some ITC premium rates respectively, for both annual and short-term policies.

Schedule 1C

1.72 Insurers must provide a summary of the assumptions adopted and base premium filed (PDF version in filing report in the form specified in Table 1.2 and an Excel version using the Authority's motor accident filing template).

Table 1.2: Premium filing summary sheet

Item	Premium factors	Assumption
1a. Assumed frequency	Claims for an industry mix of vehicles (net of sharing and nominal defendant)	%
1b.	Relativity of the claims frequency for the insurer's mix of vehicles to the claims frequency for an industry mix of vehicles	
1c.	Claims for insurer (net of sharing and nominal defendant)	%
2a. Average claims size, start of underwriting period	Claims in current dollar values for an industry mix of vehicles (gross of reinsurance, net of sharing and nominal defendant)[1]	$
2b. Average claims size, start of underwriting period	Claims in current dollar values for insurer (gross of reinsurance, net of sharing and nominal defendant)[1]	$

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Item	Premium factors	Assumption
3a. Average claims size for filing period	Claims for an industry mix of vehicles for filing period (from item 2), fully inflated and discounted to the middle of the period filed[1]	$
3b.	Relativity of the claims average claim size in current dollar values for the insurer's mix of vehicles to the claims average claim size in current dollar values for an industry mix of vehicles	
3c. Average claims size for filing period	Claims for insurer for filing period (from item 2c) fully inflated and discounted to the middle of the period filed[1]	$
4.	Insurer average risk premium (formula used to combine above assumptions to arrive at average risk premium) (1c x 3c)[1,2]	
5. Average risk premium	Excluding GST calculation (substitute values in formula)[1]	$
6. Acquisition and policy-handling expenses, including commission	Per cent gross premium excluding GST and Fund levy	$
7. Claims-handling expenses	Per cent gross premium excluding GST and Fund levy	%
8. Net cost of reinsurance loading	Per cent gross premium excluding GST and Fund levy	%
9. Other assumptions	Specify nature and value of assumption	%
10. Profit margin	Per cent gross premium excluding GST and Fund levy	%
11. Average premium	Formula used to arrive at average premium excluding GST and Fund levy) ((5 + 9)/(1 - (6 + 7 + 8 + 9 + 10))[2]	
12.	Excluding GST and Fund levy (substitute values in formula)[1]	$
12a.	Net overall impact of the REM (net REM $ per policy) (refer to the Authority motor accident filing template D3)	$
12b.	Required average premium (item 12 less item 12a)	$
13.	Ratio class 1 metro to average premium calculated in accordance with the formula in 'Ratio of insurer's average premium to class 1 metro' section of this Part of the Motor Accident Guidelines	

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Item	Premium factors	Assumption
14. Bonus malus	Bonus malus factor calculated in accordance with formula in 'Bonus malus factor' section of this Part of the Motor Accident Guidelines	
15. Class 1 metro premium	Nil ITC class 1 metro base premium excluding GST and Fund levy (12b ÷ 13 ÷ 14)	
16.	Nil ITC class 1 metro base premium including GST but excluding Fund levy	$
17.	Minimum nil ITC class 1 metro premium including GST but excluding Fund levy (ignoring premiums calculated using a bonus factor of less than 80%)	$
18.	Minimum nil ITC class 1 metro amount payable by policyholder including GST and Fund levy (ignoring amounts calculated using a bonus factor of less than 80%)	$
19.	Maximum nil ITC class 1 metro amount payable by policyholder including GST and Fund levy	$
20.	Loading applied to nil ITC premium rates to calculate some ITC premium rates (0% ITC premium rates)	%
21.	MAF levy (class 1 metro)	$
22.	Administrative costs loading for quarterly policies (X)	$
23.	Forgone investment income loading for quarterly policies (Y)	%
24.	Administrative costs loading for half-yearly policies (A)	$
25.	Forgone investment income loading for half-yearly policies (B)	%
26.	Period premiums are proposed to apply	

Notes:

1. Estimates of average claim sizes and average premiums must be those applicable to the nil ITC premium rates; that is, calculated as if no policyholders have any entitlement to an ITC, and as if the insurer has an entitlement to decreasing adjustments or ITC for all claims costs directly attributable to specific policies. The loading applied to nil ITC premium rates to calculate the insurer's some ITC premium rates is then shown as item 20.
2. Use item number for formula description.

Schedule 1D

1.73 Insurers must provide details of the calculation of the net REM amounts in the form specified in the Authority's motor accident filing template.

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Schedule 1E (transition period only)

1.74 Insurers must provide a summary of assumptions as per Schedule 1E, in the form specified in Table 1.3.

Table 1.3: Summary of claim assumptions

Assumption description (column A)	Premium parameters (column B)	Insurer's adjusted assumption for the industry (column C)	Relativity of insurer assumption to industry assumption (column D)	Insurer assumption (column E)
Claims frequency: at-fault (AF) minor injury claims	0.036%			
Claims frequency: not at-fault (NAF) minor injury claims	0.086%			
Claims frequency: NAF claims WPI >10%	0.026%			
Claims frequency: NAF claims WPI <=10%	0.038%			
Total claims frequency	0.209%			
Average claims size (ACS): AF claims (15/01/21 dollars)	$16,800			
ACS – NAF minor injury claims (15/01/21 dollars)	$5,700			
ACS: NAF claims WPI >10% (15/01/21 dollars)	$520,600			
ACS: NAF claims WPI <=10% (15/01/21 dollars)	$131,100			
Total ACS all claims (15/01/21 dollars)	$101,700			
Total ACS (inflated/discounted and 15/07/21 dollars)†	$115,200			
Weighted average duration of payments (15/01/21 dollars)	4.17			
Claims inflation: wage inflation (overall weighted average)	2.22%			

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Claims inflation: superimposed inflation (overall weighted average)	1.57%
Discount rate (overall weighed average)	0.80%
Risk premium: inflated and discounted risk premium for underwriting year beginning 15 January 2021†	$241
Claims-handling expense (% of risk premium)	7.50% ($18.05)
Net reinsurance expense	$1.20
Policy and acquisition expense	$43.60
Profit margin (% of premium excl. GST and levies)	8.00% ($26.39)
GST (10%)	$32.99
Insurer premium (incl. GST)	$363
MAF levy	$44.37
LTCS levy	$83.11
MAITC levy	$12.35
Total premium payable (incl. GST and levies)	$503

Uninflated undiscounted average claim size in 15/1/21 dollars

Totals may not add due to rounding

† Discounted to the middle of the underwriting year beginning 15 January 2021 (i.e. 15 July 2021)

Description of each column

Column A: describes the type of assumption.

Column B: sets out the Authority's scheme-wide premium parameters for the industry to achieve the overall $503 target average premium.

Column C: insurer industry assumption for an industry mix of business - allows for comparison against the Authority's independent actuary assumptions in column B.

Column D: relativity of insurer assumption to industry assumption to allow for differences in the insurer's portfolio of risks to be better or worse experience than the industry before business mix adjustment (which is based on the mix by class/region from relativities) and any other claims-related differences.

Column E: insurer assumption.

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Other notes

- Total claims frequency for column C should be the same figure as in item 1a in Schedule 1C.
- Total claims frequency for column E times the relativity for the insurer's mix of vehicles should be the same figure as in item 1c in Schedule 1C.
- Average claims size (15/01/21 dollars) for column C should be the same figure as in item 2a in Schedule 1C.
- Average claims size (15/01/21 dollars) for column E times the relativity for the insurer's mix of vehicles should be the same figure as in item 2b in Schedule 1C.
- Average claims size (inflated/discounted dollars) for column E times the relativity for the insurer's mix of vehicles should be the same figure as in item 3c in Schedule 1C.
- Column E for risk premium (fully inflated and discounted to the middle of the period filed) should be the same figure as in item 5 in Schedule 1C.
- For the accident period referenced above, the following is relevant:
    - The period represents accidents that occur from 15 January 2021 to 14 January 2022.
    - The period represents statutory benefit claims that will be reported from 15 January 2021 to 14 April 2022 allowing for the statutory 3 months reporting period. There will also be claims reported after 14 April 2022 that may also be accepted as valid statutory benefit claims depending on the circumstance of their lodgement (known as late claims). Only after all of the late claims have been reported and accepted will the actual number of statutory benefit claims be known i.e. after 14 April 2022.
    - The period represents claims for damages that will be lodged from 15 January 2021 (for claims assessed at greater than 10% whole person impairment) and from 15 September 2022 (for claims assessed at equal to or less than 10% whole person impairment) to 14 January 2025. There will also be claims for damages lodged after 15 January 2024 (for accidents on 15 January 2021) and after 14 January 2025 (for accidents on 14 January 2022) that may also be accepted as valid claims.

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Part 2 of the Motor Accident Guidelines: Market practice

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Market practice

Definitions

2.1 Table 2.1 shows the meanings of terms used in this part of the Motor Accident Guidelines.

Table 2.1: Terms used in this part of the Motor Accident Guidelines

Term	Definition
Distribution channel	A mechanism or method through which licensed insurers issue and administer third-party policies. This can include but is not limited to agents, telephone call centres, the internet and over-the-counter operations.
eGreenSlip	The electronic notification of a third-party policy by an insurer to Roads & Maritime Services.
Input Tax Credits (ITC)	That is, the credit an entity registered for GST can claim for any GST included in the third-party premium paid.
Roads & Maritime Services (RMS)	A NSW statutory authority constituted by the *Transport Administration Act 1988* (NSW).

Introduction

2.2 The Guidelines are issued under Part 9, Division 9.2, section 9.16 of the Act, to provide the regulatory framework for issuing of third-party policies by licensed insurers.

2.3 These Guidelines are principles-based. They articulate a set of objectives for issuing of third-party policies and expectations for standards of market practice for insurers. The Authority's adoption of principles-based regulation of market practice is intended to:

(a) encourage flexibility and innovation in the delivery of services to third-party insurance customers

(b) promote a competitive market for all insurers and encourage insurers to act in good faith when interacting with customers.

2.4 Insurers' market practice, including distribution arrangements, must align with these Guidelines and not contravene these Guidelines.

2.5 To further assist compliance with these Guidelines, the Authority may publish practice notes.

Commencement and revocation of previous Guidelines

2.6 These Guidelines are effective for market practice from 18 December 2020 and will remain in force until they are amended, revoked or replaced in whole or in part.

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Application of these Guidelines

2.7 The Authority will monitor and review compliance with these Guidelines, which may include audits of insurers from time to time.

2.8 Internal auditing of compliance with these Guidelines must form part of each insurer's own risk management and compliance program. Insurers have a responsibility to report to the Authority any results of audit programs conducted on issuing third-party business.

2.9 If the Authority regards an insurer or any intermediary acting on behalf of the insurer as having breached the Guidelines, the Authority may take regulatory and enforcement action, in accordance with its regulatory and enforcement policy.

2.10 All contracts or arrangements entered into by the insurer in relation to a quote and sales services for third-party policies must comply with these Guidelines.

Guiding principles

2.11 When issuing, administering or renewing third-party policies, the insurer and their agents must:

(a) act in good faith with all customers

(b) use processes and business practices that do not unfairly discriminate against individual customers or groups of customers

(c) engage in processes and business practices that are transparent and practical for the purpose of issuing policies to customers

(d) make third-party policies readily accessible and available to all customers.

Acting in good faith

2.12 The Authority's regulation of premiums includes an element of community rating, as some policies are underpriced and others overpriced relative to insurance risk. Accordingly, it may be in the insurers' financial interests to build portfolios that are overweight in low risk (overpriced) policies. Notwithstanding such financial interests and the REM, under Division 2.3, section 2.24 of the Act, insurers must make third-party policies available to all customers in a manner that complies with all of the guiding principles. In particular:

(a) insurers and their agents are required to issue policies to all properly identified vehicles

(b) insurers must avoid distribution methods and sales techniques that prejudice this obligation in any way.

Processes and business practices that do not unfairly discriminate

2.13 Insurers and their agents must use processes and business practices that do not unfairly discriminate against individual customers or groups of customers. This applies to each distribution channel.

2.14 Each insurer and its agents must apply reasonable service standards to their processes and business practices. The Authority may impose standards or restrictions on any or all insurers and their agents for specific or general circumstances where it is considered to be in the public interest.

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2.15 With the exception of pricing differentiation permitted under Part 1 of the Motor Accident Guidelines: Premium determination, the insurer and their agents must treat customers in the same manner, irrespective of the risk profile of the vehicle or its owner, or the terms of the policy.

2.16 All existing customers who are due to receive a renewal notice must be provided with a renewal notice/offer within the prescribed timeframes as specified in this Part of the Guidelines. A delay in sending renewal notices may only occur with prior approval from the Authority.

2.17 Insurers must not refer customers to other insurers or encourage customers to take their business elsewhere. Agents must not refer customers to insurers unless they have an agency arrangement with them.

2.18 Insurers must not advise customers of the prices offered by other insurers. Agents must not advise customers of prices offered by insurers unless they have an agency arrangement with them.

Transparent and practical processes and business practices

2.19 All information provided to customers must be clear and accurate, expressed in plain language and not in any way misleading.

2.20 Insurers and their agents must only charge premiums as filed and approved by the Authority. Insurers are to categorise vehicles correctly and charge the correct filed premium for that category. In order to charge the correct premium, insurers and their agents must take into account all risk factors approved by the Authority and the ITC status used to determine the customer's premium.

2.21 All agents contracted by an insurer to provide quotes and sales must ensure they disclose to customers the identity of all insurers they have a commercial arrangement with before they proceed with quotes or sales. Neither the insurer nor their agent may enter into a commercial arrangement with another agent or third party that accesses data from the Authority's Green Slip Price Check without the relevant insurer first obtaining the Authority's permission. The Authority will not unreasonably withhold such permission.

2.22 Where requested by a customer, insurers must act promptly and expeditiously when sending documents by mail or electronically:

(a) all documents agreed to be sent by mail must be lodged with Australia Post within three business days of agreeing to do so

(b) all documents agreed to be sent electronically must be sent within 24 hours of agreeing to do so

(c) should technology outages occur, the documents must be sent within 24 hours of the insurer's systems being repaired.

2.23 Offers of renewal, including eRenewals, must be sent at least four weeks and no more than six weeks in advance of the expiry date.

2.24 All information regarding third-party policies must be sent to each customer by post unless they have consented to receiving policy information electronically.

2.25 Where an incorrect address has been used, including returned letters and failed emails, insurers must take reasonable steps to correctly issue the policy information.

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2.26 When a customer purchases a third-party policy or renewal or new registration, the insurer must electronically transmit an eGreenSlip to RMS within the timeframes shown in Table 2.2. Regulatory relief timeframes apply during the health emergency caused by the COVID-19 pandemic in the period starting on 17 April 2020 and ending on the day that is 12 months after that date.

Table 2.2: Timeframes for insurers electronically transmitting an eGreenSlip

Method of payment	Requirement	Regulatory relief during COVID-19 pandemic
Directly to the insurer via a branch, telephone or electronic means	Within 1 hour of payment	Within 48 hours of payment
To the insurer's agent, including Australia Post	Within 5 business days of payment	Within 7 business days of payment
By BPAY	Within 3 business days of payment	Within 5 business days of payment
By mail to the insurer	Within 5 business days of the date of postage	Within 7 business days of the date of postage

2.27 A written quote or a renewal notice/offer for a third-party policy must:

(a) clearly communicate all relevant pricing factors applied to the third-party policy or quotation

(b) provide information about how to raise any incorrect pricing factors with the insurer or its agent, before the purchase

(c) disclose the name of the licensed insurer and if they operate under a trading name that is different from the licensed insurer name, the quote or offer must disclose both the trading name and the insurer name

(d) provide contact details for third-party policy queries

(e) detail the timeframe for eGreenSlips to be sent to RMS, including the timeframe associated with purchasing through different channels.

2.28 Common Expiry Date Fleets and Multiple Expiry Date Fleets are exempt from the transparency requirements of pricing factors. Private use vehicle classes 1, 10 and 3c are not exempt and must show the pricing factors used on Green Slips. For example, age of youngest driver, age of vehicle etc.

2.29 All customer communication must include any information required by the Authority. Insurers must ensure they and their agents use specific scripts when required by the Authority.

Readily accessible and available

2.30 Third-party policies (both quotes and sales) must be readily accessible and available to all customers. Insurers are required to give prompt, uniform access and availability to all customers who approach them, irrespective of the risk characteristics of the vehicle and its owner. Insurers may use a range of distribution channels provided that every customer has ready access to their third-party policy through at least one of those channels. Insurers must not use distribution channels to avoid sales. In particular:

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(a) insurers and their agents must not refuse to provide a third-party quote for any motor vehicle required to be insured under the Act

(b) insurers and their agents must provide customers with the ability to obtain a quote for any vehicle or vehicle class without the need to identify themselves or their vehicle's registration number

(c) insurers and their agents must make reasonable efforts to help customers provide accurate information to determine the correct premium

(d) insurers must provide customers with at least one payment option for a quote or renewal offer that is available 24 hours a day, seven days a week.

Schedule 2A: Circumstances for refusal to provide a third-party policy

2.31 This schedule relates to the section 'Readily accessible and available'.

2.32 Insurers and their agents may refuse to issue a third-party policy in the following circumstances:

(a) where the customer does not pay the required premium, the Fund levy and GST, for the third-party policy within the timeframe as agreed between the customer and the insurer or agent

(b) where the vehicle is recorded as a statutory written-off vehicle on the NSW written-off vehicles register (WOVR)

(c) where the customer is seeking to purchase a new third-party policy from an insurer and the customer does not provide the correct key identifiers used to locate and retrieve information held by RMS.

2.33 Key identifiers are:

(a) registration ID (also known as billing number) and plate number, or

(b) a combination of a customer identifier, one of:

- NSW driver or rider licence number of the vehicle owner
- NSW photo card number
- RMS customer number, and

a vehicle identifier, one or a combination of:

- vehicle identification number (VIN)
- chassis number
- engine number
- plate number.

Breaches and temporary regulatory relief arrangements

2.34 Insurers must notify the Authority of any breach of these Guidelines.

2.35 The Authority may consider a temporary relief from an enforcement response if an insurer is unable to issue timely third-party policy renewals due to unforeseen system issues.

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2.36 An application for temporary regulatory relief can be made in writing to the Authority at any time. The Authority will take into account:

(a) the reasonableness of the request

(b) the length of time the relief is requested

(c) community requirements and priorities

(d) other relevant factors.

2.37 The Authority will respond to requests in a timely manner and, where appropriate, work with the insurer to help it comply with the Guidelines as soon as possible.

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Part 3 of the Motor Accident Guidelines: Business plans

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Business plans

Requirements of the business plan

3.1 Under Division 9.2, section 9.18 of the Act, each insurer must prepare and deliver to the Authority a Motor Accident Business Plan (business plan) as soon as practicable after it is requested to do so by the Authority.

3.2 Insurers are to prepare and deliver to the Authority a business plan on, or not more than 30 days after, each anniversary of the grant of their licence. Insurers are also to prepare and deliver a revised business plan before implementing any significant change to the conduct of their third-party insurance business (including but not limited to strategy in respect of claims handling, pricing or product distribution).

3.3 If the insurer operates more than one third-party insurance business (for example, the insurer issues third-party policies under multiple brands), then the insurer must prepare and deliver a business plan covering all of the third-party insurance businesses and any business associated with third-party policies of the insurer either in a single business plan (highlighting where the practices of the businesses/brands differ from one another) or separate business plans for each.

3.4 A business plan prepared by a licensed insurer under section 9.18 must include:

(a) a complete description of the manner in which the third-party business is to be conducted (including but not limited to claims handling, management, expenses and systems). The description must:

- include the structure and operating methods for each distribution channel and any plans for change within the next 12 months
- demonstrate how the insurer's conduct, culture and appetite for risk in the business satisfies the principles and objectives of insurance, benefits and support under the Act and in these Guidelines. Culture and appetite for risk is not limited to Schedule 3A

(b) a letter from the board of directors of the insurer to the Authority (whether signed by the directors, or on behalf of the directors by an officer authorised to sign on their behalf) confirming present and continuing compliance with Australian Prudential Regulation Authority's (APRA) Prudential Standard CPS 232 or, if replaced, with the APRA prudential standard addressing business continuity management by authorised general insurers, including the development and maintenance of a business continuity plan.

3.5 The Authority may require further details by notice in writing in order to clarify the business plan. Insurers may be required by notice in writing to provide the Authority with reports on any aspect of their market practice and their compliance with these Guidelines, in a format and timeframe determined by the Authority.

3.6 Insurers must notify the Authority of any breach of these Guidelines.

3.7 Insurers must, on request from the Authority, submit copies of their customer communication templates, including third party certificates and customer information packs.

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3.8 When requested by the Authority, insurers must submit scripts, training manuals and other supporting tools used by sales staff for review and approval. Each insurer must, on request from the Authority, provide other documents related to third-party policies.

3.9 Insurers must amend any document submitted to the Authority if required to do so by the Authority.

Schedule 3A: Culture requirements for insurers

3.10 An insurer's business plan must include the matters enumerated in this section relating to the alignment of institutional culture with the objects of the Act.

3.11 A definition of the insurer's target institutional culture.

3.12 A detailed plan of the steps to be taken:

(a) to maintain or, if necessary, create an institutional culture directed to:

- openness and transparency in dealings with the Authority
- openness in the exchange of views, challenge and debate internally in relation to matters of management, regulatory compliance, claims handling and customer service
- adaptability to changing regulatory, commercial and policyholder demands
- prioritisation of customer service and outcomes, including the early resolution of motor accident claims and the quick, cost-effective and just resolution of disputes
- appropriate and balanced incentive structures, remuneration and performance metrics
- the understanding by the insurer's senior managers, and the insurer's employees generally, of the insurer's values and how they are applied in practice

(b) to embed, monitor and (where appropriate) effect changes to the insurer's institutional culture as it relates to each of the matters outlined in the above clause.

3.13 Details of:

(a) arrangements for conducting an annual employee engagement survey

(b) processes for assessing the results of employee engagement surveys.

3.14 Details of the:

(a) mechanisms established for personnel to elevate and report concerns about practices within the insurer, even when not making any specific allegation of wrongdoing

(b) processes for assessing such reports and identifying and addressing any unsatisfactory practices.

3.15 Details of:

(a) key performance indicators that apply to personnel engaged in the insurer's third-party insurance business (including claims handling, management, expenses and systems)

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(b) the processes for assessment of personnel against those key performance indicators and the effectiveness of those key performance indicators to influence desired behaviours.

3.16 Details of the processes for:

(a) annual independent assessment of the insurer's institutional culture as it relates to the matters enumerated in clause 3.12 (above)

(b) development of action items arising out of this assessment

(c) implementation of these action items.

3.17 An explanation of the organisational structures to monitor the effectiveness of, and ensure accountability for, the arrangements, mechanisms, processes and performance metrics enumerated in clauses 3.13 to 3.16 (above).

3.18 An explanation of the governance structures by which the board of directors of the insurer will form a view of the risk culture in the institution and the extent to which that culture supports the ability of the institution to operate consistently within its risk appetite, identifies any desirable changes to the risk culture and ensures the institution takes steps to address those changes.

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Complaints

3.19 A complaint is an expression of dissatisfaction made to the insurer or its agent related to its products or services, or the complaints-handling process itself, where a formal response or resolution is explicitly or implicitly requested.

3.20 All complaints made to the insurer or its agents in relation to a third-party policy or claim must be handled in a fair, transparent and timely manner.

3.21 A robust complaints-handling process provides the complainant with confidence that they are heard, their feedback is taken seriously, and insurers are accountable for their actions. The insurer must have a documented internal complaint and review procedure, the terms of which must be set out in the insurer's business plan.

3.22 Information about how to make a complaint and the complaints-handling procedures must be readily available and accessible to all stakeholders.

3.23 Complaints-handling procedures must refer to the rights of the customer to escalate a complaint to the Authority if they are dissatisfied with the insurer's response to their complaint.

3.24 The insurer must acknowledge all complaints in writing within 5 business days of their receipt. The acknowledgement must include:

(a) if the insurer can resolve the complaint to the satisfaction of the complainant within 5 business days from the receipt of the complaint – the insurer's written decision resolving the complaint

(b) if the insurer cannot resolve a complaint to the satisfaction of the complainant within 5 business days from the receipt of the complaint – a copy of the insurer's complaints procedure and the contact details of the representative(s) of the insurer handling the complaint.

3.25 If the insurer cannot resolve the complaint to the satisfaction of the complainant within 5 business days, the insurer must resolve the complaint within 20 business days from the date of receipt and notify the complainant in writing of:

(a) the insurer's decision and the reasons for that decision

(b) the opportunity to have the complaint considered by a more senior representative of the insurer who is independent of the original decision-maker

(c) information on the availability and the contact details of external complaint or dispute resolution handling bodies (including the Authority) in the event that the complainant is dissatisfied with the insurer's decision or procedures.

3.26 Insurers must keep a record of all complaints they or any of their agents receive in a complaints register and provide a summary report to the Authority every six months. This report is due within 30 business days of the end of the 30 June and 31 December reporting periods. It should be formatted as set out by the Authority and include a complaints trend analysis of the risks and potential issues.

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Information and data integrity

3.27 Information and data integrity is critical to the scheme and to demonstrating insurer performance. Accurate, up-to-date and complete information promotes the credibility and accountability of the scheme and those operating within it.

3.28 At the direction of the Authority, an insurer must provide timely, accurate and complete information, including but not limited to:

(a) insurer claims manuals, policies and procedure documents, including updates as they occur

(b) policyholder and claimant information packs

(c) standard letter templates

(d) self-audit results, including quality assurance reporting

(e) complaints received by the insurer about its handling of matters

(f) policyholder and claimant survey results

(g) training plans and logs, and/or data breaches that affect the privacy of a policyholder, claimant or their family.

3.29 An insurer must:

(a) code the claimant's injuries by using appropriately trained coders applying the Abbreviated Injury Scale (AIS) 2005 Revision (or as otherwise prescribed by the Authority) and claims in accordance with the Authority's Motor Accident Insurance Regulation Injury Coding Guidelines and agreed timeframes

(b) provide up-to-date, accurate and complete claims data to the Motor Accidents Claims Register, in accordance with the Act and the claims register coding manual, as amended, or as otherwise required by the Authority

(c) inform the Authority of any data quality issues as soon as the insurer becomes aware

(d) maintain consistency between information on the claim file and data submitted to the claims register and record any changes in accordance with the claims register coding manual, as amended.

3.30 If the Authority becomes aware of any data quality issues, the Authority may request the insurer to resubmit the data and provide information on data quality controls.

3.31 Insurers must comply with any Authority requirements for data exchange and centralised claim notification. Insurers must participate in online claims submission as determined by the Authority.

3.32 Insurers must retain digital claims files information and data for a minimum of:

(a) 30 years after the date the claim was made, or

(b) 30 years after the claimant turns 18 years of age, whichever is later.

3.33 Where an insurer notifies customers, claimants, service providers and/or the Australian Information Commissioner of a Notifiable Data Breach (in accordance with the *Privacy Act 1988*), the insurer must, at the same time, also notify the Authority. The notification to the Authority must:

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(a) confirm that the insurer has fully complied with the law in terms of the notification

(b) confirm that the insurer has investigated, or is investigating, where and why the breach occurred

(c) set out what steps are being taken or have been taken to remedy the breach and future breaches

(d) set out what has been, or is being, suggested to rebuild trust with the affected claimants, customers and/or other stakeholders in terms of the handling of their personal and health information.

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Self-assessment

3.34 An insurer must undertake self-assessment of its compliance with the Act and Guidelines in its claims management practices annually or more frequently as directed by the Authority, using SIRA's Self-Assessment Tool.

3.35 An insurer must provide a self-assessment report to the Authority. This report must include the insurer's assessment of its compliance and any failure to comply (non-compliance) with legislative, guideline and case management practice requirements.

3.36 Where an insurer identifies one or more instances of non-compliance, the insurer's self-assessment report must:

(a) set out the nature of non-compliance and if and how it has affected claimants and their entitlements under the Act

(b) advise if the same non-compliance has occurred before

(c) explain the action the insurer has taken to investigate the extent of the non-compliance

(d) explain the action the insurer has or is taking to remedy the non-compliance

(e) explain the insurer's monitoring/auditing strategy to avoid any ongoing or similar future non-compliance

(f) set out the timeframes to resolve the non-compliance.

3.37 The insurer must confirm in writing to the Authority when the non-compliance has been resolved.

3.38 The Authority may conduct a review of an insurer's self-assessment at any time by auditing the insurer's files.

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Part 4 of the Motor Accident Guidelines: Claims

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Contents

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Claims

Application of the Guidelines

4.1 These Guidelines commence on 18 December 2020 and apply to all current and future claims made on insurers in respect of motor accidents that occur on or after 1 December 2017. They apply until they are amended or replaced.

4.2 The Motor Accident Guidelines: 'Claims handling & medical (treatment, rehabilitation & care)', which were issued by the Authority on 1 January 2017, continue to apply to claims in respect of motor accidents occurring on and from 5 October 1999 to 30 November 2017.

Introduction and purpose

4.3 These Guidelines are made under the *Motor Accident Injuries Act 2017* (NSW) (the Act), including Division 6.1 of the Act. They make provision with respect to the manner in which insurers and those acting on their behalf are to deal with claims.

4.4 These Guidelines are to be read together with relevant provisions of the Act and Regulation. They are ordered in accordance with the claimant journey to help insurers read them in conjunction with the Act and Regulation, and to progress claims promptly.

Principles

4.5 Insurers and those acting on their behalf are to deal with claims in a manner consistent with the objects of the Act, the below principles and the general duties under Division 6.2 of the Act.

4.6 These principles apply across all claims management aspects for the life of a claim:

(a) proactively support the claimant to optimise their recovery and return to work or other activities

(b) make decisions justly and expeditiously

(c) act objectively with honesty and professionalism at all times

(d) detect and deter fraud

(e) communicate with the claimant and keep them informed of the progress of their claim

(f) take into account the health emergency caused by the COVID-19 pandemic on a claimant's circumstances when making decisions about a claim, including decisions related to disputes, and the claimant's ability to comply with obligations or timeframes under the Act, regulations or these Guidelines.

4.7 If an insurer does not deal with claims in a manner consistent with these principles, the Authority will take appropriate action as per the Authority's compliance and enforcement strategy.

4.8 In circumstances where more than one insurer is involved in the management of a claimant's statutory benefits claim and/or damages claim, the insurers must:

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(a) proactively and regularly share information with each other

(b) promptly respond to requests from each other

(c) ensure the claimant understands which insurer will be managing each aspect of the claim process and the reasons why

(d) work collaboratively to ensure a consistent and seamless claim experience for the claimant.

Communication with claimants

4.9 When communicating with claimants, insurers must:

(a) communicate directly with the claimant to deal with the claim, regardless of whether the claimant is legally represented, unless the clause below applies

(b) where a *friend* assists the claimant with the claim, communicate directly with that friend instead of, or in addition to, the claimant, as appropriate, regardless of whether the claimant is legally represented

(c) if requested in writing to do so by the claimant, friend or the claimant's legal representative, copy the claimant's legal representative into all written correspondence

(d) in this clause: *friend* means a person, including a family member, who is assisting the claimant with the claim and has authority from the claimant to give and receive information about the claim. It does not include a legal representative acting on instructions. The claimant can revoke the authority at any time by notifying the insurer or can limit the friend's authority to a specified timeframe.

4.10 If a dispute arises between the insurer and a legally represented claimant and is before the Dispute Resolution Service (DRS), the insurer is not to communicate with the claimant directly about the dispute and must communicate only with the claimant's legal representative.

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Making a statutory benefits claim

Verifying motor accident

4.11 As per Division 6.3, section 6.8 of the Act, to verify a motor accident before making a claim for statutory benefits, a claimant should:

(a) report the accident to the NSW Police Force within 28 days after the accident, unless a police officer attended the motor accident, and

(b) provide the accident event number from the NSW Police Force to the insurer if available.

4.12 If a claimant cannot provide the accident event number, the insurer must request other information from the claimant to verify the motor accident. Information requested may include:

(a) photographs taken at the scene of the accident

(b) witness statements

(c) a hospital discharge summary

(d) media reports

(e) property damage insurance claim information

(f) CCTV or dashcam footage.

4.13 If the claimant cannot provide the information requested by the insurer, they must provide a statutory declaration explaining why. It should include whether or not the NSW Police Force provided an accident event number.

4.14 Division 6.3, section 6.9 of the Act provides for the circumstances in which a claim may be dealt with even though the claimant has not met the above requirements.

Time for making a statutory benefits claim

4.15 As per Division 6.3, section 6.12 and section 6.13 of the Act, to make a claim for statutory benefits, a claimant must give notice of the claim to the relevant insurer within the following timeframes:

(a) three months after the date of the motor accident to which the claim relates, or

(b) to be entitled to receive weekly payments of statutory benefits from the day after the date of the motor accident, within 28 days after the date of the accident.

4.16 Where the at-fault vehicle is unidentified or uninsured, a statutory benefits claim must be made on the Nominal Defendant within 28 days after the date of accident to be entitled to receive weekly payments of statutory benefits from the day after the date of the motor accident.

4.17 If a claim is made on the CTP insurer of the vehicle alleged to be at fault in the accident and the CTP insurer is not a licenced insurer under the Act, the insurer must notify the Authority of the claim as soon as possible.

Notice of a statutory benefits claim

4.18 As per Division 6.3, section 6.15(1)-(3) of the Act, a claimant can give a notice of a claim either:

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(a) online using the online claims submission system operated by the NSW government, or

(b) in writing using the claim form available on the Authority's website and sent to the insurer by email, personal delivery, facsimile or post.

4.19 The notice must be given in the following manner and must contain the following information:

(a) For notice of a claim for statutory benefits for a personal injury claim using:

- the *CTP Green Slip claim form – Application for personal injury benefits* containing the information relevant to the claim as set out in Table 4.1 of Schedule 4.1, or
- the *CTP Green Slip claim form – Online Application for Personal Injury Benefits* containing the information relevant to the claim as set out in
- Table 4.2 of Schedule 4.1.

(b) For notice for a claim for statutory benefits for funeral expenses using:

- the *CTP Green Slip claim form – Application for funeral expenses* containing the information relevant to the claim as set out in
- Table 4.3 of Schedule 4.1.

4.20 A claimant must provide a signed authority within the claim form authorising the insurer to release information and documents to relevant parties, and obtain information and documents relevant to the claim.

4.21 In claims for personal injury, a claimant must also provide a certificate from a treating medical practitioner such as a certificate of fitness (available on the Authority's website).

4.22 A licensed insurer must enable a notice of claim for statutory benefits for personal injury to be received electronically in the following manner:

(a) as a single transfer of data from the NSW government's online claims submission system directly to the insurer's *Electronic claims-handling system*, or

(b) as a transfer of data to the *Insurer portal*, but only if the Authority grants permission to the insurer for a specified period of time.

For the purposes of this clause:

Electronic claims-handling system means an electronic system designed to enable an insurer to hold information about CTP claims made on it.

Insurer portal means the system maintained by the NSW Government which insurers can use to download attachments submitted by claimants (including the claim summary PDF form) and to enable the making of a claim.

4.23 If a claimant gives a notice of claim via the online claims submission portal, the notice must be made available electronically to the insurers when the claimant (or their representative) receives an email notification and reference number confirming a successful transmission.

4.24 If a claimant contacts the insurer by phone and provides the required details, the insurer must send a pre-filled claim form to the claimant for their review

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and declaration that the information is correct. Notice of the claim is not given until the completed form is returned to the insurer.

4.25 The insurer must acknowledge the date of receipt of the claimant's claim form, the assigned claim number and the dedicated insurer contact assigned to manage the claim, in the communication method preferred by the claimant.

4.26 In accordance with Division 6.3, section 6.15(4) of the Act, if notice of a claim has been given to an incorrect insurer and the claim must be transferred to the relevant insurer, the claimant is excused from giving notice of a claim to the relevant insurer. The insurers must cooperate so that the necessary information is exchanged, and the claimant's recovery and benefits are not adversely affected.

Sharing Agreements

4.27 If more than one vehicle is involved in the accident and the insurers agree to share the claims between or among themselves, a relevant insurer will be nominated by the insurers to manage the claims on behalf of all the insurers.

4.28 Until the relevant insurer has been nominated, the insurers on whom the claims are made must continue to manage the claims.

4.29 When the relevant insurer has been agreed to and appointed, the insurers on whom the claimant has made a claim must each immediately write to the claimant and inform the claimant:

(a) that the sharing agreement has been applied

(b) the name, contact details and reference number of the relevant insurer

(c) the role of the relevant insurer in managing all the claims,

and provide a copy of this notice to the relevant insurer.

4.30 Insurers must communicate in a clear and timely manner and give sufficient information to enable the claimant to progress the claim, including where the sharing agreement is relevant. The insurer must not require the claimant to gather evidence as to fault or as to other matters that are not needed in the circumstances. Any sharing disputes between insurers must not impede the delivery of statutory benefits to the claimant.

4.31 If the claim is transferred after resolution of the dispute, the insurer must contact the claimant and advise the reasons for the transfer of the claim and the date of the official transfer. Notice of the transfer must be given to the claimant by all insurers within two days of the transfer.

Liability decisions in a statutory benefits claim

4.32 Acceptance of liability for a claim for statutory benefits is detailed in Division 6.4, section 6.19(1)-(8) of the Act.

4.33 The insurer must give written notice to the claimant to confirm if the insurer accepts or denies liability for the payment of statutory benefits, including when the decision will take effect and how it will take effect (for example, weekly payments will be paid fortnightly for a specific amount each week).

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

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

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

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

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

(e) a list of all information relevant to the decision, regardless of whether the information supports the decision. The insurer must provide copies of all listed information to the claimant, unless the information has previously been provided to the claimant

(f) an explanation of the insurer's internal review process, including the timeframe in which an application for internal review must be made and/or right to make an application to DRS

(g) an explanation that the claimant may seek further information from the insurer or the Authority and/or a lawyer to understand the decision and rights of review.

4.35 The insurer must give notice as follows:

(a) for statutory benefits during the first 26 weeks after the accident:

- within four weeks after a claimant makes a claim for statutory benefits
- clearly identified as *Liability Notice – benefits up to 26 weeks*

(b) for statutory benefits after the first 26 weeks after the accident:

- within three months after a claimant makes a claim for statutory benefits
- clearly identified as *Liability Notice – benefits after 26 weeks*.

4.36 Where a claimant is legally represented, the insurer must provide the claimant's legal representative with a copy of the liability notice at the same time notice is provided to the claimant.

4.37 If the insurer denies liability in whole or in part for the payment of statutory benefits, the insurer must also provide to the legal representative copies of all information provided to the claimant with the notice.

4.38 Where the vehicle considered at fault was registered under the law of a place other than NSW, the NSW insurer managing payment of statutory benefits on behalf of the Nominal Defendant must provide a copy of the liability notice to the insurer of the vehicle considered at fault when the initial liability decision is made and each subsequent liability decision made under section 6.19 including *Liability Notice – benefits after 26 weeks*.

4.39 If the insurer denies liability and issues a notice to the claimant, the insurer must inform the service provider when responding to any treatment and care requests that treatment and care benefits may not be available after 26 weeks.

4.40 If the claimant is a participant (interim or lifetime) in the Lifetime Care & Support Scheme, the insurer must provide the Lifetime Care & Support

Authority with a copy of the *Liability Notice – benefits after 26 weeks* at the same time the notice is given to the claimant.

4.41 If the insurer is considering ceasing, reducing or suspending weekly payments of statutory benefits to a claimant who is a participant in the Lifetime Care & Support Scheme, the insurer must notify the Lifetime Care and Support Authority of NSW before the decision is made and briefly explain the basis of the decision.

New information relevant to a liability decision

4.42 If at any time an insurer receives new information relevant to its liability decision, the insurer must:

(a) ensure the claimant has a copy of the new information

(b) ask the claimant for any other relevant information not previously provided

(c) review the liability decision and notify the claimant of the outcome of the review within 21 days after it has received all relevant information

(d) if the new information causes the insurer to change its liability decision, issue a new liability decision in writing

(e) if the change results in a denial of liability in whole or in part, the new decision must address the matters set out in the section 'Liability decisions in a statutory benefits claim' in this Part of the Guidelines.

Weekly payments decisions

4.43 After an insurer accepts liability for statutory benefits, weekly payments may be payable to a claimant. Division 3.3 and Schedule 1 of the Act provide for Guidelines to be made in relation to:

(a) the first 13 weeks – interim payment (i.e where pre-accident weekly earnings cannot yet be determined),

(b) earning capacity decisions, and

(c) student pre-accident weekly earnings.

First 13 weeks – interim payment

4.44 The interim payment amount referred to in section 3.6(5) of the Act is calculated at 12.5% of the maximum weekly statutory benefits amount set out in section 3.9 unless the claimant nominates a lower amount.

Earning capacity decisions

4.45 Division 3.3, section 3.16(1)-(2) of the Act refers to decisions about earning capacity.

Decision-making principles

4.46 An insurer's procedures in connection with an earning capacity decision must align with the following principles and legal requirements:

(a) insurers comply with statutory duties

(b) claimants are given procedural fairness

(c) communication is in plain language

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(d) insurers fix errors promptly.

Statutory duties

4.47 The procedures to be followed in connection with a decision about a claimant's earning capacity must comply with the insurer's statutory duty to act with good faith under Division 6.2 of the Act.

Procedural fairness

4.48 An insurer must give a claimant procedural fairness when it makes a decision about that person's pre-accident earning capacity or post-accident earning capacity. In addition to the statutory duties, this includes:

(a) giving the person a fair opportunity to give information to the insurer to consider for the decision

(b) ensuring the decision-maker is not, or is not reasonably perceived to be, biased toward a particular outcome

(c) providing the person with all the information the insurer is considering in making its decision, regardless of whether that information supports the decision

(d) giving the claimant a right of response, including the right to provide new relevant information held by the claimant within a reasonable time in respect of an earning capacity decision that may adversely affect them.

4.49 If the claimant is a participant in the Lifetime Care & Support Scheme, the insurer must consult the Lifetime Care & Support Authority before any potential adverse decision.

Plain language

4.50 An insurer must give information about all decisions to a claimant in plain language. This means a claimant must be able to easily find, understand and use the information they need.

Correcting errors

4.51 An insurer must correct any errors in its decisions about a claimant's pre-accident earning capacity or post-accident earning capacity promptly after it becomes aware of the error, including after the decision has been made. An insurer is responsible for having procedures in place to fix an error of fact or law.

4.52 If an error can be corrected, the insurer must correct the error and not require a claimant to make an application for internal review or an application to DRS.

Model procedures

4.53 Alternatively, an insurer may follow the model procedures in Figure 4.1 (below).

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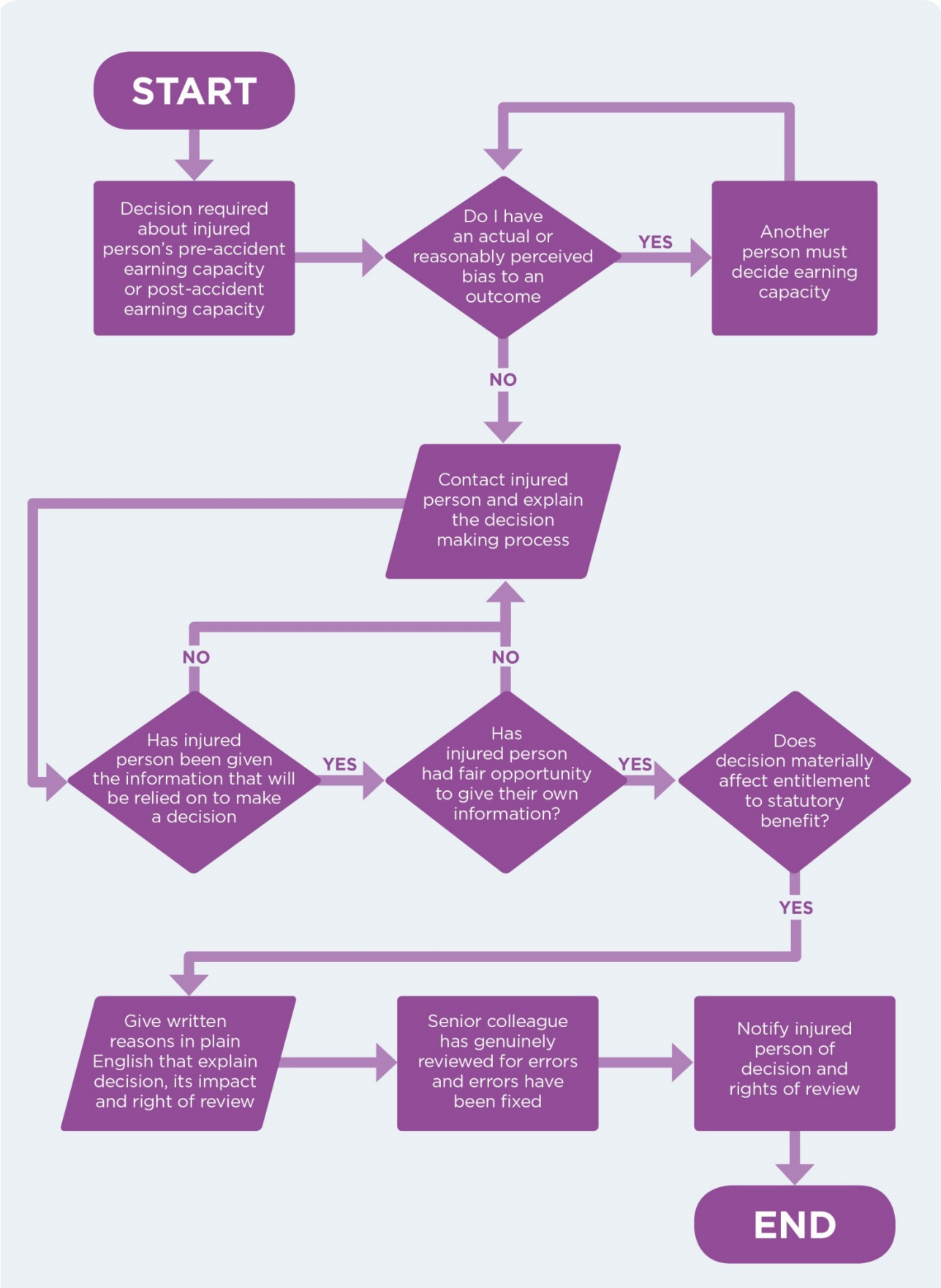
Figure 4.1: Model procedures for earning capacity decisions



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Student pre-accident weekly earnings

4.54 In making a decision regarding a student's pre-accident weekly earnings, the matters to be considered in determining the weekly earnings that the person would have received upon being employed on the completion of the course of studies in which the person was a full-time student include:

(a) the course of study being undertaken

(b) pre-accident academic results

(c) published wage data for new graduates relevant to the course undertaken

(d) previous work experience

(e) Australian Bureau of Statistics (ABS) data for age and industry

(f) the individual circumstances of the claimant

(g) any other relevant circumstances.

Post-accident earning capacity (after 78 weeks)

4.55 When determining employment reasonably available to a claimant at any time after the second entitlement period (from week 79 after the motor accident), the matters to be considered include:

(a) the nature and extent of the claimant's injuries

(b) the claimant's age, education, skills and work experience

(c) rehabilitation services that are being or have been provided

(d) the nature of the claimant's pre-injury employment

(e) the claimant's place of residence at the time of the motor accident

(f) the details given in the claimant's certificate of fitness

(g) the length of time the claimant has been seeking employment

(h) any other relevant circumstances.

Non-compliance with providing evidence of fitness for work

4.56 Before an insurer can suspend weekly payments for failure of the claimant to comply with requirements for evidence as to fitness for work, the insurer must:

(a) contact the claimant (via the claimant's preferred method of communication) to ensure that the claimant is aware of their duty to provide this evidence

(b) clearly state to the claimant the consequences of not providing the evidence

(c) provide the claimant with a reasonable time within which to comply

(d) if the claimant is a participant in the Lifetime Care & Support Scheme, the insurer must contact the Lifetime Care & Support Authority of NSW before any potential adverse decision is made

(e) provide the claimant with contact details of the Authority.

4.57 If the claimant continues to fail to comply without a reasonable excuse, a suspension notice giving the claimant seven calendar days to comply must be sent in writing.

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4.58 The suspension notice must clearly state the insurer's reasons for suspending weekly payments, actions the claimant must take to avoid suspension of their weekly payments and the claimant's rights of review. A copy of this notice must be provided to the claimant's legal representative where the claimant is legally represented.

Notice before benefits discontinued or reduced

4.59 If a decision is made to discontinue or reduce weekly payments, the insurer must give the required period of notice before that decision takes effect, in accordance with Division 3.3, section 3.19 of the Act.

4.60 Notice may be given verbally but must also be given in writing and delivered by electronic or postal means, using the claimant's preferred method of delivery. The notice must include:

(a) information about the claimant's rights of review of the insurer's decision

(b) contact details of the Authority.

4.61 A copy of this notice must be provided to the claimant's legal representative where the claimant is legally represented.

Claimant's responsibilities for ongoing weekly payments

Evidence of fitness for work

4.62 A claimant must provide to the insurer a certificate of fitness for work to be eligible for weekly payments. The required form of a certificate given under section 3.15(3) of the Act is a certificate of fitness (includingthe declaration of employment) and is available on the Authority's website.

4.63 The first certificate of fitness for work must be given by the claimant's treating medical practitioner. The second and any subsequent certificates of fitness for work must also be given by the claimant's treating medical practitioner unless it is a certificate given in *the defined period* as outlined in the clause below.

4.64 The following requirements apply during the health emergency caused by the COVID-19 pandemic in the period starting on the commencement of these Guidelines and ending on the day that is 12 months after the commencement (*the defined period*). The second and any subsequent certificates of fitness for work given during the defined period, may be given by:

(a) the claimant's treating medical practitioner, or

(b) if a health professional with general registration under the Health *Practitioner Regulation National Law (NSW) No 86a* as a physiotherapist or psychologist is providing medical or related treatment for all of claimant's injuries as a result of the motor accident – the physiotherapist or psychologist.

4.65 Where a medical practitioner or a physiotherapist or psychologist referred to in the clause above gives a certificate of fitness for work covering a period that overlaps wholly or in part with a period covered by an earlier certificate, the later certificate prevails.

4.66 The insurer that receives a certificate of fitness for work given by a physiotherapist or psychologist must, as soon as possible after receiving the certificate, give a copy of the certificate to the injured person's treating medical practitioner who provided the first certificate.

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Change in circumstances

4.67 A claimant must notify an insurer of a change in circumstances, in accordance with Division 3.3, section 3.18(1)–(2) of the Act. Initial notice may be given verbally; however, notice must also be given in writing, which may include documentary evidence, such as payslips or certificates of fitness for work depending on the change notified. If requested, other documentary evidence or written notice must be provided to the insurer as soon as possible by the claimant.

Residing outside of Australia

4.68 Division 3.3, section 3.21(1)–(2) of the Act outlines details for weekly statutory benefits to claimants residing outside Australia. The claimant must submit a certificate of fitness form (including declaration of employment) (available on the Authority's website) from a treating medical practitioner every three months to establish their identity and continued loss of earnings.

Minimising loss

4.69 The claimant must do all such things as may be reasonable and necessary for their rehabilitation.

4.70 If the claimant does not take all reasonable steps to minimise loss caused by the injury resulting from the motor accident as per Division 6.2, section 6.5(1)–(3) of the Act, the insurer is authorised to suspend weekly payments in writing, but only if the insurer contacts the claimant to ensure that the claimant:

(a) is aware of their duty to minimise loss

(b) understands what is expected of them to comply with the duty

(c) understands the consequences of failing to comply

(d) has had a reasonable opportunity to comply

(e) has the Authority's contact details.

4.71 If the insurer considers that the claimant has had a reasonable opportunity to comply with the duty but has failed to do so, a suspension notice giving the claimant 14 days to comply must be given.

4.72 The duties of the claimant must be defined in the notice. The insurer may provide notice by phone or in person; however, the notice must be confirmed in writing to the claimant.

4.73 Insurers must contact the Lifetime Care & Support Authority before making adverse decisions regarding compliance for those claimants engaged in the Lifetime Care & Support Scheme or with severe injuries.

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Treatment, rehabilitation, care and vocational support

Treatment before a claim is made

4.74 The insurer may approve access to treatment before a claim is made but after notification of injury has been given. This may also apply where a notice of claim has not included all required information and documents and the insurer is waiting for further information from the claimant.

4.75 Any treatment approved before a claim is made is approved at the insurer's discretion and will only be approved within the first 28 days from the date of the motor accident. However, if further treatment is required after 28 days, a claim for statutory benefits must be made by the injured person. The insurers' and claimants' obligations about treatment, rehabilitation and vocational training are detailed in Division 3.3, section 3.17 and Division 6.2, section 6.5(1)–(3) of the Act.

Recovery plans

Recovery approach

4.76 People respond differently after a motor accident injury. The insurer must manage claims in a manner that is tailored to the claimant, providing support based on best practice and tailored to their individual circumstances and needs.

4.77 The insurer should apply the principles of the nationally endorsed *Clinical Framework for the Delivery of Health Services*, which sets out five guiding principles for consideration by health professionals and insurers when reviewing treatment plans and requests for services:

(a) measure and demonstrate the effectiveness of the treatment

(b) adopt a biopsychosocial approach – consider the whole person and their individual circumstances

(c) empower the injured person to manage their recovery

(d) implement goals focused on optimising function, participation and where applicable, return to work

(e) base treatment on the best available research evidence.

4.78 Consideration for service requests should also include Guidelines developed by the Authority, for example:

(a) the Whiplash Guidelines for the management of acute whiplash-associated disorders for health professionals

(b) the Neuropsychological Assessment of Children & Adults with Traumatic Brain Injury Guidelines.

Screen and assess risk of poor recovery

4.79 A claimant must be screened initially for risk of poor recovery within three business days of lodgement of their claim. This must include direct contact with the claimant where available and consideration of recent information by

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the treating doctor. The outcome of this screening must be recorded on the claimant's file.

4.80 Where a claimant is identified to be at or above a medium risk of poor recovery, the insurer must take action to support the claimant through the appropriate internal claims management stream. The insurer should conduct a comprehensive assessment to determine the relevant course of treatment. The outcome of this assessment must be integrated into the claimant's recovery plan.

4.81 The insurer should regularly engage with the claimant and stakeholders involved to review progress and continue to assess risk of poor recovery. The outcome must be recorded on the claimant's file and integrated into the recovery plan.

Recovery plan

4.82 All claimants must have a tailored recovery plan with the following exceptions:

(a) where the claimant is performing their pre-injury duties

(b) where the claimant is performing their usual activities

(c) where the claimant is part of the Lifetime Care & Support Scheme

(d) where the claim is denied

(e) where a claimant has returned to their pre-injury duties and activities within 28 days of the claim being made.

4.83 The recovery plan may simply monitor treatment progress. It does not necessarily incorporate return to work support or vocational retraining where full return to work has been achieved. The recovery plan must be established, in consultation with the:

(a) claimant who has an obligation under the Act to minimise loss and participate in reasonable and necessary treatment and care and rehabilitation

(b) recent status of the claimant from the claimant's treating doctor

(c) claimant's employer, where the claimant has authorised contact with the employer and the employer elects to be part of recovery, and to the maximum extent that their cooperation and participation allows

(d) any treating clinicians or therapists as appropriate.

4.84 An insurer must, as far as possible, ensure that any vocational support provided or arranged under an individual's recovery plan is reasonable and necessary to support the claimant's return to work.

4.85 An insurer must fulfil their obligations under any recovery plan they have established for a claimant.

4.86 The recovery plan must be:

(a) completed within 28 days of the claim being made or within 28 days of the claimant's initial discharge from hospital in circumstances where the claimant has been admitted to hospital within two days of the date of the motor accident and remained in hospital for a period of not less than three continuous weeks, whichever is the later

(b) reviewed no less than at 12 weekly intervals or as pertinent changes occur.

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4.87 Where a claimant fails to comply with a recovery plan that has been developed and provided to them, the insurer must provide notice to the claimant that weekly payments may be suspended during the period of non-compliance in terms of Division 3.3, section 3.17(2) of the Act. See Division 3.3, section 3.19 of the Act for required notice periods when discontinuing weekly payments.

Development of a recovery plan

4.88 When developing a personalised recovery plan for a claimant, an insurer must consider:

(a) the nature of the injury and the likely process of recovery

(b) treatment and rehabilitation needs, including the likelihood that treatment or rehabilitation will enhance earning capacity and any temporary incapacity that may result from treatment

(c) any employment engaged in by the claimant after the accident

(d) any certificate of fitness provided by the claimant

(e) the claimant's training, skills and experience

(f) the age of the claimant

(g) accessibility of services within the claimant's residential area.

Minimum requirements in recovery plans

4.89 Within the recovery plan that is sent to both the claimant and their nominated treating doctor, the following details must be included at a minimum:

(a) name of claimant

(b) claim number

(c) date of injury

(d) current treatment being undertaken

(e) future treatment expected to be undertaken

(f) current fitness for work and/or usual activities

(g) expected fitness for work and/or usual activities with milestones

(h) obligations of the claimant

(i) consequences for the claimant if they do not adhere to the recovery plan

(j) contact details of the insurer representative

(k) what action the claimant can take if they disagree with the recovery plan.

4.90 The recovery plan may be provided to all stakeholders including treating practitioners as deemed appropriate.

Obligations of the claimant

4.91 The claimant must agree to participate in the recovery plan and must, when requested to do so by the insurer, nominate a treating medical practitioner who is prepared to participate in the development of and in the arrangements under, the recovery plan.

4.92 The insurer must advise the claimant that they may change their nominated treating practitioner if required due to, for example, the claimant moving

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house or their doctor leaving the area. The claimant needs to advise the insurer of any change and the reasons for the change.

4.93 A medical practice may be nominated as a treating medical practitioner for the purposes of a recovery plan. Such a nomination operates as a nomination of the medical practitioners of the practice who may treat the claimant from time to time. A reference in this section to the nominated treating doctor is a reference to the medical practitioners of the practice.

4.94 The claimant must authorise their nominated treating medical practitioners to provide relevant information to the insurer for the purposes of a recovery plan.

Treatment and care decisions

Limits on treatment and care expenses

4.95 In terms of section 3.31(4) of the Act, the limit is the applicable Australian Medical Association (AMA) rates at the time the treatment/service is provided.

Facilitating referrals

4.96 An insurer who has identified a claimant requiring treatment, rehabilitation and attendant care services must facilitate referral to an appropriate treatment provider (including vocational provider, if appropriate) within 10 days, with the claimant's agreement.

4.97 The insurer must refer the claimant to an appropriate service provider reasonably accessible to the claimant.

4.98 If the claimant expresses a preference for a particular provider, the insurer must refer the claimant to that provider subject to the insurer being satisfied as to the suitability of that provider. If the insurer determines that the claimant's preferred service provider is not suitable, the insurer must notify the claimant of the reasons for its decision and refer the claimant to an appropriate service provider reasonably accessible to the claimant.

Determining requests

4.99 Where the insurer determines the claimant's request for treatment, rehabilitation, vocational support and attendant care services, it must advise the claimant and service provider in writing as soon as possible but within 10 days of receipt of a request, and

(a) if approved:

- state the costs the insurer has agreed to meet
- pay the account as soon as possible but within 20 days of receipt of an invoice or expense
- advise the claimant of the insurer's obligation to pay all reasonable and necessary costs and expenses – including travel expenses to attend approved treatment, rehabilitation services or assessments, including all services or assessments conducted by DRS' medical assessors – as soon as possible (no later than 20 days after receiving the account or request for reimbursement).

(b) if declined, in whole or in part, provide:

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- the reasons for the decision with reference to the information relied upon in making the decision.
- a list of all information relevant to the decision, regardless of whether the information supports the decision. The insurer must provide copies of all listed information to the claimant, unless the information has previously been provided to the claimant
- an explanation of the insurer's internal review process, including the timeframe in which an application for internal review must be made and/or right to make an application to the DRS.

4.100 If requested by the claimant or the claimant's nominated treating doctor (subject to the claimant's authority), the insurer must provide the nominated treating doctor with a copy of any decisions that affect the claimant's treatment and care. The claimant can revoke the authority at any time by notifying the insurer.

Treatment and care after 26 weeks for claimants with only minor injuries

4.101 'Part 5 of the Motor Accident Guidelines: Minor injury (Soft tissue & minor psychological and psychiatric injuries)' outlines the specific treatment and care which may be authorised by an insurer after 26 weeks for claimants whose only injuries resulting from the motor accident are minor injuries.

Verification of expenses

4.102 Where an invoice is issued to the insurer directly from a treatment or care provider, the following should be included on the invoice:

(a) the claimant's first and last name

(b) the claim number allocated by the insurer

(c) payee details

(d) the Medicare provider number, if relevant

(e) the Australian Business Number (ABN) of the provider

(f) the name of the medical practitioner or service provider

(g) the date of the service (the date of invoice must be on the day of or after last date of service listed on the invoice)

(h) the payment classification code from the Authority or AMA item number, where applicable

(i) the service cost for each payment classification code from the Authority or AMA item number, where applicable

(j) the service duration, where applicable.

4.103 These provisions do not apply to reimbursement for treatment and/or expenses to the claimant. These expenses should be reimbursed to the claimant by the insurer on provision of a receipt confirming the expenses incurred, where the insurer has provided pre-approval and/or the expenses are reasonable and necessary in the circumstances. Insurers should request details of regular service providers to establish direct billing and reimbursement

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between the insurer and provider to reduce the financial burden on the claimant.

Lifetime Care and Support Authority's responsibility for the payment of statutory benefits for treatment and care

4.104 This clause relates to claimants for whom the Lifetime Care and Support Authority will assume responsibility for the payment of statutory benefits for treatment and care by agreement or more than 5 years after the motor accident. In such cases, the insurer and the Lifetime Care and Support Authority must:

(a) act in good faith

(b) regularly share complete, accurate and up to date information about the claim relevant to the payment of statutory benefits for treatment and care

(c) respond to requests for information about the claimant or claim as relevant to the payment of treatment and care expenses.

4.105 At least two weeks before the likely date of transfer, the insurer must notify the claimant in writing of the following:

(a) the transfer process and the likely effect on the management of the person's claim

(b) the ongoing responsibilities of the insurer including the payment of weekly statutory benefits and/or claims management of any damages claim

(c) that the Lifetime Care and Support Authority will notify the claimant in writing to confirm the transfer has taken place and the contact details for the Lifetime Care and Support Authority contact officer.

4.106 The insurer must provide the Lifetime Care and Support Authority with a copy of the notice.

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Making a damages claim

Time for making a damages claim

4.107 Division 6.3, section 6.14 of the Act provides for the timeframes in which to make a claim for damages.

Request to concede degree of permanent impairment

4.108 When the insurer receives a request by the claimant to concede that the injured person's degree of permanent impairment as a result of the injury caused by the motor accident is greater than 10%, the insurer must accept or decline the request and notify the claimant of this decision within 90 days of receipt.

4.109 The insurer must acknowledge the request within 14 days of receipt. The acknowledgement must include:

(a) any request for relevant information from the claimant required to make an assessment of the injured person's degree of permanent impairment

(b) the due date for providing a decision, and the claimant's right to request an internal review if the decision is not provided by this due date.

4.110 The notification of the insurer's decision must include:

(a) the insurer's reasons for its decision

(b) the claimant's right to request an internal review of the decision.

4.111 If the insurer fails to either accept or decline the request and notify the claimant within 90 days, the insurer's decision is taken as declining to concede that the injured person's degree of permanent impairment is greater than 10%, and the claimant may request an internal review of that decision.

Late damages claims – specific requirements

4.112 If the insurer does not accept that the claimant's explanation for the delay in lodging a claim is full and satisfactory, the insurer must explain the reasons for its decision, including informing the claimant of the matters or grounds upon which is does not consider the explanation to be full or satisfactory or both.

4.113 The insurer must not delay its investigation of the claim including each of the elements of liability on the basis that the claim is lodged late.

4.114 When exercising discretion relating to late claims (received by the insurer more than three years from the date of the accident or Nominal Defendant claims received by the Authority more than three years from the date of the accident), the insurer must act reasonably and in accordance with its duties to resolve claims justly and expeditiously. The insurer should not delay the progress of claims by relying on technical defences or minor procedural defects or irregularities.

Notice of a damages claim

4.115 A notice of a damages claim is made when an insurer receives a signed application for damages under common law form (available on the Authority's website) and all information required within the application for personal injury benefits form (available on the Authority's website).

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4.116 The notice of claim must contain the following information:

(a) for a damages claim – the *CTP Green Slip claim form – Application for damages under common law*, containing the information relevant to the claim as set out in Table 4.4 of Schedule 4.1 (below)

(b) for notice for a compensation to relatives claim – the *CTP Green Slip claim form - Application to compensate relatives* containing the information relevant to the claim as set out in Table 4.5 of Schedule 4.1 (below).

4.117 A claimant must provide a signed authority with the notice of claim authorising the insurer to release information and documents to relevant parties and obtain information and documents relevant to the claim.

Liability decisions in a damages claim

4.118 When the insurer makes a determination of liability under section 6.20 of the Act, it must notify the claimant of its decision in writing. The notice must be clearly identified as a *Liability Notice – Claim for damages,* and must explain the insurer's decision to admit or deny liability, including:

(a) whether its insured driver or owner owed the claimant a duty of care and whether they breached that duty

(b) whether the claimant suffered loss, injury or damage as a result of the insured's breach of duty

(c) a reference to the nature and the source of the evidence that supports the allegation

(d) if liability is admitted for only part of the claim, sufficient detail to ascertain the extent to which liability is admitted with reference to the nature and the source of the evidence that supports the allegation

(e) if the insurer alleges contributory negligence, the degree of contributory negligence it says can be attributed to the injured person and the reasons for that allegation, with reference to the nature and the source of the evidence that supports the allegation

(f) an explanation of the consequences of the decision, including any effects on the claimant's entitlements

(g) explanation of the review process, including the timeframe in which an application for review must be made

(h) explanation that the claimant may seek further information from the insurer or the Authority and/or a lawyer to understand the decision and rights of review.

4.119 The notice *Liability Notice – Claim for damages* must also contain copies of all the information relevant to the decision, regardless of whether the information supports the decision.

Claimant failure to provide relevant particulars – damages claim

4.120 Under Division 6.4, section 6.26 of the Act, if a claimant has failed without reasonable excuse to provide the insurer with all relevant particulars of their claim within two years and six months, insurers may send a direction to provide particulars (available on the Authority's websitewww.sira.nsw.gov.au).

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Non-economic loss – specific requirements

4.121 The insurer must make decisions relating to non-economic loss based on all the available information and documents, consistent with the facts and in accordance with the law. For example, the insurer should concede an entitlement to non-economic loss when it is in possession of health service provider examination reports that indicate that a claimant's WPI is greater than 10%.

4.122 The insurer must in every case, regardless of whether the claimant makes a damages claim for non-economic loss:

(a) clearly indicate that it has determined whether or not the claimant is entitled to non-economic loss

(b) when a claimant claims to be entitled to non-economic loss but the insurer disagrees, clearly explain the reasons and detail any medical information considered in the course of making its decision that the injured person's degree of permanent impairment is not greater than 10%,

(c) ensure that the explanation is sufficient to enable the claimant to make an informed decision about whether to accept the insurer's decision

(d) where a claimant has sufficiently recovered to enable the claim to be quantified, and the insurer is unable to determine whether the claimant's degree of permanent impairment is greater than 10%, refer the matter to the DRS for assessment.

Reasonable offers of settlement and finalising claims

4.123 In acting to resolve a claim justly and expeditiously, insurers should continually review and identify whether a claimant who is eligible for economic and/or non-economic loss has sufficiently recovered to enable quantification of the claim, and if so, make a reasonable offer of settlement. A reasonable offer is one that is based on the facts and evidence, and is reflective of the injuries and losses the injured person has suffered as a consequence of the motor vehicle accident.

4.124 The insurer must make a reasonable offer of settlement to the claimant, as required by Division 6.4, section 6.22 of the Act, unless it wholly denies liability for the claim. The offer of settlement must be recorded on the claim file.

4.125 The insurer's initial and final offer of settlement must:

(a) be set out in writing to the claimant (and copied to their legal representative where the claimant is represented)

(b) list amounts (including zero) offered for economic loss and non-economic loss separately or include a method for determining an amount of damages

(c) where the insurer admits liability for only part of the claim, include details necessary to determine the extent to which liability is admitted

(d) where applicable, identify as a separate amount any allowance for the claimant's legal costs and disbursements

(e) where applicable, identify any deductions that have been made or are likely to be made, and how they have been determined or calculated

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(f) include a reference to the insurer's duty under the Act to make an offer of settlement on a damages claim.

4.126 A damages claim cannot be settled until DRS has approved it, unless the claimant is legally represented. Where the claimant is not legally represented, the insurer must proactively approach DRS to have the settlement approved.

Confirming payment of a settlement amount

4.127 When a damages claim settles, the insurer must notify the claimant confirmingthe total settlement amount

(a) to whom the payment has been made

(b) the method of payment (for example, cheque or EFT)

(c) the date the payment was made

(d) if the claimant has engaged legal representation, the insurer must also provide them with a copy of the correspondence.

Nominal Defendant claims

4.128 The insurer acting for the Nominal Defendant in a claim for damages regarding a motor vehicle that is unidentified, will explain to the claimant in writing of the requirement for the claimant to make due inquiry and search to ascertain the identity of the vehicle alleged to have been at fault in the accident.

4.129 The insurer will promptly advise the claimant in writing whether the claimant has, in the insurer's view, satisfied the requirement for due inquiry and search, and:

(a) if the insurer determines that the requirement has not been met, it must provide details of the deficiency and the means by which the requirement could be satisfied by the claimant.

4.130 In statutory benefits claims made on the Nominal Defendant, the insurer must make the liability decision within the timeframes specified under section 6.19(1)-(2) of the Act. If the insurer has not yet determined due search and enquiry at the time the liability decision is due, the insurer must inform the claimant in the notices of liability that it will make:

(a) a decision on whether due inquiry and search has been established

(b) a further liability decision once it is satisfied that due inquiry and search has been established.

4.131 The insurer will promptly advise the claimant in writing whether the claimant has, in the insurer's view, satisfied the requirement for due inquiry and search.

4.132 An insurer's decision must be based on all available information, and should be consistent with the facts. Where the insurer alleges that the requirement has not been met, the insurer must include sufficiently detailed written reasons for its decision and details of the deficiency and manner by which the requirement could be satisfied by the claimant.

4.133 The insurer must perform as a model litigant in Nominal Defendant claims, which includes acting with complete propriety, fairly and in accordance with the highest professional standards.

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Investigations

4.134 The insurer should always consider whether investigations are required in the first instance and, if so, ensure that such investigations are appropriate with respect to the issues arising in the claim.

4.135 The insurer must promptly investigate liability for a claim by requesting information and documents about the claim in a timely manner, and regularly following up any requests.

Medical investigations

4.136 Insurers should not arrange frequent examinations. The request to arrange a medical examination should be reasonable in the circumstances and, where applicable, the medical examination should be conducted by the same examiner who previously examined the claimant if they are available.

4.137 A claimant is only required to comply with an insurer's request to arrange a medical examination if:

(a) the treating practitioner has not responded to a request for information from the insurer

(b) information provided by the treating practitioner to the insurer is inadequate

(c) the insurer's communication with the treating practitioner cannot resolve a dispute.

4.138 The insurer must retain evidence to support its decision to request a medical examination and provide this information to the claimant or the Authority on request.

4.139 For the purpose of medical investigations, an insurer may use the Authorised Health Practitioners list on the Authority's website to search for health practitioners who are authorised under Division 7.7, section 7.52(1)(b) of the Act to give evidence when required during the management of a claim.

4.140 If practitioners on the list are unavailable for an appointment within the required timeframes for the issues to be assessed, an independent medical examiner with availability chosen by the insurer or claimant may be proposed to the Authority for authorisation, following the guidelines prescribed in 'Part 8 of the Motor Accident Guidelines: Authorised Health Practitioners'.

4.141 A rehabilitation service provider cannot be deemed a health practitioner with regard to Division 7.7, section 7.52 of the Act.

Surveillance investigations

4.142 The insurer must conduct surveillance of the claimant only when there is evidence to indicate that the claimant is exaggerating an aspect of the claim or providing misleading information or documents in relation to a claim, or where the insurer reasonably believes that the claim is inconsistent with information or documents in the insurer's possession regarding the circumstances of the accident or medical evidence.

4.143 The insurer must only conduct surveillance in places regarded as public or where the claimant, while on private property, is observable by members of the public going about their ordinary daily activities.

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4.144 The investigator acting on behalf of the insurer must not actively interfere with the claimant's activities while under observation or interact with the claimant so as to have an impact on their activities.

4.145 The insurer or investigator acting on behalf of the insurer must not engage in any acts of inducement, entrapment or trespass when carrying out factual investigations and/or surveillance activities. Inducement or entrapment can include social media activities such as sending friend requests with the intention to induce, entrap or deceive.

4.146 The insurer must be sensitive to the privacy rights of children, take reasonable action to avoid unnecessary video surveillance of children and, where possible, hide images of children in reports that contain still photographs of children.

4.147 The insurer must take reasonable action to avoid unnecessary video surveillance of children when undertaking surveillance of a claimant. Persons who are under the age of 18 years are regarded as children.

4.148 Where the insurer sends surveillance material to a third party, it must inform that party about confidentiality and relevant privacy obligations.

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Schedule 4.1 CTP Green Slip Claim Forms

Table 4.1: Application for personal injury benefits

Form field	Form field	Form field
Full name	Date of birth	Gender
Interpreter language	Medicare number and reference number	Driver licence number
Mobile phone number	Home phone number	Work phone number
Email address	Home address	Contact preference
Preferred contact time	Payment preference and details	Account name
BSB	Account number	Have you ever made a CTP claim for injury
Date of injury	Claim number	CTP insurer at time of injury
Please provide your police event number	Date of the accident	Approximate time of accident
Where did the accident occur	In the accident, were you the	In your own words, please describe (or draw) the motor vehicle accident you were involved in
In your own words, please outline all injuries you received as a result of the accident you have described above	Details of all vehicles involved in the accident	What is the registration number of the car you believe to be most at fault
Did you receive treatment at hospital after the accident	Name of the hospital where you were treated	Were you taken to hospital in an ambulance
Have you been discharged from hospital	Date of discharge	Were you suffering an illness or injury affecting the same or similar parts of your body at the time of the accident
Have you been away from work as a result of the accident	Length of time off work due to the accident	What was your employment status at the time of the accident
What is your usual occupation	Please outline your earnings at the time of the accident (Please circle whichever time frame applies)	Please provide your/your employer's company name

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Form field	Form field	Form field
Were you receiving Centrelink benefits at the time of the accident	Would you like us to obtain your wages information directly from your employer	Employer contact name
Email address	Mobile phone number	Contact address (unit, street number, street name, suburb, state, postcode)
I, (print name)	Claimant's declaration, authorisation and signature	Date

Table 4.2: Online application for personal injury benefits

Form field	Form field	Form field
Accident description	Accident location	Accident location description
Accident postcode	Accident role	Accident role other
Accident state	Accident street	Accident street number
Accident suburb	Date of accident	Did the accident take place in NSW
Police event number	Time of accident	At fault vehicle known
Claimant agrees to continue (late claims)	Confirm most at fault vehicle details	Correct registration entered
Description – most at fault vehicle information does not match	Enter name – final declaration	Enter name – initial declaration
Existing claim number	Final declaration	Has claim number been provided
Initial declaration	Registration of vehicle most at fault	State of registration known
Submitter is claimant	Vehicles involved are known	Date of birth
First name	Gender	Home address
Home street address	Home suburb	Home state
Home postcode	Home country	Employer phone number
Home phone	Interpreter language	Last name
Mobile phone	Preferred contact method	Preferred contact time
Preferred email address (injured person)	Work phone	Away from
Away from work due to accident	Away until	Previous illness or injury description

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Form field	Form field	Form field
Currently away from work	Earning period	Employee or self-employed
Employer company name	Employer contact address	Employer contact first name
Employer street address	Employer suburb	Employer State
Employer postcode	Employer country	Were you in this vehicle
Employer contact last name	Employer contact email	Employment status at the time of accident
Length of time off work	Occupation description	Permission to obtain wages directly from employer
Receiving Centrelink benefits	Total earnings	Type of benefits received
Injury description	Account name	Account number
BSB	Driver license number	Medicare number
Medicare reference number	Payment method	State of driver license
Month of previous CTP claim	Year of previous CTP claim	Previous claim number
Previous CTP claim	Previous CTP insurer	Previous CTP insurer – other
Injury description	Previous illness or injury	Send correspondence to
Nominated representative required	Representative email	Representative first name
Representative language required	Representative last name	Representative phone
Representative preferred contact time	Representative role	Representative role other
Preferred submitter email address	Reason submitting	Submitter SNSW email address
Submitter first name	Submitter is a nominated representative	Submitter last name
Submitter phone	Submitter type	Submitter type other
Ambulance service received	Ambulance used	Date of discharge
Discharged from hospital	Hospital name	Treatment description
Treatment received at hospital post accident	Approximate date of previous injury	Driver's email
Driver's first name	Driver's last name	Driver's phone number
Number of passengers	Number of passengers known	Registration number

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Form field	Form field	Form field
Vehicle make	Vehicle model	Vehicle state
Vehicle year		

Table 4.3: Application for funeral expenses

Form field	Form field	Form field
Full name	Date of birth	Gender
Home address (unit, street number, street name, suburb, state, postcode)	Email address	Mobile phone number
Home phone number (if applicable)	Work phone number (if applicable)	Contact preference
Preferred contact time	If you need an interpreter, please tell us your preferred language	Full name of the deceased
Date of birth	Date of death	Address of the deceased (unit, street number, street name, suburb, state, postcode)
What is your relationship to the deceased	Please provide the police event number (e.g. E12345678)	Date of the accident
Approximate time of accident	Where did the accident occur (e.g. corner, intersection, street, number/name, suburb, state)	In the accident, the deceased was the: driver/passenger/cyclist/ pedestrian/other
Please provide a brief description of the accident.	Details of all vehicles involved in the accident	Registration
Driver's name and contact (e.g. phone, email)	Number of passengers	What is the registration number of the car you believe to be most at fault (if known)
At-fault: Still being determined/I'm unsure	Funeral director name	Funeral director contact number
How would you like to be reimbursed	Account name	BSB
Account number	I, [Name]	Signature

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Table 4.4: Application to compensate relatives

Form field	Form field	Form field
If you need an interpreter, please tell us your preferred language	Are you the executor/administrator of the person deceased Yes / No	If no, what is your relationship to the deceased
Full name	Date of birth	Gender
Mobile phone number	Home phone number (if applicable)	Work phone number (if applicable)
Email address	Home address (unit, street number, street name, suburb, state, postcode)	Contact preference - mobile, email, home phone, work phone
Preferred contact time	Are you representing or acting on behalf of the claimant identified above Yes / No	Full name
Relationship to the claimant	Mobile phone number	Home phone number (if applicable)
Work phone number (if applicable)	Contact address (unit, street number, street name, suburb, state, postcode)	Full name
Date of birth	Gender	Medicare number and reference number (if known)
Driver's licence number (if known)	What is your relationship to the deceased	Date of the accident
Please provide the police event number (e.g. E12345678)	Who was involved in the accident (Provide as much information as you can)	Were there any expenses or financial losses suffered by the deceased resulting from the accident in the time between the accident and the date of death (e.g. intensive care fees, lost wages)
If yes, please outline these expenses or financial losses	If no, skip to next page	Registration number
Driver's name	Driver's contact (e.g. phone, email)	Number of passengers
Funeral director name	Funeral director contact number	If the claimant hasn't been reimbursed for the cost of funeral expenses, please provide payment details.
Direct deposit	Cheque	Account name

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Form field	Form field	Form field
BSB	Account number	Was the deceased employed at the time of the accident No / Yes
What was the deceased's employment status at the time of the accident	Company name	Employer's phone number
Standard weekly earnings of the deceased (include overtime, regular bonuses and commission)	Name of business	Type of business (e.g. building, accounting, optometry, childcare)
Accountant's name	Estimated earnings lost (weekly)	Accountant's phone number
Employer's name	Employer's address (unit, number, street, suburb, state, postcode)	Self-employed (go to next section)
Retired/student	Was the deceased receiving any other form of income at the time of the accident	(e.g. investments, workers compensation, social security benefits or income protection payments)
Prior to the accident, had the deceased person made any firm arrangements to stop work, start a new job, change duties, change working hours or earnings	If yes, please provide workers compensation insurer and claim number; Centrelink benefit number; disability or income protection policy insurer and policy number; details of investment bonds, stocks, property etc.	New job. If yes, please provide details of when the new arrangements were expected to start and the name of the proposed employer (if applicable).
Dependant number	Full name	Relationship to the deceased
Date of birth	Gender	Relationship to the deceased
Describe how much financial support the deceased person provided the dependant each week. For example, consider money for board and allowances, food, clothing, housing services (housekeeping and childcare) rent, mortgage payments, car payments, car expenses, education expenses, health and medication expenses, utilities and entertainment.	Type of support. $ per week; how it was provided	Is the dependant employed

Form field	Form field	Form field
Does the dependant have any other employment	Does the dependant have any other income (e.g. investments, pension, Centrelink, workers compensation, disability or income protection policy)	If yes, please provide employment details below
If yes, please attach details of all other employers to this form	If yes, please describe what other kinds of income the dependant receives, including a weekly sum	Employer's phone number
Dependant's weekly earnings at time of deceased's death	Dependant's weekly earnings at present	Employer's name
Employer's address (unit, number, street, suburb, state, postcode)	Interpreter language	I, [name]
Signature	Date	

Table 4.5: Application for damages under common law

Form field	Form field	Form field
Full name	Date of birth	Gender
Mobile	Email	Home phone
Work phone	Email address	Home address (unit, street number, street name, suburb, state, postcode)
Mobile phone number	Home phone number (if applicable)	Work phone number (if applicable)
Contact preference	Preferred contact time	Medicare number and reference number
Driver licence number (if applicable)	Direct deposit	Cheque
Please provide your CTP claim number (if known)	Payment preference and details	Account name
BSB	Account number	Claimant's signature
Interpreter language	I, (print name)	Signature
Date		

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Part 5 of the Motor Accident Guidelines: Minor injury (Soft tissue & minor psychological or psychiatric injuries)

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Minor Injury

Introduction

5.1 This Part of these Guidelines is made under the Motor Accident Injuries Act 2017 *(NSW)* (the Act), including sections 1.6(5), 3.28(3), 3.31 and 10.2 of the Act with respect to:

(a) assessing whether an injury caused by the motor accident is a minor injury for the purposes of the Act

(b) the approval of domestic services and home maintenance as appropriate treatment and care for soft tissue or minor psychological or psychiatric injury or injuries

(c) the authorisation of payment of statutory benefits for treatment and care expenses incurred more than 26 weeks after the motor accident for soft tissue or minor psychological or psychiatric injury or injuries.

5.2 Division 1.2, section 1.6 of the Act and Part 1, clause 4 of the Regulation provides the definition of a minor injury.

Assessment for soft tissue & minor psychological or psychiatric injuries

General provisions for assessment

5.3 The assessment will determine whether the injury related to the claim is a soft tissue injury or a minor psychological or psychiatric injury caused by the motor accident.

5.4 Diagnostic imaging is not considered necessary to assess minor injury.

5.5 A diagnosis for the purpose of a minor injury decision should be based on a clinical assessment by a medical practitioner or other suitably qualified person independent from the insurer.

5.6 The assessment of whether an injury caused by the accident is a minor injury for the purposes of the Act should be based on the evidence available and include all relevant findings derived from:

(a) a comprehensive accurate history, including pre-accident history and pre-existing conditions

(b) a review of all relevant records available at the assessment

(c) a comprehensive description of the injured person's current symptoms

(d) a careful and thorough physical and/or psychological examination

(e) diagnostic tests available at the assessment. Imaging findings that are used to support the assessment should correspond with symptoms and findings on examination.

Soft tissue assessment – injury to a spinal nerve root

5.7 In assessing whether an injury to the neck or spine is a soft tissue injury, an assessment of whether or not radiculopathy is present is essential.

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5.8 *Radiculopathy* means the impairment caused by dysfunction of a spinal nerve root or nerve roots when two or more of the following clinical signs are found on examination when they are assessed in accordance with 'Part 6 of the Motor Accident Guidelines: Permanent impairment'.

(a) loss or asymmetry of reflexes (see the definitions of clinical findings in Table 6.8 in these Guidelines)

(b) positive sciatic nerve root tension signs (see the definitions of clinical findings in Table 6.8 in these Guidelines)

(c) muscle atrophy and/or decreased limb circumference (see the definitions of clinical findings in Table 6.8 in these Guidelines)

(d) muscle weakness that is anatomically localised to an appropriate spinal nerve root distribution

(e) reproducible sensory loss that is anatomically localised to an appropriate spinal nerve root distribution.

5.9 Where the neurological symptoms associated with the injured person's injury of the neck or spine do not meet the assessment criteria for radiculopathy, the injury will be assessed as a minor injury.

Minor psychological or psychiatric injury assessment

5.10 In assessing whether an injury is a minor psychological or psychiatric injury, an assessment of whether a psychiatric illness is present is essential.

5.11 The assessment of whether a psychiatric illness is present must be made using the *Diagnostic & Statistical Manual of Mental Disorders* (DSM-5), Fifth Edition, 2013, published by the American Psychiatric Association.

5.12 Where the symptoms associated with the injured person's psychological or psychiatric injury do not meet the assessment criteria for a recognised psychiatric illness, with the exception of acute stress disorder and adjustment disorder, the injury will be considered a minor injury.

Limits to domestic services and home maintenance

5.13 Domestic services and/or home maintenance may be approved as appropriate treatment and care for a person whose only injuries are minor injuries if the domestic service and/or home maintenance is all of the following:

(a) required as a result of injuries caused by the accident

(b) required because the person has reduced fitness for domestic tasks

(c) reasonable and necessary in the circumstances

(d) required for tasks the person used to do before the accident

(e) safe and effective

(f) a properly verified expense as set out in Part 4 of these Guidelines.

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Table 5.1: Domestic services and home maintenance availability

Weeks post the accident	Available hours
1–4	Up to 12 hours in total over the 4 weeks
5–8	Up to 8 hours in total over the 4 weeks
9–26	Up to 6 hours in total over the 18 weeks

5.14 The domestic services and home maintenance limit of hours may be exceeded in agreement with the insurer where the injured person's medical restrictions described in the certificate of fitness place a limit on the completion of pre-injury domestic tasks and responsibilities.

Treatment and care for minor injuries more than 26 weeks after the motor accident

5.15 The guidelines for claiming statutory benefits for treatment and care are found in 'Part 4 of the Motor Accident Guidelines: Claims'.

5.16 For a person whose only injuries are minor injuries, the payment of treatment and care expenses incurred more than 26 weeks after the motor accident may be authorised if the treatment and care is:

(a) medical treatment, including pharmaceuticals

(b) dental treatment

(c) rehabilitation

(d) aids and appliances

(e) education and vocational training

(f) home and transport modifications

(g) workplace and educational facility modifications

and:

(h) the treatment and care will improve the recovery of the injured person, or

(i) the insurer delayed approval for the treatment and care expenses, or

(j) the treatment and care will improve the injured person's capacity to return to work and/or usual activities.

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Part 6 of the Motor Accident Guidelines: Permanent impairment

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Permanent impairment

Introduction

6.1 'Part 6 of the Motor Accident Guidelines: Permanent impairment' has been developed for the purpose of assessing the degree of permanent impairment arising from the injury caused by a motor accident, in accordance with Division 7.5, section 7.21, and clause 2 of Schedule 2 of the *Motor Accident Injuries Act 2017 (NSW) (the Act)*.

6.2 This Part of the Motor Accident Guidelines is based on the American Medical Association's *Guides to the Evaluation of Permanent Impairment, Fourth Edition* (third printing, 1995) (AMA4 Guides). However, in this Part of the Motor Accident Guidelines, there are some very significant departures from that document. A medical assessor undertaking impairment assessments for the purposes of the Act must read this Part in conjunction with the AMA4 Guides. This Part is definitive with regard to the matters it addresses. Where it is silent on an issue, the AMA4 Guides should be followed. In particular, chapters 1 and 2 of the AMA4 Guides should be read carefully in conjunction with clauses 6.1 to 6.46 of this Part. Some of the examples in the AMA4 Guides are not valid for the assessment of impairment under the Act. It may be helpful for medical assessors to mark their working copy of the AMA4 Guides with the changes required by this Part.

Application of these Guidelines

6.3 This Part of the Motor Accident Guidelines applies under the Act to the assessment of the degree of permanent impairment that has resulted from an injury caused by a motor accident on or after 1 December 2017.

6.4 For accidents that occurred between 5 October 1999 and 30 November 2017 (inclusive), the Motor Accident Permanent Impairment Guidelines apply, as amended or replaced from time to time, as published by the Authority

Causation of injury

6.5 An assessment of the degree of permanent impairment is a medical assessment matter under clause 2(a) of Schedule 2 of the Act. The assessment must determine the degree of permanent impairment of the injured person as a result of the injury caused by the motor accident. A determination as to whether the injured person's impairment is related to the accident in question is therefore implied in all such assessments. Medical assessors must be aware of the relevant provisions of the AMA4 Guides, as well as the common law principles that would be applied by a court (or claims assessor) in considering such issues.

6.6 Causation is defined in the Glossary at page 316 of the AMA4 Guides as follows:

'Causation means that a physical, chemical or biologic factor contributed to the occurrence of a medical condition. To decide that a factor alleged to have caused or contributed to the occurrence or worsening of a medical condition has, in fact, done so, it is necessary to verify both of the following:

1. The alleged factor *could have caused* or contributed to worsening of the impairment, which is a medical determination.

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2. The alleged factor *did cause* or contribute to worsening of the impairment, which is a non-medical determination.'

This, therefore, involves a medical decision and a non-medical informed judgement.

6.7 There is no simple common test of causation that is applicable to all cases, but the accepted approach involves determining whether the injury (and the associated impairment) was caused or materially contributed to by the motor accident. The motor accident does not have to be a sole cause as long as it is a contributing cause, which is more than negligible. Considering the question 'Would this injury (or impairment) have occurred if not for the accident?' may be useful in some cases, although this is not a definitive test and may be inapplicable in circumstances where there are multiple contributing causes.

Impairment and disability

6.8 It is critically important to clearly define the term *impairment* and distinguish it from the disability that may result.

6.9 Impairment is defined as an alteration to a person's health status. It is a deviation from normality in a body part or organ system and its functioning. Hence, impairment is a medical issue and is assessed by medical means.

6.10 This definition is consistent with that of the World Health Organisation's (WHO) *International Classification of Impairments, Disabilities & Handicaps,* Geneva 1980, which has defined impairment as 'any loss or abnormality of psychological, physiological or anatomical structure or function'.

6.11 Disability, on the other hand, is a consequence of an impairment. The WHO definition is 'any restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being'.

6.12 Confusion between the two terms can arise because in some instances the clearest way to measure an impairment is by considering the effect on a person's activities of daily living (that is, on the consequent disability). The AMA4 Guides, in several places, refer to restrictions in the activities of daily living of a person. Hence the disability is being used as an indicator of severity of impairment.

6.13 Where alteration in activities of daily living forms part of the impairment evaluation, for example when assessing brain injury or scarring, refer to the 'Table of activities of daily living' on page 317 of the AMA4 Guides. The medical assessor should explain how the injury impacts on activities of daily living in the impairment evaluation report.

6.14 Two examples may help emphasise the distinction between impairment and disability:

(a) the loss of the little finger of the right hand would be an equal impairment for both a bank manager and a concert pianist and so, for these Guidelines, the impairment is identical. But the concert pianist has sustained a greater disability.

(b) an upper arm injury might make it impossible for an injured person to contract the fingers of the right hand. That loss of function is an impairment. However, the consequences of that impairment, such as an inability to hold a cup of coffee or button up clothes, constitute a disability.

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6.15 A handicap is a further possible consequence of an impairment or disability, being a disadvantage that limits or prevents fulfilment of a role that is/was normal for that individual. The concert pianist in the example above is likely to be handicapped by their impairment.

6.16 It must be emphasised, in the context of these Guidelines, that it is not the role of the medical assessor to determine disability, other than as described in clause 6.12 (above).

Evaluation of impairment

6.17 The medical assessor must evaluate the available evidence and be satisfied that any impairment:

(a) is an impairment arising from an injury caused by the accident, and

(b) is an impairment as defined in clause 6.9 (above).

6.18 An assessment of the degree of permanent impairment involves three stages:

(a) a review and evaluation of all the available evidence including:

- medical evidence (doctors', hospitals' and other health practitioners' notes, records and reports)
- medico-legal reports
- diagnostic findings
- other relevant evidence

(b) an interview and a clinical examination, wherever possible, to obtain the information specified in these Guidelines and the AMA4 Guides necessary to determine the percentage impairment

(c) the preparation of a certificate using the methods specified in these Guidelines that determines the percentage of permanent impairment, including the calculations and reasoning on which the determination is based. The applicable parts of these Guidelines and the AMA4 Guides should be referenced.

Permanent impairment

6.19 Before an evaluation of permanent impairment is undertaken, it must be shown that the impairment has been present for a period of time, and is static, well stabilised and unlikely to change substantially regardless of treatment. The AMA4 Guides (page 315) state that permanent impairment is impairment that has become static or well stabilised with or without medical treatment and is not likely to remit despite medical treatment. A permanent impairment is considered to be unlikely to change substantially (i.e. by more than 3% whole person impairment (WPI) in the next year with or without medical treatment. If an impairment is not permanent, it is inappropriate to characterise it as such and evaluate it according to these Guidelines.

6.20 Generally, when an impairment is considered permanent, the injuries will also be stabilised. However, there could be cases where an impairment is considered permanent because it is unlikely to change in future months regardless of treatment, but the injuries are not stabilised because future treatment is intended and the extent of this is not predictable. For example, for an injured person who suffers an amputation or spinal injury, the impairment is permanent and may be able to be assessed soon after the injury as it is not

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expected to change regardless of treatment. However, the injuries may not be stabilised for some time as the extent of future treatment and rehabilitation is not known.

6.21 The evaluation should only consider the impairment as it is at the time of the assessment.

6.22 The evaluation must not include any allowance for a predicted deterioration, such as osteoarthritis in a joint many years after an intra-articular fracture, as it is impossible to be precise about any such later alteration. However, it may be appropriate to comment on this possibility in the impairment evaluation report.

Non-assessable injuries

6.23 Certain injuries may not result in an assessable impairment covered by these Guidelines and the AMA4 Guides. For example, uncomplicated healed sternal and rib fractures do not result in any assessable impairment.

Impairments not covered by these Guidelines and the AMA4 Guides

6.24 A condition may present that is not covered in these Guidelines or the AMA4 Guides. If objective clinical findings of such a condition are present, indicating the presence of an impairment, then assessment by analogy to a similar condition is appropriate. The medical assessor must include the rationale for the methodology chosen in the impairment evaluation report.

Adjustment for the effects of treatment or lack of treatment

6.25 The results of past treatment (for example, operations) must be considered, since the injured person is being evaluated as they present at the time of assessment.

6.26 Where the effective long-term treatment of an injury results in apparent, substantial or total elimination of a physical permanent impairment, but the injured person is likely to revert to the fully impaired state if treatment is withdrawn, the medical assessor may increase the percentage of WPI by 1%, 2% or 3% WPI. This percentage must be combined with any other impairment percentage using the 'Combined values' chart (pages 322-324, AMA4 Guides). An example might be long-term drug treatment for epilepsy. This clause does not apply to the use of analgesics or anti-inflammatory drugs for pain relief.

6.27 For adjustment for the effects of treatment on a permanent psychiatric impairment, refer to clauses 6.222 to 6.224 under 'Mental and behavioural disorders' within this part of the Motor Accident Guidelines.

6.28 If an injured person has declined a particular treatment or therapy that the medical assessor believes would be beneficial, this should not change the impairment estimate. However, a comment on the matter should be included in the impairment evaluation report.

6.29 Equally, if the medical assessor believes substance abuse is a factor influencing the clinical state of the injured person, a comment on the matter should be included in the impairment evaluation report.

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Adjustment for the effects of prostheses or assistive devices

6.30 Whenever possible, the impairment assessment should be conducted without assistive devices, except where these cannot be removed. The visual system must be assessed in accordance with clauses 6.242 to 6.243 in this Part of the Motor Accident Guidelines.

Pre-existing impairment

6.31 The evaluation of the permanent impairment may be complicated by the presence of an impairment in the same region that existed before the relevant motor accident. If there is objective evidence of a pre-existing symptomatic permanent impairment in the same region at the time of the accident, then its value must be calculated and subtracted from the current WPI value. If there is no objective evidence of the pre-existing symptomatic permanent impairment, then its possible presence should be ignored.

6.32 The capacity of a medical assessor to determine a change in physical impairment will depend upon the reliability of clinical information on the pre-existing condition. To quote the AMA4 Guides (page 10): 'For example, in apportioning a spine impairment, first the current spine impairment would be estimated, and then impairment from any pre-existing spine problem would be estimated. The estimate for the pre-existing impairment would be subtracted from that for the present impairment to account for the effects of the former. Using this approach to apportionment would require accurate information and data on both impairments.' Refer to clause 6.218 for the approach to a pre-existing psychiatric impairment.

6.33 Pre-existing impairments should not be assessed if they are unrelated or not relevant to the impairment arising from the motor accident.

Subsequent injuries

6.34 The evaluation of permanent impairment may be complicated by the presence of an impairment in the same region that has occurred subsequent to the relevant motor accident. If there is objective evidence of a subsequent and unrelated injury or condition resulting in permanent impairment in the same region, its value should be calculated. The permanent impairment resulting from the relevant motor accident must be calculated. If there is no objective evidence of the subsequent impairment, its possible presence should be ignored.

Psychiatric impairment

6.35 Psychiatric impairment is assessed in accordance with 'Mental and behavioural disorders' within this part of the Motor Accident Guidelines.

Psychiatric and physical impairments

6.36 Impairment resulting from a physical injury must be assessed separately from the impairment resulting from a psychiatric or psychological injury (see section 1.7(2) of the Act).

6.37 When determining whether the degree of permanent impairment of the injured person resulting from the motor accident is greater than 10%, the impairment

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rating for a physical injury cannot be combined with the impairment rating for a psychiatric or psychological injury.

Pain

6.38 Some tables require the pain associated with a particular neurological impairment to be assessed. Because of the difficulties of objective measurement, medical assessors must not make separate allowance for permanent impairment due to pain, and Chapter 15 of the AMA4 Guides must not be used. However, each chapter of the AMA4 Guides includes an allowance for associated pain in the impairment percentages.

Rounding up or down

6.39 Medical assessors must not round WPI values at any point of the assessment process. During the impairment calculation process, however, fractional values might occur when evaluating the regional impairment (for example, an upper extremity impairment value of 13.25%) and this should be rounded (in this case to 13%). WPI values can only be integers (not fractions).

Consistency

6.40 The medical assessor must use the entire gamut of clinical skill and judgement in assessing whether or not the results of measurements or tests are plausible and relate to the impairment being evaluated. If, in spite of an observation or test result, the medical evidence appears not to verify that an impairment of a certain magnitude exists, the medical assessor should modify the impairment estimate accordingly, describe the modification and outline the reasons in the impairment evaluation report.

6.41 Where there are inconsistencies between the medical assessor's clinical findings and information obtained through medical records and/or observations of non-clinical activities, the inconsistencies must be brought to the injured person's attention; for example, inconsistency demonstrated between range of shoulder motion when undressing and range of active shoulder movement during the physical examination. The injured person must have an opportunity to confirm the history and/or respond to the inconsistent observations to ensure accuracy and procedural fairness.

Assessment of children

6.42 The determination of the degree of permanent impairment in children may be impossible in some instances due to the natural growth and development of the child (examples are injuries to growth plates of bones or brain damage). In some cases, the effects of the injury may not be considered permanent and the assessment of permanent impairment may be delayed until growth and development is complete.

Additional investigations

6.43 The injured person who is being assessed should attend with radiological and medical imaging. It is not appropriate for a medical assessor to order additional investigations such as further spinal imaging.

6.44 There are some circumstances where testing is required as part of the impairment assessment; for example, respiratory; cardiovascular;

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ophthalmology; and ear, nose and throat (ENT). In these cases, it is appropriate to conduct the prescribed tests as part of the assessment.

Combining values

6.45 In general, when separate impairment percentages are obtained for various impairments being assessed, these must be combined using the 'Combined values' chart (pages 322-324, AMA4 Guides). This process is necessary to ensure the total whole person or regional impairment does not exceed 100% of the person or region (see page 53 of the AMA4 Guides for examples). Note, however, that in a few specific instances, for example for ranges of motion of the thumb joints (AMA4 Guides, page 16), the impairment values are directly added. Multiple impairment scores should be treated precisely as the AMA4 Guides or these Guidelines instruct.

Lifetime Care & Support Scheme

6.46 An injured person who has been accepted as a lifetime participant of the Lifetime Care & Support Scheme under section 9 of the *Motor Accidents (Lifetime Care and Support) Act 2006* (NSW) has a degree of permanent impairment greater than 10%.

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Upper extremity

Introduction

6.47 The hand and upper extremity are discussed in section 3.1 of Chapter 3 of the AMA4 Guides (pages 15-74). This section provides guidance on methods of assessing permanent impairment involving the upper extremity. It is a complex section that requires an organised approach with careful documentation of findings.

Assessment of the upper extremity

6.48 Assessment of the upper extremity involves a physical evaluation that can use a variety of methods. The assessment in this Part of the Motor Accident Guidelines does not include a cosmetic evaluation, which should be done with reference to 'Other body systems' within this part of the Motor Accident Guidelines and Chapter 13 of the AMA4 Guides.

6.49 The assessed impairment of a part or region can never exceed the impairment due to amputation of that part or region. For an upper limb, therefore, the maximum evaluation is 60% WPI.

6.50 Although range of motion appears to be a suitable method for evaluating impairment, it can be subject to variation because of pain during motion at different times of examination and/or a possible lack of cooperation by the person being assessed. Range of motion is assessed as follows:

(a) a goniometer should be used where clinically indicated

(b) passive range of motion may form part of the clinical examination to ascertain clinical status of the joint, but impairment should only be calculated using active range of motion measurements

(c) if the medical assessor is not satisfied that the results of a measurement are reliable, active range of motion should be measured with at least three consistent repetitions

(d) if there is inconsistency in range of motion, then it should not be used as a valid parameter of impairment evaluation (see clause 6.40 of these Guidelines)

(e) if range of motion measurements at examination cannot be used as a valid parameter of impairment evaluation, the medical assessor should then use discretion in considering what weight to give other available evidence to determine if an impairment is present.

6.51 If the contralateral uninjured joint has a less than average mobility, the impairment value(s) corresponding with the uninjured joint can serve as a baseline, and are subtracted from the calculated impairment for the injured joint only if there is a reasonable expectation that the injured joint would have had similar findings to the uninjured joint before injury. The rationale for this decision must be explained in the impairment evaluation report.

6.52 When using clause 6.51 (above), the medical assessor must subtract the total upper extremity impairment (UEI) for the uninjured joint from the total UEI for the injured joint. The resulting percentage UEI is then converted to WPI. Where

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more than one joint in the upper limb is injured and clause 6.51 is used, clause 6.51 must be applied to each joint.

6.53 Figure 1 of the AMA4 Guides (pages 16-17) is extremely useful to document findings and guide assessment of the upper extremity. Note, however, that the final summary part of Figure 1 (pages 16-17, AMA4 Guides) does not make it clear that impairments due to peripheral nerve injuries cannot be combined with other impairments in the upper extremities unless they are separate injuries.

6.54 The hand and upper extremity are divided into the regions of the thumb, fingers, wrist, elbow and shoulder. The medical assessor must follow the instructions in Figure 1 (pages 16-17, AMA4 Guides) regarding adding or combining impairments.

6.55 The measurement of radial and ulnar deviation must be rounded to the nearest 5° and the appropriate impairment rating read from Figure 29 (page 38, AMA4 Guides).

6.56 Table 3 (page 20, AMA4 Guides) is used to convert UEI to WPI. Note that 100% UEI is equivalent to 60% WPI.

6.57 If the condition is not in the AMA4 Guides it may be assessed using another like condition. For example, a rotator cuff injury may be assessed by impairment of shoulder range of movement or other disorders of the upper extremity (pages 58-64, AMA4 Guides).

Specific interpretation of the AMA4 Guides

Impairment of the upper extremity due to peripheral nerve disorders

6.58 If an impairment results solely from a peripheral nerve injury, the medical assessor must not evaluate impairment from sections 3.1f to 3.1j (pages 24-45, AMA4 Guides). section 3.1k and subsequent sections must be used for evaluation of such impairment. For peripheral nerve lesions, use Table 15 (page 54, AMA4 Guides) together with Tables 11a and 12a (pages 48-49, AMA4 Guides) for evaluation. Table 16 (page 57, AMA4 Guides) must not be used.

6.59 When applying Tables 11a and 12a (pages 48-49, AMA4 Guides), the maximum value for each grade must be used unless assessing complex regional pain syndrome (CRPS).

6.60 For the purposes of interpreting Table 11 (page 48, AMA4 Guides), *abnormal sensation* includes disturbances in sensation such as dysaesthesia, paraesthesia and cold intolerance. *Decreased sensibility* includes anaesthesia and hypoaesthesia.

Impairment of the upper extremity due to CRPS

6.61 The section, 'Causalgia and reflex sympathetic dystrophy' (page 56, AMA4 Guides) must not be used. These conditions have been better defined since the AMA4 Guides were published. The current terminology is CRPS type I (referring to what was termed *reflex sympathetic dystrophy*) and CRPS type II (referring to what was termed *causalgia*).

6.62 For a diagnosis of CRPS, at least eight of the following 11 criteria must be present:

(a) skin colour is mottled or cyanotic

(b) cool skin temperature

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(c) oedema

(d) skin is dry or overly moist

(e) skin texture is smooth and non-elastic

(f) soft tissue atrophy (especially fingertips)

(g) joint stiffness and decreased passive motion

(h) nail changes with blemished, curved or talon-like nails

(i) hair growth changes with hair falling out, longer or finer

(j) X-rays showing trophic bone changes or osteoporosis

(k) bone scan showing findings consistent with CRPS.

6.63 When the diagnosis of CRPS has been established, impairment due to CRPS type I is evaluated as follows:

(a) rate the UEI resulting from the loss of motion of each individual joint affected by CRPS

(b) rate the UEI resulting from sensory deficits and pain according to the grade that best describes the severity of interference with activities of daily living as described in Table 11a (page 48, AMA4 Guides). The maximum value is not applied in this case (clause 6.59 above). The value selected represents the UEI. A nerve multiplier is not used;

(c) combine the upper extremity value for loss of joint motion (clause (a)) with the value for pain and sensory deficits (clause (b)) using the 'Combined values' chart (pages 322-324, AMA4 Guides).

(d) convert the UEI to WPI by using Table 3 (page 20, AMA4 Guides).

6.64 When the diagnosis of CRPS has been established, impairment due to CRPS type II is evaluated as follows:

(a) rate the UEI resulting from the loss of motion of each individual joint affected by CRPS

(b) rate the UEI resulting from sensory deficits and pain according to the methods described in section 3.1k (pages 46-56, AMA4 Guides) and Table 11a (page 48, AMA4 Guides)

(c) rate the UEI upper extremity impairment resulting from motor deficits and loss of power of the injured nerve according to the determination method described in section 3.1k (pages 46-56, AMA4 Guides) and Table 12a (page 49, AMA4 Guides)

(d) combine the UEI percentages for loss of joint motion (clause (a)), pain and sensory deficits (clause (b)) and motor deficits (clause (c)) using the 'Combined values' chart (pages 322-324, AMA4 Guides)

(e) convert the UEI to WPI by using Table 3 (page 20, AMA4 Guides).

Impairment due to other disorders of the upper extremity

6.65 Section 3.1m 'Impairment due to other disorders of the upper extremity, (pages 58-64, AMA4 Guides) should be rarely used in the context of motor accident injuries. The medical assessor must take care to avoid duplication of impairments.

6.66 Radiographs for carpal instability (page 61, AMA4 Guides) should only be considered if available, along with the clinical signs.

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6.67 Strength evaluations and Table 34 (pages 64-65, AMA4 Guides) must not be used as they are unreliable indicators of impairment. Where actual loss of muscle bulk has occurred, the assessment can be completed by analogy, for example, with a relevant peripheral nerve injury. Similar principles can be applied where tendon transfers have been performed or after amputation reattachment if no other suitable methods of impairment evaluation are available.

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Lower extremity

Introduction

6.68 The lower extremity is discussed in section 3.2 of Chapter 3 in the AMA4 Guides (pages 75-93). This section provides a number of alternative methods of assessing permanent impairment involving the lower extremity. A lower extremity worksheet may be included as provided in these Guidelines at Table 6.6. Each method should be calculated in lower extremity impairment percentages and then converted to WPI using Table 6.4 in these Guidelines.

Assessment of the lower extremity

6.69 Assessment of the lower extremity involves a physical evaluation that can use a variety of methods. In general, the method that most specifically addresses the impairment should be used. For example, impairment due to a peripheral nerve injury in the lower extremity should be assessed with reference to that nerve rather than by its effect on gait.

6.70 There are several different forms of evaluation that can be used as indicated in sections 3.2a to 3.2m (pages 75-89, AMA4 Guides). Table 6.5 in these Guidelines indicates which evaluation methods can and cannot be combined for the assessment of each injury. This table can only be used to assess one combination at a time. It may be possible to perform several different evaluations as long as they are reproducible and meet the conditions specified below and in the AMA4 Guides. The most specific method, or combination of methods, of impairment assessment should be used. However, when more than one equally specific method or combination of methods of rating the same impairment is available, the method providing the highest rating should be chosen. Table 6.6 can be used to assist the process of selecting the most appropriate method(s) of rating lower extremity impairment.

6.71 If there is more than one injury in the limb, each injury must be assessed separately and then the WPIs combined. For example, a fractured tibial plateau and laxity of the medial collateral ligament are separately assessed and their WPI combined.

6.72 If the contralateral uninjured joint has a less than average mobility, the impairment value(s) corresponding with the uninjured joint can serve as a baseline, and are subtracted from the calculated impairment for the injured joint, only if there is a reasonable expectation that the injured joint would have had similar findings to the uninjured joint before injury. The rationale for this decision must be explained in the impairment evaluation report.

6.73 The assessed impairment of a part or region can never exceed the impairment due to amputation of that part or region. For a lower limb, therefore, the maximum evaluation is 40% WPI.

6.74 When the 'Combined values' chart is used, the medical assessor must ensure that the values all relate to the same system (i.e. WPI or lower extremity impairment or foot impairment). Lower extremity impairment can then be combined with impairments in other parts of the body using the same table and ensuring only WPIs are combined.

6.75 Refer to Table 6.5 to determine which impairments can and cannot be combined.

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Specific interpretation of the AMA4 Guides

Leg length discrepancy

6.76 When true leg length discrepancy is determined clinically (page 75, AMA4 Guides), the method used must be indicated (for example, tape measure from anterior superior iliac spine to medial malleolus). Clinical assessment of legislation length discrepancy is an acceptable method, but if computerised tomography films are available they should be used in preference, but only when there are no fixed deformities that would make them clinically inaccurate.

6.77 Table 35 (page 75, AMA4 Guides) must have the element of choice removed such that impairments for leg length should be read as the higher figure of the range quoted, being 0, 3, 5, 7 or 8 for WPI, or 0, 9, 14, 19 or 20 for lower limb impairment.

Gait derangement

6.78 Assessment of impairment based on gait derangement should be used as the method of last resort (pages 75-76, AMA4 Guides). Methods most specific to the nature of the disorder must always be used in preference. If gait derangement is used, it cannot be combined with any other impairment evaluation in the lower extremity. It can only be used if no other valid method is applicable, and reasons why it was chosen must be provided in the impairment evaluation report.

6.79 The use of any walking aid must be necessary and permanent.

6.80 Item b of Table 36 (page 76, AMA4 Guides) is deleted as the Trendelenburg sign is not sufficiently reliable.

Muscle atrophy (unilateral)

6.81 This section (page 76, AMA4 Guides) is not applicable if the limb other than that being assessed is abnormal (for example, if varicose veins cause swelling, or if there are other injuries).

6.82 Table 37 'Impairments from leg muscle atrophy' (page 77, AMA4 Guides) must not be used. Unilateral leg muscle atrophy must be assessed using Table 6.1(a): and (b) (below).

Table 6.1(a): Impairment due to unilateral leg muscle atrophy

Thigh: The circumference is measured 10 cm above the patella with the knee fully extended and the muscles relaxed.

Difference in circumference (cm)	Impairment degree	Whole person impairment (%)	Lower extremity impairment (%)
0–0.9	None	0	0
1–1.9	Mild	2	6
2–2.9	Moderate	4	11
3+	Severe	5	12

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Table 6.1(b): Impairment due to unilateral leg muscle atrophy

Calf: The maximum circumference on the normal side is compared with the circumference at the same level on the affected side.

Difference in circumference (cm)	Impairment degree	Whole person impairment (%)	Lower extremity impairment (%)
0–0.9	None	0	0
1–1.9	Mild	2	6
2–2.9	Moderate	4	11
3+	Severe	5	12

Manual muscle strength testing

6.83 The Medical Research Council (MRC) grades for muscle strength are universally accepted. They are not linear in their application, but ordinal. The descriptions in Table 38 (page 77, AMA4 Guides) are to be used. The results of electrodiagnostic methods and tests are not to be considered in the evaluation of muscle testing, which is performed manually. Table 39 (page 77, AMA4 Guides) must be used for this method of evaluation.

Range of motion

6.84 Although range of motion (pages 77-78, AMA4 Guides) appears to be a suitable method for evaluating impairment, it can be subject to variation because of pain during motion at different times of examination and/or a possible lack of cooperation by the injured person being assessed. Range of motion is assessed as follows:

(a) a goniometer should be used where clinically indicated

(b) passive range of motion may form part of the clinical examination to ascertain clinical status of the joint, but impairment should only be calculated using active range of motion measurements

(c) if the medical assessor is not satisfied that the results of a measurement are reliable, active range of motion should be measured with at least three consistent repetitions

(d) if there is inconsistency in range of motion, then it should not be used as a valid parameter of impairment evaluation (see clause 6.40 of these Guidelines)

(e) if range of motion measurements at examination cannot be used as a valid parameter of impairment evaluation, the medical assessor should then use discretion in considering what weight to give other evidence available to determine if an impairment is present.

6.85 Tables 40 to 45 (page 78, AMA4 Guides) are used to assess range of motion in the lower extremities. Where there is loss of motion in more than one direction/axis of the same joint, only the most severe deficit is rated - the ratings for each motion deficit are not added or combined. However, motion deficits arising from separate tables can be combined.

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Ankylosis

6.86 For the assessment of impairment when a joint is ankylosed (pages 79-82, AMA4 Guides), the calculation to be applied is to select the impairment if the joint is ankylosed in optimum position and then, if not ankylosed in the optimum position (Table 6.2), by adding (not combining) the values of WPI using Tables 46-61 (pages 79-82, AMA4 Guides). Note: The example listed under the heading 'Hip' on page 79 of the AMA4 Guides is incorrect.

Table 6.2: Impairment for ankylosis in the optimum position

Joint	Whole person (%)	Lower extremity (%)	Ankle or foot (%)
Hip	20	50	–
Knee	27	67	–
Ankle	4	10	14
Foot	4	10	14

6.87 Note that the WPI from ankylosis of a joint, or joints, in the lower limb cannot exceed 40% WPI or 100% lower limb impairment. If this figure is exceeded when lower limb impairments are combined, then only 40% can be accepted as the maximum WPI.

Arthritis

6.88 Impairment due to arthritis (pages 82-83, AMA4 Guides) can be assessed by measuring the distance between the subchondral bone ends (joint space) if radiography is performed in defined positions. It indicates the thickness of articular cartilage. No notice is to be taken of other diagnostic features of arthritis such as osteophytes or cystic changes in the bone.

6.89 Hip radiography can be done in any position of the hip, but specified positions for the knee and ankle (page 82, AMA4 Guides) must be achieved by the radiographer.

6.90 Table 62 (page 83, AMA4 Guides) indicates the impairment assessment for arthritis based on articular cartilage thickness.

6.91 If arthritis is used as the basis for impairment assessment in this way, then the rating cannot be combined with gait derangement, muscle atrophy, muscle strength or range of movement assessments. It can be combined with a diagnosis-based estimate (Table 6.5).

6.92 When interpreting Table 62 (page 83, AMA4 Guides), if the articular cartilage interval is not a whole number, round to the higher impairment figure.

Amputation

6.93 Where there has been amputation of part of a lower extremity Table 63 applies (page 83, AMA4 Guides). The references to 3 *inches below knee amputation* should be converted to 7.5 centimetres.

Diagnosis-based estimates (lower extremity)

6.94 Section 3.2i (pages 84-88, AMA4 Guides) lists a number of conditions that fit a category of diagnosis-based estimates. They are listed in Table 64 (pages 85-86, AMA4 Guides). It is essential to read the footnotes.

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6.95 It is possible to combine impairments from Table 64 for diagnosis-based estimates with other injuries (for example, nerve injury) using the 'Combined values' chart (pages 322-324, AMA4 Guides).

6.96 Pelvic fractures must be assessed using section 3.4 (page 131, AMA4 Guides). Fractures of the acetabulum should be assessed using Table 64 (pages 85 86, AMA4 Guides).

6.97 Residual signs must be present at examination and may include anatomically plausible tenderness, clinically obvious asymmetry, unilateral limitation of hip joint range of motion not associated with fractured acetabulum and/or clear evidence of malalignment.

6.98 Where both collateral and cruciate ligament laxity of mild severity is present, these must be assessed separately as 3% WPI for each ligament and then combined, resulting in a total of 6% WPI.

6.99 Rotational deformity following tibial shaft fracture must be assessed analogously to Table 64 'Tibial shaft fracture, malalignment of' (page 85, AMA4 Guides).

6.100 To avoid the risk of double assessment, if avascular necrosis of the talus is used as the basis for assessment, it cannot be combined with intra-articular fracture of the ankle with displacement or intra-articular fracture of the hind foot with displacement in Table 64, column 1 (page 86, AMA4 Guides).

6.101 Tables 65 and 66 (pages 87-88, AMA4 Guides) use a different method of assessment. A point score system is applied, and then the total of points calculated for the hip or knee joint respectively is converted to an impairment rating from Table 64. Tables 65 and 66 refer to the hip and knee joint replacement respectively. Note that, while all the points are added in Table 65, some points are deducted when Table 66 is used.

6.102 In Table 65, references to *distance walked* under 'b. Function', *six blocks* should be construed as being *600 metres*, and *three blocks* as being *300 metres.*

Skin loss (lower extremity)

6.103 Skin loss can only be included in the calculation of impairment if it is in certain sites and meets the criteria listed in Table 67 (page 88, AMA4 Guides). Scarring otherwise in the lower extremity must be assessed with reference to 'Other body systems' within this part of the Motor Accident Guidelines.

Impairment of the lower extremity due to peripheral nerve injury

6.104 Peripheral nerve injury should be assessed by reference to section 3.2k (pages 88-89, AMA4 Guides). Separate impairments for the motor, sensory and dysaesthetic components of nerve dysfunction in Table 68 (page 89, AMA4 Guides) are combined.

6.105 The posterior tibial nerve is not included in Table 68, but its contribution can be calculated by subtracting common peroneal nerves rating from sciatic nerve rating as shown in Table 6.3 (below). The values in brackets are lower extremity impairment values.

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Table 6.3: Impairment for selected lower extremity peripheral nerves

Nerve	Motor %	Sensory %	Dysaesthesia %
Sciatic nerve	30 (75)	7 (17)	5 (12)
Common peroneal nerve	15 (42)	2 (5)	2 (5)
Tibial nerve	15 (33)	5 (12)	3 (7)

6.106 Peripheral nerve injury impairments can be combined with other impairments, but not those for muscle strength, gait derangement, muscle atrophy and CRPS, as shown in Table 6.5. When using Table 68, refer to Tables 11a and 12a (pages 48-49, AMA4 Guides) and clauses 6.58, 6.59 and 6.60 of these Guidelines.

Impairment of the lower extremity due to CRPS

6.107 The section 'Causalgia and reflex sympathetic dystrophy' (page 89, AMA4 Guides) must not be used. These conditions have been better defined since the AMA4 Guides were published. The current terminology is CRPS type I (referring to what was termed reflex sympathetic dystrophy) and CRPS type II (referring to what was termed causalgia).

6.108 When complex CRPS occurs in the lower extremity it must be evaluated as for the upper extremity using clauses 6.61-6.64 within this part of the Motor Accident Guidelines.

Impairment of the lower extremity due to peripheral vascular disease

6.109 Lower extremity impairment due to peripheral vascular disease is evaluated using Table 69 (page 89, AMA4 Guides). Table 14 (page 198, AMA4 Guides) must not be used. In Table 69, there is a range of lower extremity impairments, not WPI, within each of the classes 1 to 5. Where there is a range of impairment percentages listed, the medical assessor must nominate an impairment percentage based on the complete clinical circumstances revealed during the examination and provide reasons.

6.110 Lower extremity impairment values must be converted to WPI using Table 6.4.

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Table 6.4: WPI values calculated from lower extremity impairment – % of impairment

Lower extremity	Whole person	Lower extremity	Whole person	Lower extremity	Whole person	Lower extremity	Whole person
1 =	0	26 =	10	51 =	20	76 =	30
2 =	1	27 =	11	52 =	21	77 =	31
3 =	1	28 =	11	53 =	21	78 =	31
4 =	2	29 =	12	54 =	22	79 =	32
5 =	2	30 =	12	55 =	22	80 =	32
6 =	2	31 =	12	56 =	22	81 =	32
7 =	3	32 =	13	57 =	23	82 =	33
8 =	3	33 =	13	58 =	23	83 =	33
9 =	4	34 =	14	59 =	24	84 =	34
10 =	4	35 =	14	60 =	24	85 =	34
11 =	4	36 =	14	61 =	24	86 =	34
12 =	5	37 =	15	62 =	25	87 =	35
13 =	5	38 =	15	63 =	25	88 =	35
14 =	6	39 =	16	64 =	26	89 =	36
15 =	6	40 =	16	65 =	26	90 =	36
16 =	6	41 =	16	66 =	26	91 =	36
17 =	7	42 =	17	67 =	27	92 =	37
18 =	7	43 =	17	68 =	27	93 =	37
19 =	8	44 =	18	69 =	28	94 =	38
20 =	8	45 =	18	70 =	28	95 =	38
21 =	8	46 =	18	71 =	28	96 =	38
22 =	9	47 =	19	72 =	29	97 =	39
23 =	9	48 =	19	73 =	29	98 =	39
24 =	10	49 =	20	74 =	30	99 =	40
25 =	10	50 =	20	75 =	30	100 =	40

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Table 6.5: Permissible combinations of lower extremity assessment methods

	Limb length discrepancy	Gait derangement	Muscle atrophy	Muscle strength	Range of motion or ankylosis	Arthritis	Amputations	Diagnosis-based estimates	Skin loss	Peripheral nerve injuries	CRPS	Vascular disorders
Limb length discrepancy	–		✓	✓	✓	✓		✓	✓	✓	✓	✓
Gait derangement		–										
Muscle atrophy	✓		–						✓			✓
Muscle strength	✓			–			✓		✓		•	✓
Range of motion or ankylosis	✓				–		✓		✓	✓	•	✓
Arthritis	✓					–	✓	✓	✓	✓	✓	✓
Amputations				✓	✓	✓	–	✓	✓	✓	✓	✓
Diagnosis-based estimates	✓					✓	✓	–	✓	✓	✓	✓
Skin loss	✓		✓	✓	✓	✓	✓	✓	–	✓	✓	✓
Peripheral nerve injuries	✓				✓	✓	✓	✓	✓	–		✓
Complex regional pain syndrome	✓			•	•	✓	✓	✓	✓		–	
Vascular disorders	✓		✓	✓	✓	✓	✓	✓	✓	✓		–

Key: ✓ You may combine these methods of assessment
• See specific instructions for CRPS in lower extremity

Source: American Medical Association, *The Guides Newsletter,* January/February, 1998, Lower Extremity section, pages 3/75–3/93, American Medical Association's *Guides to the Evaluation of Permanent Impairment, Fourth Edition.* Organisation – Format © 1992, Randall D. Lea MD, FAADEP. Second Revision Feb 1998, Third Revision March 1999. Anthony J. Dorto, MD, FAADEP. Reprinted with permission of American Academy of Disability Evaluating Physicians, DISABILITY, May 1999, Vol. 8, No. 2

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Table 6.6: Lower extremity worksheet

Line	Impairment	Table	AMA4 page no	Potential impairment	Selected impairment
1	Gait derangement	36	76		
2	Unilateral muscle atrophy	37	77		
3	True muscle weakness	39	77		
4	Range of motion	40–45	78		
5	Joint ankylosis	46–61	79–82		
6	Arthritis	62	83		
7	Amputation	63	83		
8	Diagnosis-based estimates	64	85–86		
9	Limb length discrepancy	35	75		
10	Skin loss	67	88		
11	Peripheral nerve deficit	68	89		
12	Peripheral vascular disease	69	89		
13	Complex regional pain syndrome	See clauses 6.107–6.108	AMA4 not used		

Note: For a combined impairment rating, refer to Table 6.5 for permissible combinations.

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Spine

Introduction

6.111 The spine is discussed in section 3.3 of Chapter 3 in the AMA4 Guides (pages 94-138). Only the diagnosis-related estimate (DRE) method must be used for evaluating impairment of the spine, as modified by this Part of the Motor Accident Guidelines. The AMA4 Guides use the term *injury model* for this method.

6.112 The injury model relies especially on evidence of neurological deficits and uncommon, adverse structural changes, such as fractures and dislocations. Under this model, DREs are differentiated according to clinical findings that are verifiable using standard medical procedures.

6.113 The assessment of spinal impairment is made at the time the injured person is examined. If surgery has been performed, then the effect of the surgery, as well as the structural inclusions, must be taken into consideration when assessing impairment. Refer also to clause 6.20 in these Guidelines.

6.114 Medical assessors must consider whether any pre-existing spinal condition or surgery is related to the motor accident, is symptomatic and whether this would result in any or total apportionment. Where a pre-existing spinal condition, or spinal surgery, is unrelated to the injury from the relevant motor accident, the medical assessor should rely on clause 6.33.

6.115 The AMA4 Guides use the terms *cervicothoracic, thoracolumbar* and *lumbosacral* for the three spine regions. These terms relate to the cervical, thoracic and lumbar regions respectively.

Assessment of the spine

6.116 The range of motion (ROM) model and Table 75 are not to be used for spinal impairment evaluation (pages 112-130, AMA4 Guides).

6.117 The medical assessor may consider Table 6.7 (below) to establish the appropriate category for the spine impairment. Its principal difference from Table 70 (page 108, AMA4 Guides) is the removal of the term *motion segment integrity* wherever it appears (see clause 6.123).

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Table 6.7: Assessing spinal impairment - DRE category

Injured person's condition	I	II	III	IV	V
Low back pain, neck pain, back pain or symptoms	I				
Vertebral body compression < 25%		II			
Low back pain or neck pain with guarding or non-verifiable radicular complaints or non-uniform range of motion (dysmetria)		II			
Posterior element fracture, healed, stable, no dislocation or radiculopathy		II			
Transverse or spinous process fracture with displacement of fragment, healed, stable		II			
Low back or neck pain with radiculopathy			III		
Vertebral body compression fracture 25–50%			III		
Posterior element fracture with spinal canal deformity or radiculopathy, stable, healed			III		
Radiculopathy			III		
Vertebral body compression > 50%				IV	V
Multilevel structural compromise				IV	V
Spondylolysis with radiculopathy			III	IV	V
Spondylolisthesis without radiculopathy	I	II			
Spondylolisthesis with radiculopathy			III	IV	V
Vertebral body fracture without radiculopathy		II	III	IV	
Vertebral body fracture with radiculopathy			III	IV	V
Vertebral body dislocation without radiculopathy		II	III	IV	
Vertebral body dislocation with radiculopathy			III	IV	V
Previous spine operation without radiculopathy		II	III	IV	
Previous spine operation with radiculopathy			III	IV	V
Stenosis, facet arthrosis or disease	I	II			
Stenosis, facet arthrosis or disease with radiculopathy			III		

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6.118 The evaluation must not include any allowance for predicted long-term change. For example, a spinal stenosis syndrome after vertebral fracture or increased back pain due to osteoarthritis of synovial joints after intervertebral disc injury must not be factored into the impairment evaluation.

6.119 All impairments in relation to the spine should be calculated in terms of WPI and assessed in accordance with clauses 6.1 to 6.46 within these Motor Accident Guidelines and Chapter 3.3 of AMA4 Guides.

6.120 The assessment should include a comprehensive accurate history, a review of all relevant records available at the assessment, a comprehensive description of the individual's current symptoms, a careful and thorough physical examination and all findings of relevant diagnostic tests available at the assessment. Imaging findings that are used to support the impairment rating should be concordant with symptoms and findings on examination. The medical assessor should record whether diagnostic tests and radiographs were seen or whether they relied on reports.

6.121 While imaging and other studies may assist medical assessors in making a diagnosis, it is important to note that the presence of a morphological variation from what is called normal in an imaging study does not make the diagnosis. Several reports indicate that approximately 30% of people who have never had back pain will have an imaging study that can be interpreted as positive for a herniated disc, and 50% or more will have bulging discs. Further, the prevalence of degenerative changes, bulges and herniations increases with advancing age. To be of diagnostic value, imaging findings must be concordant with clinical symptoms and signs, and the history of injury. In other words, an imaging test is useful to confirm a diagnosis, but an imaging result alone is insufficient to qualify for a DRE category.

6.122 The medical assessor must include in the report a description of how the impairment rating was calculated, with reference to the relevant tables and/or figures used.

Specific interpretation of the AMA4 Guides

Loss of motion segment integrity

6.123 The section 'Loss of motion segment integrity' (pages 98-99, AMA4 Guides) and all subsequent references to it must not be applied, as the injury model (DRE method) covers all relevant conditions.

Definitions of clinical findings used to place an individual in a DRE category

6.124 Definitions of clinical findings, which are used to place an individual in a DRE category, are provided in Table 6.8 (below). A definition of a muscle spasm has been included; however, it is not a clinical finding used to place an individual in a DRE category.

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Table 6.8: Definitions of clinical findings

Term	Definition
Atrophy	Atrophy is measured with a tape measure at identical levels on both limbs. For reasons of reproducibility, the difference in circumference should be 2 cm or greater in the thigh and 1 cm or greater in the arm, forearm or calf. The medical assessor can address asymmetry due to extremity dominance in the report. Measurements should be recorded to the nearest 0.5 cm. The atrophy should be clinically explicable in terms of the relevant nerve root affected.
Muscle guarding	Guarding is a contraction of muscle to minimise motion or agitation of the injured or diseased tissue. It is not a true muscle spasm because the contraction can be relaxed. In the lumbar spine, the contraction frequently results in loss of the normal lumbar lordosis, and it may be associated with reproducible loss of spinal motion.
Muscle spasm	Muscle spasm is a sudden, involuntary contraction of a muscle or a group of muscles. Paravertebral muscle spasm is common after acute spinal injury but is rare in chronic back pain. It is occasionally visible as a contracted paraspinal muscle but is more often diagnosed by palpation (a hard muscle). To differentiate true muscle spasm from voluntary muscle contraction, the individual should not be able to relax the contractions. The spasm should be present standing as well as in the supine position and frequently causes scoliosis. The medical assessor can sometimes differentiate spasm from voluntary contraction by asking the individual to place all their weight first on one foot and then the other while the medical assessor gently palpates the paraspinal muscles. With this manoeuvre, the individual normally relaxes the paraspinal muscles on the weight-bearing side. If the medical assessor witnesses this relaxation, it usually means that true muscle spasm is not present.
Non-uniform loss of spinal motion (dysmetria)	Non-uniform loss of motion of the spine in one of the three principle planes is sometimes caused by muscle spasm or guarding. To qualify as true non-uniform loss of motion, the finding must be reproducible and consistent, and the medical assessor must be convinced that the individual is cooperative and giving full effort. When assessing non-uniform loss of range of motion (dysmetria), medical assessors must include all three planes of motion for the cervicothoracic spine (flexion/extension, lateral flexion and rotation), two planes of motion for the thoracolumbar spine (flexion/extension and rotation) and two planes of motion for the lumbosacral spine (flexion/ extension and lateral flexion). Medical assessors must record the range of spinal motion as a fraction or percentage of the normal range, such as cervical flexion is 3/4 or 75% of the normal range. Medical assessors must not refer to body landmarks (such as able to touch toes) to describe the available (or observed) motion.

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Term	Definition
Non-verifiable radicular complaints	Non-verifiable radicular complaints are symptoms (for example, shooting pain, burning sensation, tingling) that follow the distribution of a specific nerve root, but there are no objective clinical findings (signs) of dysfunction of the nerve root (for example, loss or diminished sensation, loss or diminished power, loss or diminished reflexes).
Reflexes	Reflexes may be normal, increased, reduced or absent. For reflex abnormalities to be considered valid, the involved and normal limbs should show marked asymmetry on repeated testing. Abnormal reflexes such as Babinski signs or clonus may be signs of corticospinal tract involvement.
Sciatic nerve root tension signs	Sciatic nerve tension signs are important indicators of irritation of the lumbosacral nerve roots. While most commonly seen in individuals with a herniated lumbar disc, this is not always the case. In chronic nerve root compression due to spinal stenosis, tension signs are often absent. A variety of nerve tension signs have been described. The most commonly used is the straight leg raising (SLR) test. When performed in the supine position, the hip is flexed with the knee extended. In the sitting position, with the hip flexed 90 degrees, the knee is extended. The test is positive when thigh and/or leg pain along the appropriate dermatomal distribution is reproduced. The degree of elevation at which pain occurs is recorded. Research indicates that the maximum movement of nerve roots occurs when the leg is at an angle of 20 degrees to 70 degrees relative to the trunk. However, this may vary depending on the individual's anatomy. Further, the L4, L5 and S1 nerve roots are those that primarily change their length when straight leg raising is performed. Thus, pathology at higher levels of the lumbar spine is often associated with a negative SLR test. Root tension signs are most reliable when the pain is elicited in a dermatomal distribution. Back pain on SLR is not a positive test. Hamstring tightness must also be differentiated from posterior thigh pain due to root tension.
Weakness and loss of sensation	To be valid, the sensory findings must be in a strict anatomic distribution, i.e. follow dermatomal patterns. Motor findings should also be consistent with the affected nerve structure(s). Significant longstanding weakness is usually accompanied by atrophy.

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Diagnosis-related estimates model

6.125 To determine the correct diagnosis-related estimates (DRE) category, the medical assessor may start with Table 6.7 in these Guidelines, and use this table in conjunction with the DRE descriptors (pages 102-107, AMA4 Guides), as clarified by the definitions in Table 6.8 (above), with the following amendments to pages 102-107 of the AMA4 Guides:

(a) *or history of guarding* is deleted from DRE category I for the lumbosacral spine (page 102) and DRE category I for the cervicothoracic spine (page 103)

(b) *no significant…roentgenograms* is deleted from DRE category I for the lumbosacral spine (page 102) and DRE category I for the cervicothoracic spine (page 103) and DRE category I for the thoracolumbar (page 106)

(c) *documented or* as it relates to muscle guarding is deleted from DRE category I for the thoracolumbar spine (page 106)

(d) replace *that has been observed and documented by a physician* with *that has been observed and documented by the medical assessor* in DRE category II for the lumbosacral spine (page 102)

(e) replace *observed by a physician* with *observed by the medical assessor* in the descriptors for DRE category II for the cervicothoracic spine (page 104) and thoracolumbar spine (page 106)

(f) replace *or displacement* with *with displacement* in the descriptors for DRE category II for the thoracolumbar spine (page 106).

6.126 If unable to distinguish between two DRE categories, the higher of those two categories must apply. The inability to differentiate must be noted and explained in the medical assessor's report.

6.127 Table 71 (page 109, AMA4 Guides) is not to be used. The definitions of clinical findings in Table 6.8 should be the criteria by which a diagnosis and allocation of a DRE category are made.

Applying the DRE method

6.128 Section 3.3f 'Specific procedures and directions' (page 101, AMA4 Guides) indicates the steps that should be followed. Table 6.7 in these Guidelines is a simplified version of that section and must be interpreted in conjunction with the amendments listed in clause 6.125 (above).

6.129 DRE I applies when the injured person has symptoms but there are no objective clinical findings by the medical assessor. DRE II applies when there are clinical findings made by the medical assessor, as described in the sections 'Description and Verification' (pages 102-107, AMA4 Guides) with the amendments in clause 6.125, for each of the three regions of the spine. Note that symmetric loss of movement is not dysmetria and does not constitute an objective clinical finding.

6.130 When allocating the injured person to a DRE category, the medical assessor must reference the relevant differentiators and/or structural inclusions.

6.131 Separate injuries to different regions of the spine must be combined.

6.132 Multiple impairments within one spinal region must not be combined. The highest DRE category within each region must be chosen.

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Loss of structural integrity

6.133 The AMA4 Guides (page 99) use the term *structural inclusions* to define certain spine fracture patterns that may lead to significant impairment and yet not demonstrate any of the findings involving differentiators. Some fracture patterns are clearly described in the examples of DRE categories in sections 3.3g, 3.3h and 3.3i. They are not the only types of injury in which there is a loss of structural integrity of the spine. In addition to potentially unstable vertebral body fractures, loss of structural integrity can occur by purely soft tissue flexion-distraction injuries.

Spondylolysis and spondylolisthesis

6.134 Spondylolysis and spondylolisthesis are conditions that are often asymptomatic and are present in 5-6% of the population. In assessing their relevance, the degree of slip (anteroposterior translation) is a measure of the grade of spondylolisthesis and not in itself evidence of loss of structural integrity. To assess an injured person as having symptomatic spondylolysis or spondylolisthesis requires a clinical assessment as to the nature and pattern of the injury, the injured person's symptoms and the medical assessor's findings on clinical examination. Table 6.8 can be used to allocate spondylolysis or spondylolisthesis to categories I-V depending on the descriptor's clinical findings in the appropriate DRE. The injured person's DRE must fit the description of clinical findings described in Table 6.8.

6.135 Medical assessors should be aware that acute traumatic spondylolisthesis is a rare event.

Sexual functioning

6.136 Sexual dysfunction should only be assessed as an impairment related to spinal injury where there is other objective evidence of spinal cord, cauda equina or bilateral nerve root dysfunction (Table 19, page 149, AMA4 Guides). There is no additional impairment rating for sexual dysfunction in the absence of objective neurological impairment.

6.137 Chapter 11 'The urinary and reproductive systems' of the AMA4 Guides should only be used to assess impairment for impotence where there has been a direct injury to the urinary tract. If this occurs, the impairment for impotence must be combined with any spine-related WPI. An example is provided in the AMA4 Guides (page 257) where there is a fracture and dissociation of the symphysis pubis and a traumatic disruption of the urethra.

Radiculopathy

6.138 Radiculopathy is the impairment caused by dysfunction of a spinal nerve root or nerve roots. To conclude that a radiculopathy is present, two or more of the following signs should be found:

(a) loss or asymmetry of reflexes (see the definitions of clinical findings in Table 6.8 in these Guidelines)

(b) positive sciatic nerve root tension signs (see the definitions of clinical findings in Table 6.8 in these Guidelines)

(c) muscle atrophy and/or decreased limb circumference (see the definitions of clinical findings in Table 6.8 in these Guidelines)

(d) muscle weakness that is anatomically localised to an appropriate spinal nerve root distribution

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(e) reproducible sensory loss that is anatomically localised to an appropriate spinal nerve root distribution.

6.139 Spinal injury causing sensory loss at C2 or C3 must be assessed by first using Table 23 (page 152) of the AMA4 Guides, rather than classifying the injury as DRE cervicothoracic category III (radiculopathy). The value must then be combined with the DRE rating for the cervical vertebral injury.

6.140 Note that complaints of pain or sensory features that follow anatomical pathways but cannot be verified by neurological findings do not by themselves constitute radiculopathy. They are described as non-verifiable radicular complaints in the definitions of clinical findings (Table 6.8 in these Guidelines).

6.141 Global weakness of a limb related to pain or inhibition or other factors does not constitute weakness due to spinal nerve malfunction.

6.142 Electrodiagnostic tests are rarely necessary investigations and a decision about the presence of radiculopathy can generally be made on clinical grounds. The diagnosis of radiculopathy should not be made solely from electrodiagnostic tests.

Multilevel structural compromise

6.143 Multilevel structural compromise (Table 70, page 108, AMA4 Guides) refers to those DREs that are in categories IV and V. It is constituted by *structural inclusion,* which by definition (page 99, AMA4 Guides) is related to *spine fracture patterns* and is different from the differentiators and clinical findings in Table 6.8.

6.144 Multilevel structural compromise must be interpreted as fractures of more than one vertebra. To provide consistency of interpretation of the meaning of multiple vertebral fractures, the definition of a vertebral fracture includes any fracture of the vertebral body or of the posterior elements forming the ring of the spinal canal (the pedicle or lamina). It does not include fractures of transverse processes or spinous processes, even at multiple levels (see also clause 6.149 in these Guidelines).

6.145 Multilevel structural compromise also includes spinal fusion and intervertebral disc replacement.

6.146 Multilevel structural compromise or spinal fusion across regions is assessed as if it is in one region. The region giving the highest impairment value must be chosen. A fusion of L5 and S1 is considered to be an intervertebral fusion.

6.147 A vertebroplasty should be assessed on the basis of the fracture for which it was performed.

6.148 Compression fracture: The preferred method of assessing the amount of compression is to use a lateral X-ray of the spinal region with the beam parallel to the disc spaces. If this is not available, a CT scan can be used. Caution should be used in measuring small images as the error rate will be significant unless the medical assessor has the ability to magnify the images electronically. Medical assessors should not rely on the estimated percentage compression reported on the radiology report, but undertake their own measurements to establish an accurate percentage using the following method:

(a) the area of maximum compression is measured in the vertebra with the compression fracture

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(b) the same area of the vertebrae directly above and below the affected vertebra is measured and an average obtained.

(c) the measurement from the compressed vertebra is then subtracted from the average of the two adjacent vertebrae

(d) the resulting figure is divided by the average of the two unaffected vertebrae and turned into a percentage

(e) if there are not two adjacent normal vertebrae, then the next vertebra that is normal and adjacent (above or below the affected vertebra) is used.

The calculations must be documented in the impairment evaluation report.

6.149 Fractures of transverse or spinous processes (one or more) with displacement within a spinal region are assessed as DRE category II because they do not disrupt the spinal canal (pages 102, 104, 106, AMA4 Guides) and they do not cause multilevel structural compromise.

6.150 One or more end-plate fractures in a single spinal region without measurable compression of the vertebral body are assessed as DRE category II.

6.151 In the application of Table 6.7 regarding multilevel structural compromise:

(a) multiple vertebral fractures without radiculopathy are classed as category IV

(b) multiple vertebral fractures with radiculopathy are classed as category V.

Spinal cord injury

6.152 The assessment of spinal cord injury is covered in clause 6.161 in these Guidelines.

6.153 Cauda equina syndrome: In the AMA4 Guides, this term does not have its usual medical meaning. For the purposes of the AMA4 Guides, an injured person with cauda equina syndrome has objectively demonstrated permanent partial loss of lower extremity function bilaterally. This syndrome may have associated objectively demonstrated bowel or bladder impairment.

Pelvic fractures

6.154 Pelvic fractures must be assessed using section 3.4 (page 131, AMA4 Guides). Fractures of the acetabulum must be assessed using Table 64 (pages 85-86, AMA4 Guides).

6.155 Multiple fractures of the pelvis must be assessed separately and then combined.

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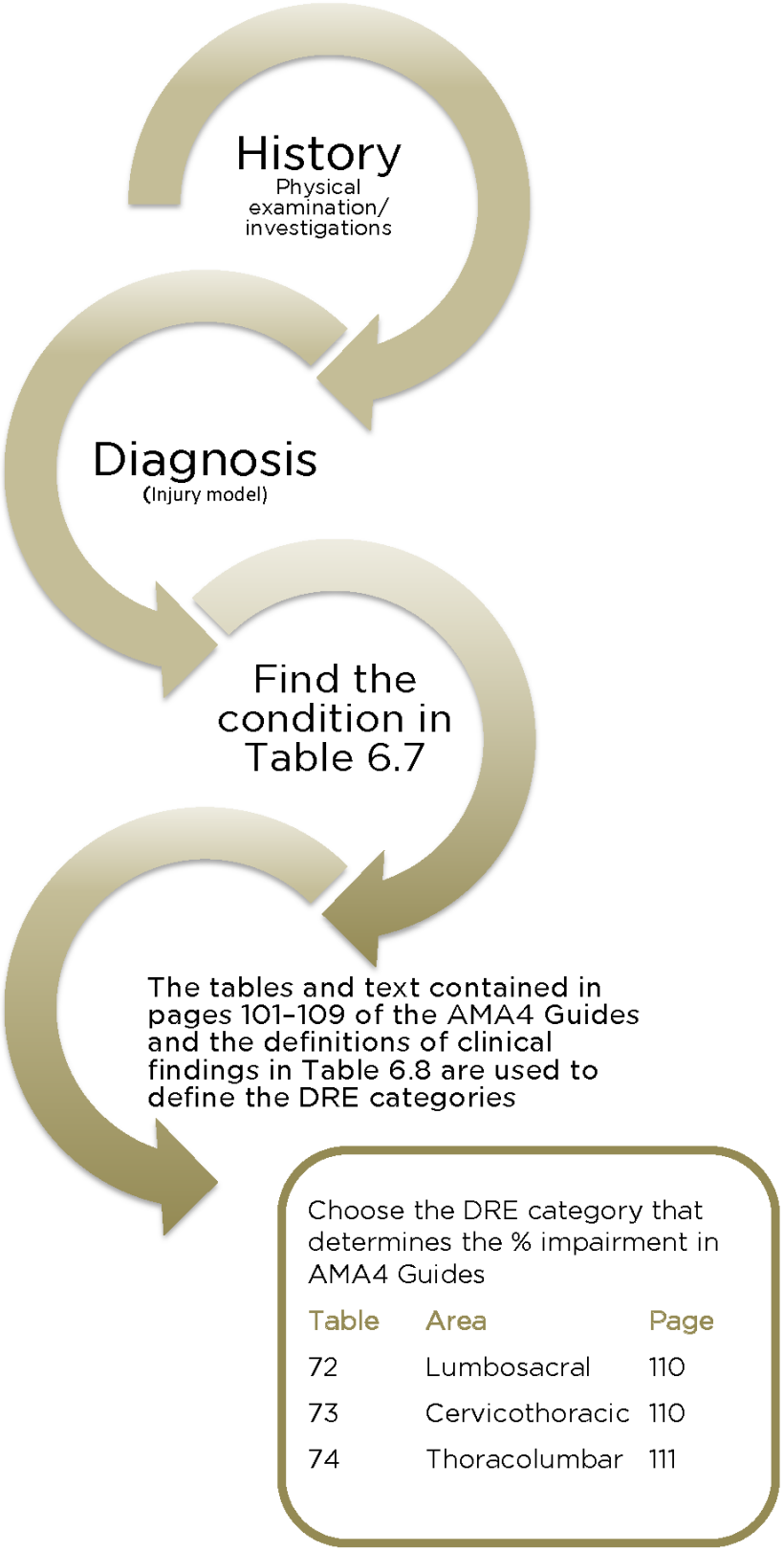
Figure 6.1: Spine – summary of spinal DRE assessment

The terms *cervicothoracic, thoracolumbar and lumbosacral* have been defined in clause 6.115.



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Nervous system

Introduction

6.156 Chapter 4 (pages 139-152, AMA4 Guides) provides guidance on methods of assessing permanent impairment involving the central nervous system. Elements of the assessment of permanent impairment involving the peripheral nervous system can be found in relevant parts of the 'Upper extremity', 'Lower extremity' and 'Spine' sections.

6.157 Chapter 4 is logically structured and consistent with the usual sequence of examining the nervous system. Cortical functions are discussed first, followed by the cranial nerves, the brain stem, the spinal cord and the peripheral nervous system.

6.158 Spinal cord injuries (SCI) must be assessed using the 'Nervous system' and 'Musculoskeletal system' chapters of the AMA4 Guides and these Guidelines. See clause 6.161.

6.159 The relevant parts of the 'Upper extremity', 'Lower extremity' and 'Spine' chapters of the AMA4 Guides must be used to evaluate impairments of the peripheral nervous system.

Assessment of the nervous system

6.160 The introduction to Chapter 4 'Nervous system' in the AMA4 Guides is ambiguous in its statement about combining nervous system impairments. The medical assessor must consider the categories of:

(a) aphasia or communication disorders

(b) mental status and integrative functioning abnormalities

(c) emotional and behavioural disturbances

(d) disturbances of consciousness and awareness (permanent and episodic).

The medical assessor must select the highest rating from categories 1 to 4. This rating can then be combined with ratings of other nervous system impairments or from other body regions.

6.161 A different approach is taken in assessing spinal cord impairment (section 4.3, pages 147-148, AMA4 Guides). In this case, impairments due to this pathology can be combined using the 'Combined values' chart (pages 322-324, AMA4 Guides). It should be noted that section 4.3 'Spinal cord' must be used for motor or sensory impairments caused by a central nervous system lesion. Impairment evaluation of spinal cord injuries should be combined with the associated DRE I-V from section 3.3 in the 'Musculoskeletal system' Chapter (pages 101-107, AMA4 Guides). This section covers hemiplegia due to cortical injury as well as SCI.

6.162 Headache or other pain potentially arising from the nervous system, including migraine, is assessed as part of the impairment related to a specific structure. The AMA4 Guides state that the impairment percentages shown in the chapters of the AMA4 Guides make allowance for the pain that may accompany the impairing condition.

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6.163 The 'Nervous system' Chapter of the AMA4 Guides lists many impairments where the range for the associated WPI is from 0% to 9% or 0% to 14%. Where there is a range of impairment percentages listed, the medical assessor must nominate an impairment percentage based on the complete clinical circumstances revealed during the examination and provide reasons.

Specific interpretation of the AMA4 Guides

The central nervous system - cerebrum or forebrain

6.164 For an assessment of mental status impairment and emotional and behavioural impairment there should be:

(a) evidence of a significant impact to the head or a cerebral insult, or that the motor accident involved a high-velocity vehicle impact, and

(b) one or more significant, medically verified abnormalities such as an abnormal initial post-injury Glasgow Coma Scale score, or post traumatic amnesia, or brain imaging abnormality.

6.165 The results of psychometric testing, if available, must be taken into consideration.

6.166 Assessment of disturbances of mental status and integrative functioning: Table 6.9 in these Guidelines - the clinical dementia rating (CDR), which combines cognitive skills and function, must be used for assessing disturbances of mental status and integrative functioning.

6.167 When using the CDR, the injured person's cognitive function for each category should be scored independently. The maximum CDR score is 3. Memory is considered the primary category; the other categories are secondary.

(a) if at least three secondary categories are given the same numeric score as memory, then the CDR = M

(b) if three or more secondary categories are given a score greater or less than the memory score, CDR = the score of the majority of secondary categories, unless

- three secondary categories are scored less than M and two secondary categories are scored greater than M, then the CDR = M

(c) similarly, if two secondary categories are greater than M, two are less than M and one is the same as M, CDR = M.

6.168 In Table 6.9, 'Personal care' (PC) for the level of impairment is the same for a CDR score of 0 and a CDR score of 0.5, being *fully capable of self-care.* In order to differentiate between a personal care CDR score of 0 and 0.5, a rating that best fits with the pattern of the majority of other categories must be allocated. For example, when the personal care rating is *fully capable of self-care* and at least three other components of the CDR are scored at 0.5 or higher, the PC must be scored at 0.5. If three or more ratings are less than 0.5, then a rating of 0 must be assigned. Reasons to support all ratings allocated must be provided.

6.169 Corresponding impairment ratings for CDR scores are listed in Table 6.10 in these Guidelines.

6.170 Emotional and behavioural disturbances assessment: Table 3 (page 142, AMA4 Guides) must be used to assess emotional or behavioural disturbances.

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6.171 Sleep and arousal disorders assessment: Table 6 (page 143, AMA4 Guides) must be used to assess sleep and arousal disorders. The assessment is based on the clinical assessment normally done for clinically significant disorders of this type.

6.172 Visual impairment assessment: An ophthalmologist must assess all impairments of visual acuity, visual fields or extra-ocular movements (page 144, AMA4 Guides).

6.173 Trigeminal nerve assessment: Sensory impairments of the trigeminal nerve must be assessed with reference to Table 9 (page 145, AMA4 Guides). The words *or sensory disturbance* are added to the table after the words *neuralgic pain* in each instance. Impairment percentages for the three divisions of the trigeminal nerve must be apportioned with extra weighting for the first division (for example, division 1 - 40%, and division 2 and 3 - 30% each). If present, motor loss for the trigeminal nerve must be assessed in terms of its impact on mastication and deglutition (page 231, AMA4 Guides).

6.174 As per clause 6.189, regarding bilateral total facial paralysis in Table 4 (page 230, AMA4 Guides) total means all branches of the facial nerve.

6.175 Sexual functioning assessment: Sexual dysfunction is assessed as an impairment only if there is an associated objective neurological impairment (page 149, AMA4 Guides). This is consistent with clauses 6.136 and 6.137 in these Guidelines.

6.176 Olfaction and taste assessment: The assessment of olfaction and taste is covered in clauses 6.192 and 6.193 in these Guidelines.

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Table 6.9: Clinical dementia rating (CDR)

	Impairment level and CDR score				
	None 0	Questionable 0.5	Mild 1.0	Moderate 2.0	Severe 3.0
Memory (M)	No memory loss or slight inconsistent forgetfulness	Consistent slight forgetfulness; partial recollection of events; *benign* forgetfulness	Moderate memory loss; more marked for recent events; defect interferes with everyday activities	Severe memory loss; only highly learned material retained; new material rapidly lost	Severe memory loss; only fragments remain
Orientation (O)	Fully oriented	Fully oriented except for slight difficulty with time relationships	Moderate difficultly with time relationships; oriented in place at examination; may have geographic disorientation elsewhere	Severe difficulty with time relationships; usually disoriented to time, often to place	Oriented to person only
Judgement and problem solving (JPS)	Solves everyday problems and handles business and financial affairs well; judgement good in relation to past performance	Slight impairment in solving problems, similarities and differences	Moderate difficulty in handling problems, similarities and differences; social judgement usually maintained	Severely impaired in handling problems, similarities and differences; social judgement usually impaired	Unable to make judgements or solve problems
Community affairs (CA)	Independent function at usual level in job, shopping, volunteer and social groups	Slight impairment in these activities	Unable to function independently in these activities although may still be engaged in some; appears normal to casual inspection	No pretence of independent function outside home; appears well enough to be taken to functions outside a family home	No pretence of independent function outside home; appears too ill to be taken to functions outside a family home
Home and hobbies (HH)	Life at home, hobbies and intellectual interests well maintained	Life at home, hobbies and intellectual interests slightly impaired	Mild but definite impairment of function at home; more difficult chores abandoned; more complicated hobbies and interests abandoned	Only simple chores preserved; very restricted interests, poorly maintained	No significant function at home
Personal care (PC)	Fully capable of self-care	Fully capable of self-care* *see clause 6.168	Needs prompting	Requires assistance in dressing, hygiene, keeping of personal effects	Requires much help with personal care; frequent incontinence

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Table 6.10: Criteria for rating impairment related to mental status

Class 1 1-14% WPI	Class 2 15-29% WPI	Class 3 30-49% WPI	Class 4 50-70% WPI
Impairment exists, but ability remains to perform satisfactorily most activities of daily living	Impairment requires direction of some activities of daily living	Impairment requires assistance and supervision for most activities of daily living	Unable to care for self and be safe in any situation without supervision
CDR = 0.5	CDR = 1.0	CDR = 2.0	CDR = 3.0

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Ear, nose and throat, and related structures

Introduction

6.177 Chapter 9 of the AMA4 Guides (pages 223-234) provides guidance on methods of assessing permanent impairment involving the ear, nose and throat, and related structures, including the face.

6.178 Chapter 9 discusses the ear, hearing, equilibrium, the face, respiratory (air passage) obstruction, mastication and deglutition, olfaction and taste, and speech. There is potential overlap with other chapters, particularly the nervous system, in these areas.

Assessment of ear, nose and throat, and related structures

6.179 To assess impairment of the ear, nose and throat, and related structures, the injured person must be assessed by the medical assessor. While the assessment may be based principally on the results of audiological or other investigations, the complete clinical picture must be elaborated through direct consultation with the injured person by the medical assessor.

Specific interpretation of the AMA4 Guides

Ear and hearing

6.180 Ear and hearing (pages 223-224, AMA4 Guides): Tinnitus is only assessable in the presence of hearing loss, and both must be caused by the motor accident. An impairment of up to 5% can be added, not combined, to the percentage binaural hearing impairment before converting to WPI hearing loss if tinnitus is permanent and severe.

Hearing impairment

6.181 Hearing impairment (pages 224-228, AMA4 Guides): sections 9.1a and 9.1b of the AMA4 Guides are replaced with the following section.

6.182 Impairment of an injured person's hearing is determined according to evaluation of the individual's binaural hearing impairment.

6.183 Hearing impairment must be evaluated when the impairment is permanent. Prosthetic devices (i.e. hearing aids) must not be used during evaluation of hearing sensitivity.

6.184 Hearing threshold level for pure tones is defined as the number of decibels above a standard audiometric zero level for a given frequency at which the listener's threshold of hearing lies when tested in a suitable sound-attenuated environment. It is the reading on the hearing level dial of an audiometer calibrated according to current Australian standards.

6.185 Binaural hearing impairment is determined by using the 1988 National Acoustics Laboratory tables 'Improved procedure for determining percentage loss of hearing', with allowance for presbyacusis according to the presbyacusis correction table in the same publication (NAL Report No. 118, National Acoustics Laboratory, Commonwealth of Australia, 1988).

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6.186 Table 3 (page 228, AMA4 Guides) is used to convert binaural hearing impairment to impairment of the whole person. For example, a person aged 50 with a total unilateral hearing loss in the right ear and no hearing loss in the left ear has 17% binaural hearing impairment less 0% presbyacusis correction, which is equivalent to 6% WPI.

Equilibrium

6.187 Assessment of impairment due to disorders of equilibrium (pages 228-229, AMA4 Guides) is dependent on objective findings of vestibular dysfunction. Such data must be available to the medical assessor.

6.188 There is an error in the description of classes 3, 4 and 5 in 'Criteria of vestibular impairment' (page 229, AMA4 Guides). Class 3 of impairment of vestibular function is associated with a WPI of 11% to 30%. Class 4 is 31% to 60% and class 5, 61% to 95%.

Face

6.189 Facial scarring and disfigurement are assessed separately to scarring elsewhere on the body. This scarring is combined with any other assessment of scarring and/or other permanent impairment assessments. In Table 4 (page 230, AMA4 Guides), total means all branches of the facial nerve.

6.190 Loss of the entire outer ear is 11% WPI.

6.191 The assessment of permanent impairment involving scarring of the face may be undertaken using Chapter 13 'The skin' (pages 279-280, AMA4 Guides) and/or section 9.2 'The face' (pages 229-230, AMA4 Guides).

Olfaction and taste

6.192 There is a discrepancy in the AMA4 Guides in the treatment of olfaction and taste between the 'Nervous system' Chapter (pages 144, 146) and the 'ENT' Chapter (pages 231-232). To resolve this difference, the medical assessor may assign a value of WPI from 1% to 5% for loss of sense of taste and a value of WPI from 1% to 5% for loss of sense of olfaction. Where there is a range of impairment percentages listed, the medical assessor must nominate an impairment percentage based on the complete clinical circumstances revealed during the examination and provide reasons.

6.193 However, the very rare case of total permanent loss of taste and olfaction is deemed in these Guidelines to constitute greater than 10% permanent impairment.

Teeth

6.194 An impairment assessment for loss of teeth must be done with the injured person wearing their dental prosthesis if this was normal for the injured person before the accident. If, as a result of the motor accident, the injured person required a removable dental prosthesis for the first time, or a different dental prosthesis, the difference should be accounted for in the assessment of permanent impairment.

6.195 Damage to the teeth can only be assessed when there is a permanent impact on mastication and deglutition (page 231, AMA4 Guides) and/or loss of structural integrity of the face (pages 229-230, AMA4 Guides).

6.196 Where loss of structural integrity occurs as a result of a dental injury, the injury must be assessed for a loss of functional capacity (mastication) and a loss of structural integrity (cosmetic deformity) and any impairment combined.

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6.197 When using Table 6 'Relationship of dietary restrictions to permanent impairment' (page 231, AMA4 Guides) the first category must be 0-19%, not 5-19%.

6.198 In some cases, it will be necessary to access current dental X-rays to assess permanent impairment.

Respiration

6.199 When Table 5 (page 231, AMA4 Guides) is used for the evaluation of air passage defects, these Guidelines allow 0-5% WPI where there is significant difficulty in breathing through the nose and examination reveals significant partial obstruction of the right and/or left nasal cavity or nasopharynx, or significant septal perforation.

Speech

6.200 When Table 7 'Speech impairment criteria' (page 233, AMA4 Guides) is used, the percentage from the table must be converted to WPI using Table 9 (page 234, AMA4 Guides).

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Mental and behavioural disorders

Introduction

6.201 Psychiatric disorders have complex effects on the individual, and impairment must be assessed by a psychiatrist.

6.202 The AMA4 Guides do not give percentages of psychiatric impairment in Chapter 14 (pages 291-302), which deals with mental and behavioural disorders. Medically determinable impairments in thinking, affect, intelligence, perception, judgement and behaviour are difficult to translate into functional limitations.

6.203 The assessment of mental and behavioural disorders must be undertaken in accordance with the psychiatric impairment rating scale (PIRS) as set out in these Guidelines. Chapter 14 of the AMA4 Guides (pages 291-302) is to be used for background or reference only.

6.204 The PIRS draws heavily on Chapter 14 of the AMA4 Guides.

6.205 The AMA4 Guides provide a framework to determine whether a motor accident has caused psychiatric impairment. They bridge the gap between impairment and disability by focusing on four areas or aspects of functioning:

(a) activities of daily living (ADL). Three aspects of ADL are used in the PIRS system

(b) social functioning

(c) concentration, persistence and pace

(d) adaptation.

6.206 These areas are described in detail on pages 294-295 of the AMA4 Guides.

6.207 Activities of daily living include self-care, personal hygiene, communication, ambulation, travel and social and recreational activities.

6.208 Social functioning refers to the capacity to get along with others and communicate effectively.

6.209 Concentration, persistence and pace is defined as the ability to sustain focused attention, for long enough to permit the timely completion of tasks commonly found in work settings.

6.210 Adaptation (also called deterioration or de-compensation in work or work-like settings) refers to the repeated failure to adapt to stressful circumstances.

6.211 Impairment is divided into five classes ranging from no impairment to extreme impairment.

6.212 Mental and behavioural disorders resulting from an organic brain injury are most suitably assessed as an organic problem under clause 6.156 to 6.176 in these Guidelines.

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Assessment of mental and behavioural disorders

6.213 The impairment must be attributable to a psychiatric diagnosis recognised by the current edition of the *Diagnostic & Statistical Manual of Mental Disorders* (DSM) or the current edition of the *International Statistical Classification of Diseases & Related Health Problems* (ICD). The impairment evaluation report must specify the diagnostic criteria on which the diagnosis is based.

6.214 Impairment due to physical injury is assessed using different criteria outlined in other parts of these Guidelines.

6.215 The PIRS must not be used to measure impairment due to somatoform disorders or pain.

6.216 Where cognitive deficits are suspected, the medical assessor must carefully consider the history of the injury, medical treatment and progress through rehabilitation. The medical assessor must also take into account the results of CT and MRI scans, electroencephalograms (EEGs) and psychometric tests.

6.217 The scale must be used by a properly trained medical assessor. The psychiatrist's clinical judgement is the most important tool in the application of the scale. The impairment rating must be consistent with a recognised psychiatric diagnosis and based on the psychiatrist's clinical experience.

6.218 In order to measure impairment caused by a specific event, the medical assessor must, in the case of an injured person with a pre-existing psychiatric diagnosis or diagnosable condition, estimate the overall pre-existing impairment using precisely the method set out in this part of the Guidelines, and subtract this value from the current impairment rating.

The psychiatric impairment rating scale

6.219 Behavioural consequences of psychiatric disorders are assessed on six areas of function, each of which evaluates an area of functional impairment:

(a) self-care and personal hygiene (Table 6.11)

(b) social and recreational activities (Table 6.12)

(c) travel (Table 6.13)

(d) social functioning (relationships) (Table 6.14)

(e) concentration, persistence and pace (Table 6.15)

(f) adaptation (Table 6.16).

6.220 Impairment in each area of function is rated using class descriptors. Classes range from 1 to 5 according to severity. The standard form (Figure 6.2) must be used when scoring the PIRS. The classes in each area of function are described through the use of common examples. These are intended to be illustrative rather than literal criteria. The medical assessor should obtain a history of the injured person's pre-accident lifestyle, activities and habits, and then assess the extent to which these have changed as a result of the psychiatric injury. The medical assessor should take into account variations in lifestyle due to age, gender, cultural, economic, educational and other factors.

6.221 Where adaptation cannot be assessed by reference to work or a work-like setting, consideration must be given to the injured person's usual pre-injury roles and functions such as caring for others, housekeeping, managing personal/family finances, voluntary work, education/study or the discharge of other obligations and responsibilities.

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Adjustment for the effects of treatment

6.222 An adjustment for the effects of prescribed treatment may be made by the medical assessor if all of the following requirements are met:

(a) there is research evidence demonstrating that the treatment prescribed is effective for the injured person's diagnosed psychiatric condition

(b) the medical assessor is satisfied that the treatment has been appropriate, for example, medication has been taken in the appropriate dose and duration

(c) there is clear clinical evidence that the treatment has been effective, that is, the injured person's symptoms have improved and/or functioning has improved

(d) it is the clinical judgement of the medical assessor that ceasing treatment will result in a deterioration of symptoms and/or a worsening in function.

6.223 The medical assessor may increase the percentage of WPI by:

(a) 0% WPI (no or negligible treatment effect)

(b) 1% WPI (a mild treatment effect)

(c) 2% WPI (a moderate treatment effect)

(d) 3% WPI (a full remission).

6.224 This clause does not apply to the use of analgesics, anti-inflammatory or antidepressant drugs for analgesia or pain management.

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Table 6.11: Psychiatric impairment rating scale (PIRS)

	Self-care and personal hygiene
Class 1	No deficit, or minor deficit attributable to normal variation in the general population.
Class 2	Mild impairment. Able to live independently and look after self adequately, although may look unkempt occasionally. Sometimes misses a meal or relies on takeaway food.
Class 3	Moderate impairment. Cannot live independently without regular support. Needs prompting to shower daily and wear clean clothes. Cannot prepare own meals, frequently misses meals. Family member or community nurse visits (or should visit) 2–3 times per week to ensure minimum level of hygiene and nutrition.
Class 4	Severe impairment. Needs supervised residential care. If unsupervised, may accidentally or purposefully hurt self.
Class 5	Totally impaired. Needs assistance with basic functions, such as feeding and toileting.

Table 6.12: Psychiatric impairment rating scale (PIRS)

	Social and recreational activities
Class 1	No deficit or minor deficit attributable to normal variation in the general population. Able to go out regularly to cinemas, restaurants or other recreational venues. Belongs to clubs or associations and is actively involved with these.
Class 2	Mild impairment. Able to occasionally go out to social events without needing a support person, but does not become actively involved; for example, in dancing, cheering favourite team.
Class 3	Moderate impairment. Rarely goes to social events, and mostly when prompted by family or close friend. Unable to go out without a support person. Not actively involved, remains quiet and withdrawn.
Class 4	Severe impairment. Never leaves place of residence. Tolerates the company of family member or close friend, but will go to a different room or the garden when others visit family or flatmate.
Class 5	Totally impaired. Cannot tolerate living with anybody, extremely uncomfortable when visited by close family member.

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Table 6.13: Psychiatric impairment rating scale (PIRS)

	Travel
Class 1	No deficit, or minor deficit attributable to normal variation in the general population. Able to travel to new environments without supervision.
Class 2	Mild impairment. Able to travel without support person, but only in a familiar area such as local shops or visiting a neighbour.
Class 3	Moderate impairment. Unable to travel away from own residence without support person. Problems may be due to excessive anxiety or cognitive impairment.
Class 4	Severe impairment. Finds it extremely uncomfortable to leave own residence even with a trusted person.
Class 5	Totally impaired. Cannot be left unsupervised, even at home. May require two or more persons to supervise when travelling.

Table 6.14: Psychiatric impairment rating scale (PIRS)

	Social functioning
Class 1	No deficit, or minor deficit attributable to normal variation in the general population. No difficulty in forming and sustaining relationships; for example, a partner or close friendships lasting years.
Class 2	Mild impairment. Existing relationships strained. Tension and arguments with partner or close family member, loss of some friendships.
Class 3	Moderate impairment. Previously established relationships severely strained; evidenced, for example, by periods of separation or domestic violence. Partner, relatives or community services looking after children.
Class 4	Severe impairment. Unable to form or sustain long-term relationships. Pre-existing relationships ended; for example, lost partner, close friends. Unable to care for dependants; for example, own children, elderly parent.
Class 5	Totally impaired. Unable to function within society. Living away from populated areas, actively avoids social contact.

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Table 6.15: Psychiatric impairment rating scale (PIRS)

	Concentration, persistence and pace
Class 1	No deficit, or minor deficit attributable to normal variation in the general population. Able to operate at previous educational level; for example, pass a TAFE or university course within normal timeframe.
Class 2	Mild impairment. Can undertake a basic retraining course, or a standard course at a slower pace. Can focus on intellectually demanding tasks for up to 30 minutes, for example, then feels fatigued or develops headache.
Class 3	Moderate impairment. Unable to read more than newspaper articles. Finds it difficult to follow complex instructions; for example, operating manuals, building plans, make significant repairs to motor vehicle, type detailed documents, follow a pattern for making clothes, tapestry or knitting.
Class 4	Severe impairment. Can only read a few lines before losing concentration. Difficulties following simple instructions. Concentration deficits obvious even during brief conversation. Unable to live alone, or needs regular assistance from relatives or community services.
Class 5	Totally impaired. Needs constant supervision and assistance within an institutional setting.

Table 6.16: Psychiatric impairment rating scale (PIRS)

	Adaptation
Class 1	No deficit, or minor deficit attributable to normal variation in the general population. Able to work full time. Duties and performance are consistent with injured person's education and training. The injured person is able to cope with the normal demands of the job.
Class 2	Mild impairment. Able to work full time in a different environment. The duties require comparable skill and intellect. Can work in the same position, but no more than 20 hours per week; for example, no longer happy to work with specific persons, work in a specific location due to travel required.
Class 3	Moderate impairment. Cannot work at all in same position as previously. Can perform less than 20 hours per week in a different position, which requires less skill or is qualitatively different; for example, less stressful.
Class 4	Severe impairment. Cannot work more than one or two days at a time, less than 20 hours per fortnight. Pace is reduced, attendance is erratic.
Class 5	Totally impaired. Cannot work at all.

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Calculation of psychiatric impairment

6.225 Rating psychiatric impairment using the PIRS is a three-step procedure:

(a) determine the median class score

(b) calculate the aggregate score

(c) convert the median class and aggregate score to % WPI.

6.226 Determining the median class score: Each area of function described in the PIRS is given an impairment rating ranging from class 1 to class 5. The six class scores are arranged in ascending order using the standard form (Figure 6.2). The median class is then calculated by averaging the two middle scores. For example:

Example	Impairment rating	Median class
A	1, 2, **3, 3,** 4, 5	= 3
B	1, 2, **2, 3,** 3, 4	= 2.5 = 3
C	1, 2, **3, 5,** 5, 5	= 4

If a score falls between two classes, it is rounded up to the next class. A median class score of 2.5 thus becomes 3. The median class score method was chosen as it is not influenced by extremes. Each area of function is assessed separately. While impairment in one area is neither equivalent to nor interchangeable with impairment in other areas, the median seems the fairest way to translate different impairments onto a linear scale.

6.227 Calculation of the aggregate score: The aggregate score is used to determine an exact percentage of impairment within a particular class range. The six class scores are added to give the aggregate score.

6.228 Converting the median class and aggregate score: The median class and aggregate score are converted to a percentage impairment score using Table 6.17 'Conversion table'.

Table 6.17: Conversion table

	Aggregate score																								
	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Class 1	0	0	1	1	2	2	2	3	3																
Class 2				4	5	5	6	7	7	8	9	9	10												
Class 3								11	13	15	17	19	22	24	26	28	30								
Class 4												31	34	37	41	44	47	50	54	57	60				
Class 5																61	65	70	74	78	83	87	91	96	100

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Conversion table - Explanatory notes

1. Distribution of aggregate scores:
   - The lowest aggregate score that can be produced is 1 + 1 + 1 + 1 + 1 + 1 = 6.
   - The highest score that can be produced is 5 + 5 + 5 + 5 + 5 + 5 = 30.
   - Table 6.17 therefore has aggregate scores ranging from 6 to 30.
   - Each median class score has a range of possible aggregate scores and hence a range of possible impairment scores (for example, class 3 = 11% - 30% WPI).
   - Table 6.17 distributes the impairment percentages across the possible range of aggregate scores.
2. Same aggregate score in different classes:
   - Table 6.17 shows that the same aggregate score leads to different impairment percentages for different median classes. For example, an aggregate score of 18 is equivalent to an impairment rating of:
     - 10% in class 2
     - 22% in class 3
     - 34% in class 4.
   - This is because the injured person whose impairment is in median class 2 is likely to have a lower score across most areas of function. The injured person may be significantly impaired in one aspect of their life, such as travel, yet have low impairment in social function, self-care or concentration. In contrast, someone whose impairment reaches median class 4 will experience significant impairment across most aspects of their life.

Examples

Example A

List classes in ascending order							Median class value	
1	2	**3**	**3**	4	5			3
Aggregate score							Total	%
1 +	2 +	3 +	3 +	4 +	5	=	18	22% WPI

Example B

List classes in ascending order							Median class value	
1	2	**2**	**3**	3	5			3
Aggregate score							Total	%
1 +	2 +	2 +	3 +	3 +	5	=	16	17% WPI

Example C

List classes in ascending order							Median class value	
1	2	**3**	**5**	5	5			4
Aggregate score							Total	%

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1 +	2 +	3 +	5 +	5 +	5	=	21	44% WPI

Figure 6.2: Psychiatric impairment rating scale – Assessment form

Psychiatric diagnoses	1.			2.				
	3.			4.				
Psychiatric treatment								
Category	**Class**	**Reason for decision**						
Self-care and personal hygiene								
Social and recreational activities								
Travel								
Social functioning								
Concentration, persistence and pace								
Adaptation								
List classes in ascending order							Median class value	
Aggregate score							Total	%
+	+	+	+	+		=		
Pre-existing/subsequent impairment? If applicable, determine % as above								
List classes in ascending order							Median class value	
Aggregate score							Total	%
+	+	+	+	+		=		
Final % WPI _____								

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Other body systems

Respiratory system

6.229 The system of respiratory impairment classification is based on a combination of forced vital capacity (FVC), forced expiratory volume (FEV1) and diffusing capacity of carbon monoxide (DCO) or measurement of exercise capacity (VO2 max). Chapter 5 (pages 153-167, AMA4 Guides) should be infrequently used in assessing impairment following a motor accident. Healed sternal and rib fractures do not result in any assessable impairment unless they result in a permanent impairment of respiratory function.

6.230 Table 8 (page 162, AMA4 Guides) provides the classification of respiratory impairment. A footnote to the table reinforces that conditions other than respiratory disease may reduce maximum exercise capacity and medical assessors must carefully interpret the clinical presentation of the injured person.

6.231 The medical assessor must provide a specific percentage impairment for permanent impairment due to respiratory conditions. Table 8 (page 162, AMA4 Guides) must be used to classify the injured person's impairment. Classes 2, 3 and 4 define a range of WPI percentages. The medical assessor must provide a specific percentage impairment within the range for the class that best describes the clinical status of the injured person. Class 2 (10-25% WPI) will need careful consideration.

6.232 Use of Tables 2 to 7 (pages 156-161, AMA4 Guides) may give rise to an inaccurate interpretation of lung function and impairment due to age or race. Where appropriate, Tables 2 to 7 should be replaced with relevant guidelines from a substantial body of peer-reviewed research literature, which must be referenced.

Cardiovascular system

Introduction and assessment of the cardiovascular system

6.233 Chapter 6 (pages 169-199, AMA4 Guides) provides a clear explanation of the methods required for the assessment of the cardiovascular system.

6.234 The results from all relevant diagnostic tests must be taken into account by the medical assessor, including:

(a) ECG (including an exercise ECG)

(b) standard and trans-oesophageal echocardiogram

(c) exercise thallium scan, exercise echo scan

(d) coronary angiograms

(e) operative notes for coronary artery bypass grafts, coronary angioplasty or other surgery

(f) Holter monitoring results

(g) electrodiagnostic studies

(h) serum urea/electrolytes and urinalysis (particularly if hypertensive).

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6.235 Diagnostic tests should not be ordered by the medical assessor for the purpose of rating impairment. This is in keeping with the approach taken elsewhere in Part 6 of the Guidelines.

6.236 Functional classification of cardiovascular system impairments: Table 2 (page 171, AMA4 Guides) should be used as an option if the medical assessor is not sure into which category the injured person should be placed based on specific pathology (refer to Tables 4-12, pages 172-195, AMA4 Guides). Table 2 can be used as a *referee or umpire* if there is doubt about the level of impairment that is obtained using the other recommended tables in this section.

6.237 Hypertensive cardiovascular disease (section 6.4, pages 185-188, AMA4 Guides): This type of cardiovascular disease (Table 9, page 187, AMA4 Guides) requires medical documentation of the hypertension. If the injured person's illness is controlled with medication, then they might not be assessable under this table. The medical assessor should refer to clauses 6.25-6.29 of these Guidelines.

6.238 Vascular diseases affecting the extremities (pages 196-198, AMA4 Guides): Impairments due to upper or lower extremity peripheral vascular disease resulting from vascular trauma must be assessed using the 'Musculoskeletal' Chapter of the AMA4 Guides. Tables 13 and 14 (pages 197-198, AMA4 Guides) must not be used.

6.239 Impairment scores from Table 17 'Impairment of the upper extremity due to peripheral vascular disease' (page 57, AMA4 Guides) and Table 69 'Impairment of the lower extremity due to peripheral vascular disease' (page 89, AMA4 Guides) must be converted to WPI.

Haematopoietic system

Introduction and assessment of the haematopoietic system

6.240 Chapter 7 (pages 201-207, AMA4 Guides) will be infrequently used in the motor accident context. The methods of impairment assessment suggested in this Part of the Motor Accident Guidelines should be used.

6.241 Splenectomy is covered in this chapter (page 205, AMA4 Guides). An injured person with post-traumatic splenectomy must be assessed as having 3% WPI.

Visual system

Introduction and assessment of the visual system

6.242 The visual system must be assessed by an ophthalmologist. Chapter 8 of the AMA4 Guides (pages 210-222) must be used.

6.243 Impairment of vision should be measured with the injured person wearing their corrective spectacles or contact lenses, if it was normal for the injured person to wear them before the motor accident, or if the need for such spectacles has become necessary due to normal physiological changes to the refractive error either in distance or near vision. If as a result of the injury, the injured person has been prescribed corrective spectacles and/or contact lenses for the first time, or different spectacles and/or contact lenses than those prescribed pre-injury, the difference should be accounted for in the assessment of permanent impairment.

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Digestive system

Introduction and assessment of the digestive system

6.244 Assessments must be performed using the methods outlined in Chapter 10 (pages 235-248, AMA4 Guides).

6.245 Tables 2 to 7 in Chapter 10 (pages 239-247, AMA4 Guides) give details of the components to be assessed. Examples are given that assist by describing illustrative cases. Note that splenectomy is discussed in the 'Haematopoietic system' chapter.

6.246 In Table 2, 'Classes of impairment of the upper digestive tract' (page 239, AMA4 Guides), the reference to *Loss of weight below desirable weight does not exceed 10%* in class 2 must be replaced with *Loss of weight below desirable weight (if any) does not exceed 10%.*

6.247 Upper digestive tract disease caused by the commencement and ongoing use of anti-inflammatory medications must be assessed as 0-2% WPI class 1 impairment according to Table 2 (page 239, AMA4 Guides). Upper digestive tract disease caused by the use of anti-inflammatory medications resulting in severe and specific signs or symptoms must be assessed as a class 2 impairment according to Table 2 (page 239, AMA4 Guides).

6.248 Colonic and/or rectal disease caused by the use of opiate medication must be assessed as 0-2% WPI class 1 impairment according to Table 2 (page 239, AMA4 Guides). Assessment of constipation alone results in 0% WPI.

6.249 Table 7 (page 247, AMA4 Guides): In classes 1 and 2 the first criterion must be present, together with the second or third criterion. In class 3, all three criteria must be present.

Urinary and reproductive systems

Introduction and assessment of the urinary and reproductive systems

6.250 Chapter 11 (pages 249-262, AMA4 Guides) is used for the assessment of urinary and reproductive systems and provides clear methods for assessing impairment in these systems.

6.251 For male and female sexual dysfunction, objective pathology should be present for an impairment percentage to be given.

6.252 Objective evidence of neurological impairment is necessary to assess incontinence related to spinal injury (AMA4 Guides, Chapter 4, 4.3d). Objective evidence of injury to the bladder and urethra associated with urinary incontinence is necessary to assess urinary incontinence due to trauma (AMA4 Guides, Chapter 11, 11.3 and 11.4)

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Endocrine system

Introduction and assessment of the endocrine system

6.253 Chapter 12 (pages 263-275, AMA4 Guides) is used to assess the endocrine system. Each endocrine organ or system is listed separately.

6.254 Where an impairment class defines a range of WPI percentages, the medical assessor must define a specific percentage impairment within the range described by the class that best describes the clinical status of the injured person and provide reasons.

6.255 Where injury has resulted in fat necrosis in the mammary glands, this must be assessed using Chapter 13 'The skin' (pages 278-289, AMA4 Guides).

6.256 Section 12.8 'Mammary glands' (page 275, AMA4 Guides) is replaced by these Guidelines. Total loss of one or both mammary glands is deemed to be an impairment of greater than 10% WPI.

6.257 Injury to the breast(s) caused by damage to a breast implant(s) must be assessed as class 1, Table 2 (page 280, AMA4 Guides).

Skin

Introduction and assessment of the skin

6.258 Chapter 13 (pages 277-289, AMA4 Guides) refers to skin diseases generally. In the context of injury, sections 13.4 'Disfigurement' (page 279, AMA4 Guides) and 13.5 'Scars and skin grafts' are particularly relevant.

6.259 The assessment of permanent impairment involving scarring of the face may be undertaken using Chapter 13 'The skin' (pages 279-280, AMA4 Guides) and/or section 9.2 'The face' (pages 229-230, AMA4 Guides). Criteria for facial impairment are listed on page 229 of the AMA4 Guides. Specific facial disfigurements may also be assessed by reference to Table 4 (page 230, AMA4 Guides).

6.260 Disfigurement, scars and skin grafts may be assessed as causing significant permanent impairment when the skin condition causes limitation in performance of activities of daily living. Assessment should include a history that sets out any alterations in activities of daily living. The AMA4 Guides (page 317) contain a table of activities of daily living. Any impairment secondary to severe scarring, such as contracture or nerve damage, is assessed using other chapters and combined with the assessment for scarring.

6.261 A scar may be present and rated 0% WPI.

6.262 Table 2 (page 280, AMA4 Guides) provides the method of classifying impairment due to skin disorders. Three components - namely signs and symptoms of skin disorder, limitation of activities of daily living and requirements for treatment - define five classes of impairment. Determining which class is applicable is primarily dependent on the impact of the skin disorder on daily activities. The medical assessor must derive a specific percentage impairment within the range described by the class that best describes the clinical status of the injured person. All three criteria must be present. Impairment values are WPI.

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6.263 When using Table 2 (page 280, AMA4 Guides), the medical assessor is reminded to consider the skin as an organ. The effect of scarring (whether single or multiple) must be considered as the total effect of the scar on the organ system as it relates to the criteria in Table 2 'Table for the evaluation of minor skin impairment' (TEMSKI). Multiple scars must not be assessed individually. The medical assessor must not add or combine the assessment of individual scars but assess the total effect of the scarring on the entire organ system.

6.264 The TEMSKI (Table 6.18) is an extension of Table 2 (page 280, AMA4 Guides). The TEMSKI divides class 1 into five categories of impairment. When a medical assessor determines that a skin disorder falls into class 1, they must assess the skin disorder in accordance with the TEMSKI criteria. The medical assessor must evaluate all scars either individually or collectively with reference to the five criteria and 10 descriptors of the TEMSKI. The medical assessor should address all descriptors.

6.265 The TEMSKI must be used in accordance with the principle of *best fit.* The medical assessor must be satisfied that the criteria within the chosen category of impairment best reflect the skin disorder being assessed. The skin disorder should meet most, but does not need to meet all, of the criteria within the impairment category in order to satisfy the principle of best fit. The medical assessor must provide reasons as to why this category has been selected.

6.266 Where there is a range of values in the TEMSKI categories, the medical assessor should use clinical judgement to determine the exact impairment value and provide reasons that clearly link their clinical judgement to the impairment value selected.

6.267 For the purpose of assessing fat necrosis, Chapter 13 'The skin' (pages 277-289, AMA4 Guides) may be used by analogy where appropriate.

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Table 6.18: Table for the evaluation of minor skin impairment (TEMSKI)

Criteria	0% WPI	1% WPI	2% WPI	3–4% WPI	5–9% WPI
Description of the scar(s) and/or skin condition(s) (shape, texture, colour)	Injured person is not conscious or is barely conscious of the scar(s) or skin condition	Injured person is conscious of the scar(s) or skin condition	Injured person is conscious of the scar(s) or skin condition	Injured person is conscious of the scar(s) or skin condition	Injured person is conscious of the scar(s) or skin condition
	Good colour match with surrounding skin and the scar(s) or skin condition is barely distinguishable	Some parts of the scar(s) or skin condition colour contrast with the surrounding skin as a result of pigmentary or other changes	Noticeable colour contrast of scar(s) or skin condition with surrounding skin as a result of pigmentary or other changes	Easily identifiable colour contrast of scar(s) or skin condition with surrounding skin as a result of pigmentary or other changes	Distinct colour contrast of scar(s) or skin condition with surrounding skin as a result of pigmentary or other changes
	Injured person is unable to easily locate the scar(s) or skin condition	Injured person is able to locate the scar(s) or skin condition	Injured person is able to easily locate the scar(s) or skin condition	Injured person is able to easily locate the scar(s) or skin condition	Injured person is able to easily locate the scar(s) or skin condition
	No trophic changes	Minimal trophic changes	Trophic changes evident to touch	Trophic changes evident to touch	Trophic changes are visible
	Any staple marks or suture marks are barely visible	Any staple marks or suture marks are visible	Any staple marks or suture marks are clearly visible	Any staple marks or suture marks are clearly visible	Any staple marks or suture marks are clearly visible
Location	Anatomic location of the scar(s) or skin condition is not clearly visible with usual clothing/hairstyle	Anatomic location of the scar(s) or skin condition is not usually visible with usual clothing/hairstyle	Anatomic location of the scar(s) or skin condition is usually visible with usual clothing/hairstyle	Anatomic location of the scar(s) or skin condition is usually visible with usual clothing/hairstyle	Anatomic location of the scar(s) or skin condition is usually and clearly visible with usual clothing/hairstyle
Contour	No contour defect	Minor contour defect	Contour defect visible	Contour defect easily visible	Contour defect easily visible
ADL/ treatment	No effect on any ADL	Negligible effect on any ADL	Minor limitation in the performance of few ADL	Minor limitation in the performance of few ADL *and* exposure to chemical or physical agents (for example sunlight, heat, cold, etc.) may temporarily increase limitation	Limitation in the performance of few ADL (*in addition to* restriction in grooming and dressing) *and* exposure to chemical or physical agents (for example sunlight, heat, cold, etc.) may temporarily increase limitation or restriction
	No treatment, or intermittent treatment only, required	No treatment, or intermittent treatment only, required	No treatment, or intermittent treatment only, required	No treatment, or intermittent treatment only, required	No treatment, or intermittent treatment only, required
Adherence to underlying structures	No adherence	No adherence	No adherence	Some adherence	Some adherence

Note: This table uses the principle of best fit. Medical assessors should assess the impairment to the whole skin system against each criteria and then determine which impairment category best fits (or describes) the impairment. A skin impairment will usually meet most, but does not need to meet all, criteria to best fit a particular impairment category.

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Part 7 of the Motor Accident Guidelines: Dispute resolution

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Preliminary

Explanatory note

7.1 'Part 7 of the Motor Accident Guidelines: Dispute resolution' is made under those sections of the *Motor Accident Injuries Act 2017* (NSW) (the Act) relating to dispute resolution in the NSW motor accident injuries (MAI) scheme, including internal reviews by insurers and the Dispute Resolution Service (DRS) of the State Insurance Regulatory Authority (the Authority).

7.2 DRS has been established by the Authority under Division 7.2, section 7.2 of the Act, as a dispute resolution service that is independent of insurers and claimants, to resolve disputes as they arise during the course of a claim.

7.3 The power to make this Part of the Motor Accident Guidelines comes from the Act, including Part 7, Division 7.3 (Internal review), Division 7.4 (Merit review), Division 7.5 (Medical assessment) and Division 7.6 (Claims assessment).

Definitions

7.4 The definitions of terms in this clause apply to this Part of the Motor Accident Guidelines. For terms that are not included here, the definitions provided by the Act apply. The terms used in 'Part 7 of the Motor Accident Guidelines: Dispute resolution' have the following meanings:

Act – the *Motor Accident Injuries Act 2017* (NSW).

Advisory service – An advisory service under section 7.49 of the Act to assist claimants in connection with their claims and with the dispute resolution procedures under Part 7 of the Act.

Applicant – The party that refers a claim or dispute in connection with a claim.

Application – The way a party refers a merit review matter, medical assessment and claims assessment matter to DRS.

Claims for insurers – 'Part 4 of the Motor Accident Guidelines: Claims', which is made under section 6.1 of the Act, and which makes provision with respect to the manner in which insurers and those acting on their behalf are to deal with claims.

Decision-maker – A DRS merit reviewer, DRS claims assessor, DRS principal claims assessor, DRS proper officer or DRS medical assessor.

DRS – The Dispute Resolution Service of the Authority.

EDM system – Electronic Dispute Management system.

Health Practitioner – Has the same meaning as in the *Health Practitioner Regulation National Law* (NSW).

Internal reviewer – An insurer's internal reviewer who may conduct an internal review under Division 7.3 of the Act.

MAI scheme – The NSW motor accident injuries scheme created under the Act.

Matters – A merit review matter, medical assessment matter, or miscellaneous claims assessment matter as declared by Schedule 2 of the Act.

Officer of DRS – A staff member of DRS.

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Parties – A reference in this Part of the Motor Accident Guidelines to a party includes a reference to any representative of that party, unless otherwise specified.

PCA – The principal claims assessor of DRS appointed under Schedule 3 of the Act.

Regulation – The Motor Accident Injuries Regulation 2017.

Representative – A person representing an insurer or claimant.

Reply – The response to an application.

Respondent – A party who replies to an application.

Obligations and duties

Obligations and duties of the insurer

7.5 An insurer must:

(a) act in accordance with the objects of the Act and the objects of DRS

(b) comply with its duty to act in good faith under section 6.3 of the Act

(c) comply with its duty to endeavour to resolve a claim as justly and expeditiously as possible under section 6.4 of the Act

(d) act honestly and fairly while participating in any dispute resolution processes, including complying with any requests or directions made by decision-makers

(e) not mislead the parties, representatives, DRS or any decision-maker

(f) attempt to identify and narrow any issues in dispute before any application is lodged with DRS and continue to do so while any application is being considered by DRS

(g) comply with the requirements of 'Part 7 of the Motor Accident Guidelines: Dispute resolution'.

Obligations and duties of the claimant

7.6 A claimant must:

(a) act in accordance with the objects of the Act and the objects of DRS

(b) comply with their duty to act in good faith under section 6.3 of the Act

(c) comply with their duty to endeavour to resolve a claim as justly and expeditiously as possible under section 6.4 of the Act

(d) comply with their duty to take all reasonable steps to minimise their loss under section 6.5 of the Act

(e) comply with any requests or directions made by decision-makers

(f) act honestly and not mislead the parties, representatives, DRS or any decision-maker

(g) attempt to identify and narrow any issues in dispute before any application is lodged with DRS and continue to do so while any application is being considered by DRS

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(h) comply with the requirements of 'Part 7 of the Motor Accident Guidelines: Dispute resolution'.

Obligations of a representative of a party

7.7 A representative of a claimant or insurer must:

(a) act honestly and not mislead the parties, representatives, DRS or any decision-maker

(b) assist the party they are representing to act in accordance with the objects of the Act and the objects of DRS

(c) assist the party they are representing to meet their obligations and duties under these Guidelines

(d) ensure that they do not, by their conduct, cause the party they represent to fail to meet their obligations and duties under these Guidelines.

Obligations of DRS

7.8 Decision-makers of DRS must:

(a) assist the parties to resolve the issues in dispute referred to them

(b) assist the parties to further the objects of the Act and the objects of DRS

(c) assist the parties to meet their obligations and duties under these Guidelines

(d) act honestly and not mislead the parties, representatives or any decision-maker

(e) interpret and apply the provisions of this Part of the Motor Accident Guidelines in a way that best supports the objects of the Act, and the objects of DRS.

7.9 Officers of DRS must:

(a) assist the parties and decision-makers to resolve any issues in dispute in the claim

(b) assist the parties and decision-makers to further the objects of the Act and the objects of DRS

(c) assist the parties, their representatives and decision-makers to meet their obligations and duties under these Guidelines.

7.10 DRS may provide reports to the Authority on the failure of a claimant or insurer to comply with any duty, under section 6.7 of the Act.

Expert witness code of conduct

7.11 Any party who retains an expert to provide evidence or a report for use at DRS must bring to the expert's attention relevant statutory regulations and guidelines, including this section.

7.12 Individuals that must comply with this code of conduct include any person engaged as an expert witness to provide a report or to give opinion evidence in:

(a) a dispute about a merit review matter, medical assessment matter, or a miscellaneous claims assessment matter

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(b) the assessment of a claim under Division 7.6

(c) the exercise of a function, not included in Schedule 2, by a decision-maker designated by the DRS.

7.13 An expert witness has an overriding duty to assist DRS impartially on matters relevant to the expert witness's area of expertise.

Expert reports

7.14 An expert witness is not an advocate for a party.

7.15 Every report prepared by an expert witness must include the following:

(a) the name and address of the expert

(b) an acknowledgement that the expert has read this code of conduct and agrees to be bound by it

(c) the expert's qualifications to prepare the report

(d) the facts and assumptions of fact, on which the opinions in the report are based (a letter of instructions may be annexed)

(e) the expert's reasons for each opinion expressed

(f) if applicable, that a particular issue falls outside the expert's field of expertise

(g) any literature or other materials used in support of the opinions

(h) any examinations, tests or other investigations on which the expert has relied, including details of the qualifications of the person who carried them out

(i) whether any opinion expressed in the report is not a concluded opinion because of insufficient research, data or for any other reason

(j) in the case of a report that is lengthy or complex, a brief summary of the report (to be located at the beginning of the report).

7.16 If an expert witness changes their opinion on a material matter after providing a report, the expert witness must immediately provide a supplementary report to that effect containing all relevant information as listed above.

Working co-operatively with other expert witnesses

7.17 An expert witness must promptly comply with all directions given by a DRS decision-maker, including to confer with another expert witness or to prepare a joint report with another expert witness on any issue. The expert witness must:

(a) exercise professional judgment on that issue

(b) endeavour to reach agreement with another expert witness on that issue

(c) not act on any instructions or request to withhold or avoid agreement with any other expert witness.

Conclaves, conferences and evidence

7.18 An expert witness must abide by any direction of a DRS decision-maker to:

(a) attend a conclave or conference with any other expert witness

(b) endeavour to reach agreement on any matters in issue

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(c) prepare a joint report, specifying matters agreed and matters not agreed and reasons for any disagreement

(d) base any joint report on specified facts or assumptions of fact

(e) give evidence concurrently with other experts.

7.19 An expert witness must exercise his or her independent, professional judgment regarding such a conclave or conference and joint report and must not act on any instruction or request to withhold or avoid agreement.

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Insurer internal review

Guideline powers

7.20 This Part of the Motor Accident Guidelines, in relation to internal reviews by insurers, is made under the Act, including under Division 7.3, section 7.9 of the Act.

Internal review matters

Decisions subject to an internal review

7.21 A claimant may request an internal review by the insurer of its decision about a merit review matter, medical assessment matter, or a miscellaneous claims assessment matter.

7.22 Merit review matters, medical assessment matters and miscellaneous claims assessment matters are defined in section 7.1 of the Act to be those matters that are declared by Schedule 2 of the Act.

Decisions not subject to an internal review

7.23 An application to DRS may be made without an internal review, under sections 7.11(2), 7.19(2) and 7.41(2) of the Act, if the insurer has failed to complete an internal review and notify the claimant of the decision on the internal review as and when required to do so, or has declined to conduct a review.

7.24 Part 5, Division 1 of the Regulation prescribes the types of matters that do not require an internal review before an application to DRS is made.

Requesting an internal review

Time for requesting an internal review

7.25 A claimant may request an internal review of a decision within 28 days of receiving notice of the decision from the insurer.

7.26 If a claimant requests an internal review more than 28 days after receiving notice of the decision from the insurer, the insurer may decline or accept the application. The insurer must provide the claimant with a written notice of its decision to decline a late application for internal review. The notice must state that the claimant may apply to DRS to dispute a reviewable decision of the insurer because the insurer has declined to conduct an internal review.

Application requirements

7.27 A claimant may request an internal review by the insurer by:

(a) application form – completing the approved form for requesting an internal review by the insurer and delivering it to the insurer by post, email, facsimile or in person

(b) online application process – completing an approved online application for requesting an internal review by the insurer

(c) letter – contacting the insurer by letter and requesting an internal review

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(d) telephone – contacting the insurer by telephone and requesting an internal review.

7.28 A request for an internal review of an insurer's decision must include:

(a) all requirements specified in any paper or online application form approved by the Authority for making a request for an internal review

(b) details of:

- the decision of the insurer that is being referred for internal review
- the alternative decision sought in the internal review
- issues under review – the elements of the original decision that the claimant wishes to be reviewed
- the reasons the claimant believes the decision should be changed
- any additional documentation or materials that the claimant considers relevant to a review of the decision.

7.29 A claimant may withdraw a request for an internal review of a decision by letter, facsimile, telephone, email, or in person at any time before the insurer sends notification of the internal review decision to the claimant. The insurer must confirm the withdrawal of the request for an internal review in writing to the claimant.

Responding to an internal review application

7.30 The insurer must acknowledge receipt of the application for internal review by notifying the claimant within two business days of receiving the application.

7.31 The notification must be in writing and must be delivered either by post, email, online electronic delivery, or a combination of these methods, depending on the claimant's preference.

7.32 The notification from the insurer must advise the claimant whether the insurer accepts that it has power to conduct an internal review of the decision, or alternatively whether the insurer does not accept it has the power to conduct an internal review. The notification must include the date that the application was received and the date the internal review decision is due to be issued.

7.33 If the insurer accepts that it has the power to conduct an internal review of the decision, the insurer must advise the claimant as soon as practicable, and preferably within seven days of receiving the application, of:

(a) issues under review – the elements of the original decision that the insurer understands are under review

(b) internal reviewer – the person allocated as the internal reviewer to conduct the internal review

(c) additional information – any additional relevant documents or information required from the claimant for the internal review, and any additional information or documentation that the insurer has that is relevant to the internal review and has not previously been provided to the claimant

(d) how to make contact – how the claimant can contact the insurer about the internal review, and how the claimant can contact the advisory service about the internal review.

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7.34 If the insurer does not accept it can conduct an internal review, the insurer must notify the claimant in writing as soon as practicable and preferably within seven days of receiving the application of:

(a) reasons for decision – brief reasons for the decision to decline to conduct the review

(b) the internal reviewer – the person who decided to decline to conduct the review

(c) how to make contact – how the claimant can contact the insurer about the decision to decline to conduct the review, and how the claimant can contact the advisory service about the decision

(d) next steps for the claimant – the options available to the claimant if they disagree with the decision, including that they can seek legal advice as to the options available

(e) that the claimant may apply to DRS to dispute a reviewable decision of the insurer because the insurer has declined to conduct an internal review.

7.35 If an insurer accepts it can conduct an internal review and then subsequently determines it cannot do so, the insurer must notify the claimant as soon as practicable of its decision to decline the application in accordance with the notification requirements set out above.

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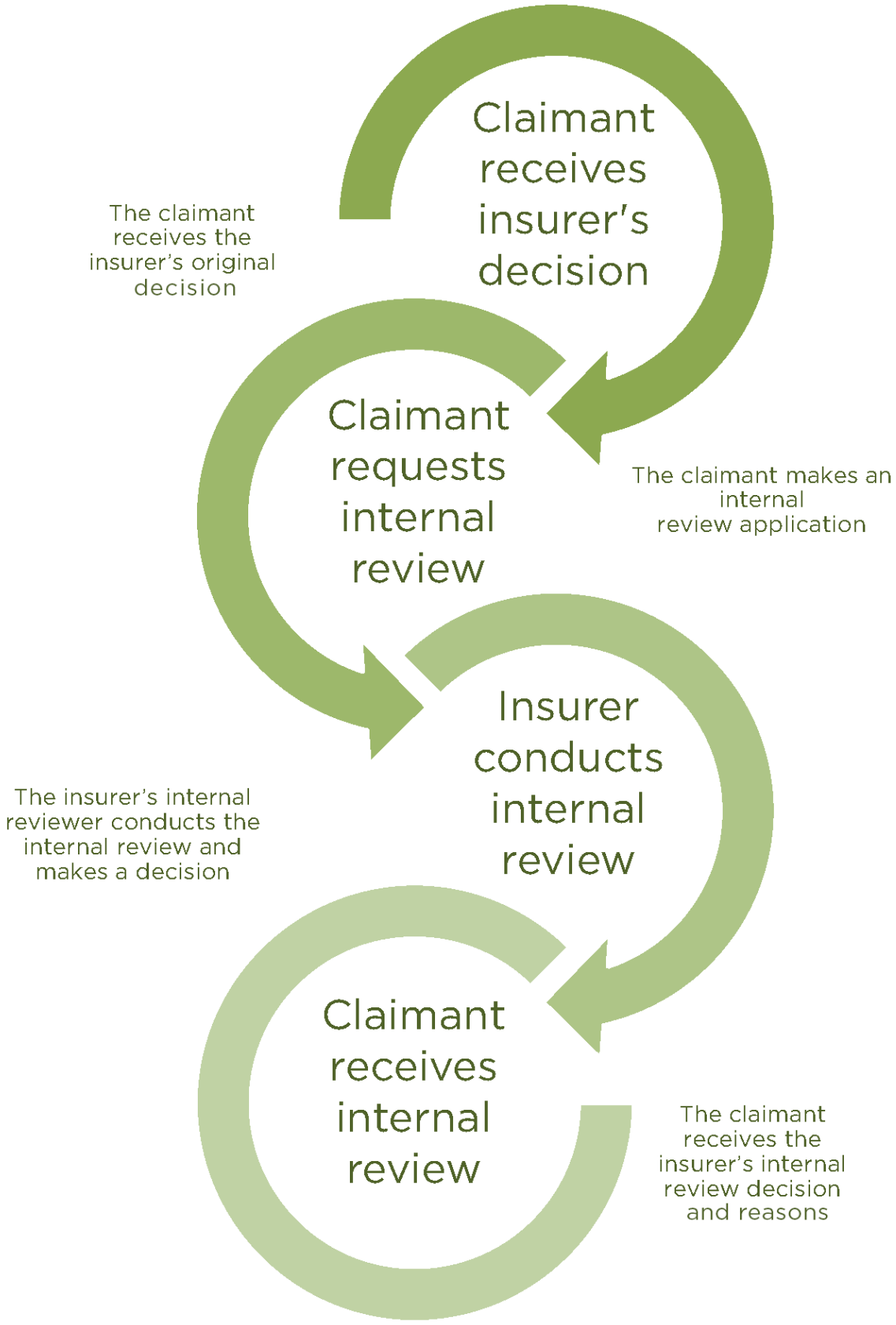
Figure 7.1: The internal review process



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The internal review

The internal reviewer

7.36 The insurer must appoint an internal reviewer who:

(a) has the required skills, experience, knowledge and capability to conduct the internal review in accordance with the objects of the Act, the obligations and duties established in this Part of the Motor Accident Guidelines

(b) has not been involved in making or advising on the insurer's initial decision, has not previously managed any aspect of the claim or is not someone the initial decision-maker reports to or manages directly

(c) may have previously conducted an internal review in relation to the same claim.

The internal review process

7.37 The internal review must be conducted in the way that best supports the objects of the Act, given the facts and circumstances of the particular claim and the particular internal review, which may include undertaking the review on the papers, using teleconferences, video conferences or face-to-face meetings as appropriate.

7.38 The internal reviewer may determine the internal review procedure, is not bound by the rules of evidence and may inquire into any matter relevant to the issues under review in such manner as the internal reviewer thinks fit.

7.39 The claimant may submit new information to the insurer to be considered by the internal reviewer.

7.40 The internal reviewer may consider information that was not provided before the decision being reviewed was made, under section 7.9(6) of the Act. The insurer must provide any such information to the claimant if it has not already been provided to the claimant and the claimant the opportunity to respond to the information.

7.41 The insurer may reasonably request information from the claimant for the purposes of the internal review, which the claimant must provide, under section 7.9(2) of the Act.

7.42 If the claimant does not provide the insurer with the information reasonably requested, the insurer may decline to conduct an internal review.

The internal review decision

7.43 In determining an internal review application, the internal reviewer must review the matter on the merits and make their decision having regard to the material before them, including the relevant factual material and applicable law.

7.44 In determining an internal review application, the internal reviewer may decide to:

(a) affirm the original decision

(b) vary the original decision

(c) set aside the original decision and make a decision in substitution for the original decision.

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7.45 The insurer must notify the claimant of the results of the internal review within the period of time specified in Table 7.1 after receiving the request for review, under section 7.9(4) of the Act, unless the circumstances outlined below apply to allow a longer period.

Table 7.1: Internal review notification period

Internal review matter types	Internal review period
Merit review matters: 1. all matters (Schedule 2, clause 1)	14 days
Medical assessment matters about: 2. treatment and care being reasonable and necessary and causally related (Schedule 2, clause 2(b)) 3. treatment and care improving recovery (Schedule 2, clause 2(c)) 4. degree of impairment of earning capacity (Schedule 2, clause 2(d))	14 days
Medical assessment matters about: 5. degree of permanent impairment (Schedule 2, clause 2(a)) 6. minor injury (Schedule 2, clause 2(e))	21 days
Miscellaneous claims assessment matters: 7. excluding those matters listed below (Schedule 2, clause 3)	14 days
Miscellaneous claims assessment matters about: 8. fault (Schedule 2, clause 3(d)) 9. person mostly at fault (Schedule 2, clause 3(e)) 10. serious driving offence exclusion (Schedule 2, clause 3(f)) 11. contributory negligence (Schedule 2, clause 3(g))	21 days

7.46 In any application for internal review, insurer has a longer period, under section 7.9(5) of the Act, to complete and give notice of the results of an internal review where:

(a) the claimant provides, at some point after the application for an internal review was lodged, new information of their own or at the insurer's request that is relevant to the issues under review, an additional period of up to 14 days after the information is provided is allowed; and

(b) in any case, the maximum period including any longer periods above, must be no more than 28 days after the claimant's request for the insurer to complete and give notice of the results of the internal review.

7.47 The internal review decision of the insurer should be applied and given effect to as quickly as is practicable, in accordance with the insurer's responsibilities under this Part of the Motor Accident Guidelines.

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7.48 A claimant who has received an internal review decision made by the insurer may refer that decision to DRS.

7.49 In notifying the claimant of the results of the internal review, the insurer must provide the claimant with:

(a) the internal reviewer's certificate including brief reasons for the decision and supporting documents

(b) details of how and when the insurer will give effect to the internal reviewer's decision

(c) details of the result of the internal reviewer's decision on the claimant's entitlement to statutory benefits

(d) information on how a claimant may apply to DRS, including DRS contact details.

Legal costs for internal reviews

7.50 The Regulation in Part 6, Division 2, clause 23 provides that no costs are payable for legal services to a claimant or to an insurer in connection with an application for an internal review by the insurer.

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Dispute Resolution Service

Lodging applications and replies

7.51 The general process for referring a dispute to DRS for resolution is by lodging an application in accordance with the standard DRS application requirements set out in the 'Lodging applications and replies' section of this Part of the Motor Accident Guidelines.

7.52 Additional application requirements for each specific type of dispute referral are also set out in subsequent clauses in this Part of the Motor Accident Guidelines in relation to merit review matters, medical assessment matters, and claims assessment matters.

7.53 For functions conferred on DRS by the Act in relation to any matter other than a merit review matter, medical assessment matter or miscellaneous claims assessment matter, to the extent that those functions require or permit an application to be made by a party, such matters may be referred to DRS by lodging an application in accordance with the standard DRS application requirements. The Executive Director, a Director, or the PCA of DRS will designate the appropriate type of decision-maker or decision-makers to determine the application.

Contacting DRS

7.54 The DRS office is located at 1 Oxford Street, Darlinghurst, Sydney, and is open to the public for lodgement of documents and general enquiries from 8:30am to 5:00pm except on Saturdays, Sundays and public holidays.

7.55 DRS may make provision for lodgement of documents electronically and also outside the usual opening hours. Any documents lodged electronically after 11:59pm will be deemed to have been received on the next day that DRS is open to the public for lodgement of documents in person.

7.56 The contact details for DRS are:

Phone: 1800 34 77 88

Address: 1 Oxford St, Darlinghurst, NSW 2010

Email: drsenquiries@sira.nsw.gov.au

Lodging an application with DRS

7.57 A claimant may lodge an application with DRS by:

(a) application form – completing the approved DRS application form, and lodging it with DRS by post, email, or in person

(b) online application process – completing an approved online DRS application process through an electronic dispute management (EDM) system

(c) telephone – contacting DRS by telephone to make an application, which DRS will confirm in writing to the parties, confirming the nature and extent of the application.

7.58 An insurer or its representative must lodge an application with DRS by completing an approved online DRS application through electronic dispute management (EDM) system. If the EDM system or the insurer's system is

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unavailable at the time of lodgement, the insurer may complete a DRS application form and lodge it with DRS by post, email or in person.

7.59 DRS will, as soon as practicable, and preferably within two business days, acknowledge receipt of the application, and will give notice of the application to the other party, providing them with access to the application and all supporting documents and materials.

Application requirements

7.60 An application to DRS must include:

(a) all requirements specified in any approved application form

(b) all requirements specified in any approved online application process through any EDM system

(c) all information requested by a DRS officer while a telephone application is being made.

7.61 A claimant who is making an application should list all documents relevant to their application, but they do not need to attach copies of documents or materials they have previously provided to the insurer. The claimant only needs to provide copies of new documents or materials.

7.62 The insurer is required to provide to DRS all of the documents or materials in its possession relevant to the proceedings, including documents and materials listed in the application by the claimant and all documents the claimant has previously provided to the insurer.

7.63 When providing the documents through the EDM, the insurer must upload the documents individually and categorise them, by selecting the most relevant category for each document. Failure to categorise documents lodged by an insurer may result in an application being rejected.

7.64 DRS may decline to accept an application if the application does not comply with the above requirements, and will notify the parties as soon as practicable, providing brief reasons for its decision.

7.65 An applicant may withdraw or amend an application to DRS online, by letter, telephone, email, or in person at any time before DRS notifies the parties of the outcome. DRS will confirm the withdrawal or amendment of the application in writing to the parties.

Lodging a reply with DRS

7.66 A reply should be lodged as soon as practicable by a respondent and within any time limits specified in the Act, the Regulation or this Part of the Motor Accident Guidelines.

7.67 A claimant may lodge a reply to an application with DRS by:

(a) reply form – completing the approved DRS reply form, and lodging it with DRS by post, email, or in person

(b) online reply process – completing an approved online DRS reply process through an EDM system

(c) telephone – contacting DRS by telephone, which DRS will confirm in writing to the parties, confirming the nature and extent of the claimant's reply.

7.68 An insurer or its representative must lodge a reply with DRS by completing an approved online DRS application through the EDM. If the EDM or the insurer's

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system is unavailable at the time of lodgement, the insurer can complete a DRS application form and lodge it with DRS by post, email or in person.

7.69 As soon as practicable, and preferably within two business days of receiving the reply, DRS will acknowledge receipt of the reply to the respondent will give notice of the reply to the applicant, providing them with access to the reply, all supporting documents and materials and opportunity to make any further submissions.

Reply requirements

7.70 A reply to an application must include:

(a) all requirements specified in any approved reply form for responding to an application

(b) all requirements specified in any approved online reply process through any EDM system for responding to an application

(c) all information requested by an officer of DRS while a telephone reply is being made.

7.71 A claimant who is lodging a reply should list all documents relevant to their reply, but they do not need to attach copies of documents or materials they have previously provided to the insurer. The claimant only needs to provide copies of documents or materials not previously provided.

7.72 The insurer must provide to DRS all of the documents or materials in its possession relevant to the application and reply, including documents and materials listed in the reply that the claimant has previously supplied to the insurer. When providing the documents through the EDM, the insurer must upload the documents individually and categorise them, by selecting the most relevant category for each document. Failure to categorise documents may result in the reply being rejected.

7.73 DRS may decline to accept a reply if the reply does not comply with the above requirements. DRS may also proceed to hear and determine an application in the absence of a reply.

7.74 An officer of DRS may reject any form, part of a form or supporting document if it does not substantially comply with this Part of the Motor Accident Guidelines, unless the non-compliance is technical and of no significance.

Representation

7.75 If the claimant is represented in respect of an application before DRS:

(a) it is sufficient notification for a decision-maker, officer of DRS or an insurer to send any document required to be sent to the claimant to the representative, and

(b) a decision-maker or officer of DRS may contact the claimant directly in relation to the application before DRS to make arrangements for medical examinations, teleconferences or assessment conferences where the attendance of the claimant in person may assist in the resolution or determination of the issues in dispute.

7.76 If the insurer is represented in respect of an application before DRS:

(a) it is sufficient notification for a decision-maker, officer of DRS or a claimant to send any document required to be sent to the insurer to the representative, and

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(b) a decision-maker or officer of DRS may contact the insurer directly in relation to the application before DRS.

7.77 If a party retains a representative or changes their representative after an application is lodged at DRS, that party or their representative must notify DRS and the other party of the change in representation as soon as possible.

Legal incapacity and appointed representatives

7.78 A claimant who is a person under legal incapacity may not make any application, or refer any matter, or carry on proceedings at DRS except by an appointed representative, under section 7.47(1) of the Act.

7.79 An appointed representative is a person appointed to represent the claimant under legal incapacity, and may be a relative, friend or other suitable person who is willing and able to be appointed to represent the claimant.

7.80 A person may be appointed to represent the person under legal incapacity in accordance with this Part of the Motor Accident Guidelines, under section 7.47(2) of the Act.

7.81 An appointed representative may do anything that this Part of the Motor Accident Guidelines allows or requires a party to do, and anything required in this Part of the Motor Accident Guidelines of that party is also required of the appointed representative.

7.82 If legal incapacity ends during the course of proceedings – for example where a person turns 18 years of age – the appointed representative will no longer be appointed as the claimant's representative.

7.83 A person may make an application to DRS for appointment as an appointed representative for a claimant at any time.

7.84 If the claimant already has an appointed representative, the representative should notify DRS and the other party of the terms of that existing appointment.

7.85 Any person may be appointed as a representative of a claimant except:

(a) a person under legal incapacity

(b) a person who has an interest in the proceedings that may be adverse to the interests of the person under legal incapacity.

7.86 An application for appointment as an appointed representative for a claimant under legal incapacity may be referred to a claims assessor for determination.

7.87 The application must include:

(a) evidence that the claimant is a person under legal incapacity

(b) evidence that the proposed representative consents to being appointed and does not have any interest in the proceedings adverse to the interests of the person under legal incapacity.

7.88 A claims assessor may determine their own procedure, is not bound by the rules of evidence and may inquire into any matter relevant to the proposed appointment in such manner as they think fit.

7.89 A claims assessor must issue a decision on whether or not to appoint a person as an appointed representative for a claimant as soon as practicable, preferably within seven days of the lodgement of the application, providing brief reasons for that decision.

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7.90 An appointed representative of a claimant under legal incapacity may apply to a claims assessor to cease their appointment.

7.91 If an appointed representative for a claimant under legal incapacity ceases their appointment, the DRS proceedings will be stayed pending the appointment of a new representative for the claimant under a legal incapacity.

7.92 A claims assessor may decide that a person is to be an appointed representative for a specified period of time, such as until a claimant turns 18 years of age within the meaning of section 7.47(2) of the Act.

Interpreters

7.93 If a party indicates that an interpreter is required in relation to an application to DRS, an officer of DRS will arrange for an interpreter to be available when required as part of the dispute resolution process, and DRS will meet the costs of the interpreter.

7.94 If a decision-maker indicates that an interpreter would assist their determination of an application to DRS, an officer of DRS will arrange for an interpreter to be available when required as part of the dispute resolution process, and DRS will meet the costs.

7.95 Interpreters and translators accredited by National Accreditation Authority for Translators & Interpreters (NAATI) will be preferred; however, a non-NAATI accredited interpreter may be used at the discretion of DRS. DRS will provide reasons where it considers that a non-NAATI accredited interpreter is required.

Time limits on applications

7.96 A DRS decision-maker may, if the circumstances justify, abridge or extend any time limit fixed by this Part or by a direction of a decision-maker.

7.97 In considering whether to abridge or extend any time limit, a DRS decision-maker will consider all relevant factors and circumstances surrounding the claim and the application, including:

(a) the objects of the Act

(b) the objects of DRS

(c) the obligations and duties of the parties and DRS

(d) the reasons for seeking expedition or extension of time

(e) the submissions, if any, of the parties

(f) the interests of both parties to the application.

7.98 A DRS decision-maker may extend a time limit before or after the time has expired.

7.99 Where a period of time, dating from a given day, act or event, is prescribed or allowed for any purpose, the time will be counted exclusive of that day or of the day of that act or event.

7.100 Where, apart from this subsection, the period in question, being a period of five days or less, would include a day on which DRS is closed for lodgement in person, that day will be excluded.

7.101 Where the last day for doing a thing is a day on which DRS is closed for lodgement in person, the thing may be done on the next day on which the registry is open for lodgement in person.

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7.102 A party may request that an application to DRS be expedited by notifying DRS and the other party, providing reasons why the application should be expedited.

7.103 In the absence of a request by a party, an officer of DRS or a decision-maker may also determine that an application should be expedited.

7.104 In considering whether an application should be expedited, DRS will consider all relevant factors and circumstances surrounding the claim and the application, including:

(a) the objects of the Act

(b) the objects of DRS

(c) the obligations and duties of the parties and DRS

(d) the reasons for seeking expedition

(e) the submissions, if any, of the other parties

(f) the interests of both parties to the application

(g) the interests of other parties to other disputes, particularly regarding the equity of prioritising the application seeking expedition ahead of other applications.

7.105 If an application is to be expedited, DRS will take all reasonable steps to ensure the application is dealt with as quickly as possible.

Documents and other supporting material

Language requirements

7.106 If a party wishes to lodge a document with DRS in a language other than English, that party is responsible for arranging for the document to be translated.

7.107 Documents in a language other than English lodged with DRS should be accompanied by an English translation, and a declaration by the translator that the translation is an accurate translation.

7.108 If a party is unable to arrange for such a document to be translated, DRS will arrange to have the document translated, with the insurer to pay the costs of translation.

Surveillance images

7.109 If surveillance images or footage are to be lodged with DRS, they should be lodged at the same time the party lodges the application or reply, and:

(a) all surveillance images or footage relevant to the issues in dispute must be lodged, not just some selected images or selected footage

(b) any investigators or loss adjusters report concerning those surveillance images or footage must also be lodged

(c) the surveillance images or footage must be provided in an unedited digital format, with details also provided advising which specific portions of the images or footage are relevant to the issues in dispute.

7.110 Surveillance images and footage held by the Authority that contains personal information are subject to the *Privacy and Personal Information Protection Act 1998* (NSW).

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Medical imaging

7.111 To provide DRS with medical imaging:

(a) all relevant medical imaging must be listed by the parties in the application or reply, and, if an electronic copy is available, it must be included in the application or reply

(b) the original medical image should not be lodged, and only a copy of the medical image or a report on the content of the medical imaging should be lodged

(c) the claimant should take the original medical imaging listed in the application or reply, whether in a physical or electronic format, to any relevant medical assessment examination.

7.112 A medical assessor will consider any original medical imaging and accompanying reports that are taken to the examination, and:

(a) where the medical imaging or reports have not previously been included in the documentation supporting the application or reply and exchanged by the parties, the medical assessor will list the medical imaging in their certificate and attach a copy of any associated reports to their certificate

(b) the party in possession of the medical imaging will make those images, or an electronic version of those images, available to the other party to inspect on request.

Additional documents

7.113 Parties may only lodge additional documents after they have lodged their application or reply either:

(a) with the consent of the other party, or

(b) in response to a specific request or direction from the decision-maker or an officer of DRS, and

(c) with approval of the decision-maker or an officer of DRS, having considered all of the circumstances of the application and the claim.

Unknown delivery dates

7.114 For the purpose of this Part of the Motor Accident Guidelines, if the date of delivery or receipt of a document cannot be ascertained, and the document was delivered to the address given by a claimant or insurer for delivery of documents, then the following deeming provisions apply.

7.115 Unless there is evidence to the contrary, the documents are to be taken to be received by the person as follows:

(a) in the case of personal delivery to a physical address, the day the document is delivered to that address

(b) in the case of postage to a postal address, seven business days after the document is posted as provided in section 76(1)(b) of the *Interpretation Act 1987*

(c) in the case of sending to a DX box, two business days after the document is left in that DX box or in another DX box for transmission to that DX box

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(d) in the case of an email to an email address, on the day the email is sent if received by 11:59pm

(e) in the case of a facsimile to a facsimile number, on the day the facsimile is sent if received before 11:59pm.

DRS electronic dispute management system

7.116 DRS may establish an EDM system to help support the objects of DRS, including to:

(a) enable applications and replies to DRS to be created, lodged, exchanged and accessed in an electronic form

(b) enable documents with respect to applications to DRS to be created, exchanged, lodged, issued and accessed in electronic form by the parties and DRS

(c) enable parties to applications to DRS to communicate in an electronic form with DRS and with other parties

(d) enable information concerning the progress of applications to DRS to be provided in an electronic form to parties to those disputes

(e) enable officers of DRS and decision-makers to communicate in an electronic form with parties to applications to DRS.

7.117 DRS may issue a protocol for the use of the EDM system, and establish requirements for persons to become registered users of the EDM system, in addition to decision-makers and officers of DRS.

7.118 Subject to any protocol, a person other than a decision-maker and an officer of DRS may not use the EDM system for a particular application unless they are a registered user of the EDM system and are:

(a) a party to the application to DRS, or

(b) a legal practitioner or agent representing a party to the application regarding to DRS.

7.119 In relation to any application, the level of access to the EDM system to which a user is entitled, and the conditions of use applicable to a user, are subject to any decision of DRS.

7.120 Documents and information lodged via the EDM system may be dealt with in accordance with the provisions of the *Electronic Transactions Act 2000* (NSW).

7.121 When DRS sends documents or forwards correspondence to a party who is a registered user of the EDM system, it will generally only do so via electronic communication to that party through the EDM system.

Managing applications made to DRS

7.122 The application will be allocated to an officer of DRS as the contact point for the parties, who will be responsible for the management of the application.

7.123 DRS will notify the parties of how the application will be managed, and about any preliminary issues arising in the application, as soon as practicable, and preferably within two business days of receiving the application.

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7.124 DRS will consider the application, reply, documentation and materials to triage the application and determine how it will be managed, and identify and determine any relevant preliminary issues arising in the application, including:

(a) jurisdiction – whether DRS may accept the application

(b) issues in dispute – the issues that are the subject of the application that are in dispute between the parties and whether it may be possible to narrow or resolve those issues, including issues relating to admissibility of evidence under section 7.52 of the Act

(c) process – the process for resolving the issues in dispute between the parties that are the subject of the application

(d) decision-maker – an appropriate decision-maker or decision-makers to determine the application

(e) additional documentation and materials – if any additional documentation and materials relevant to the application are required from the parties to help resolve the issues in dispute and to determine the application.

7.125 The decision-maker who the application is then referred to is not bound by any determination made by DRS in triaging the application.

7.126 In managing the application, DRS may:

(a) contact the parties by email, letter, telephone, in person, teleconference, videoconference, face-to-face meetings or via any other method as appropriate

(b) inquire into any matter relevant to the issues in dispute in such manner as it thinks fit

(c) clarify the issues in dispute and whether it may be possible for the parties to narrow or resolve those issues.

7.127 DRS may defer the allocation of the application for a period of time that it considers appropriate in the following circumstances:

(a) further information or documentation has been requested

(b) there are other claims or issues in dispute or likely to be in dispute which would more conveniently be determined at the same time

(c) if DRS is satisfied that the matter may be resolved by the parties and to allow the parties an opportunity to settle the claim

(d) the issues in dispute involve medical disputes which require a medical assessment and that medical assessment has not occurred

(e) the claimant's injury has not sufficiently recovered to enable the claim to be quantified having regard to any medical evidence attached to the application or reply

(f) if there are other good reasons to defer the allocation of the application.

7.128 If DRS proposes to defer the application for more than 3 months, it will give the parties an opportunity to make submissions on that proposed deferral.

7.129 DRS will keep the parties informed of the application's progress.

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Dismissing an application

7.130 A DRS decision-maker may at any stage dismiss an application if the decision-maker is satisfied that:

(a) the applicant has withdrawn the application

(b) the application is not likely to be ready to be determined within the next 12 months

(c) the applicant failed without reasonable excuse to comply with the DRS decision-maker's directions

(d) the applicant has ceased to pursue or prosecute the dispute, application or the claim

(e) it is not a dispute under the Act

(f) the application is frivolous, vexatious, misconceived or lacking in substance

(g) the application is being used for an improper purpose or is otherwise an abuse of process

(h) the application is made by a person who has died after the application was referred to DRS, unless a copy of the grant of probate or letters of administration or equivalent are provided, and the DRS decision-maker is satisfied that the estate seeks to pursue the claim or the application.

7.131 An application may be dismissed at the applicant's request or if determined by the DRS decision-maker. If the DRS decision-maker proposes to dismiss the application, the decision-maker must give all parties to the dispute a reasonable opportunity to make submissions about the proposed dismissal by writing to parties to request the provision of submissions on or before a given date.

Applying for a different decision-maker

7.132 Either party may apply to DRS in writing to have the application reallocated to a different merit reviewer, proper officer, medical assessor or claims assessor.

7.133 A request for reallocation must include submissions and reasons as to why the party is of the view that the decision-maker or proper officer should not determine the dispute or make a proper officer decision.

7.134 The party seeking the reallocation must provide a copy of the request for reallocation and the submissions in support to the other party to the dispute.

7.135 Where request for reallocation concerns a merit reviewer or claims assessor, DRS will forward the application for reallocation to the decision-maker to whom the application has been allocated. If the decision-maker determines that it is not appropriate for them to determine the application or dispute, the decision-maker will notify the parties and return the application to DRS for reallocation.

7.136 Where an application concerns a medical assessor, DRS will forward the application for reallocation to a proper officer. If a proper officer determines that it is not appropriate for the medical assessor to determine the application or dispute, the proper officer will reallocate the matter and notify the parties.

7.137 DRS, or the proper officer in case of medical assessments, may reallocate an application to a different decision-maker if the original decision-maker

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becomes unwell, retires or is otherwise unable to determine the application or is no longer appropriate to determine the application.

7.138 DRS will advise the parties of the decision in response to the request for reallocation.

Contacting decision-makers

7.139 Parties must not correspond with a decision-maker directly in respect of a current or finalised application, and should direct any communication to DRS, unless otherwise directed by the decision-maker.

7.140 All correspondence to, and communication with, DRS and a decision-maker must be directed to DRS, unless otherwise directed by the decision-maker.

Publication of decisions

7.141 Details of the decisions of merit reviewers and claims assessors may be published in accordance with this Part of the Motor Accident Guidelines, under section 7.50 of the Act.

7.142 Publication of decisions is in the public interest. It promotes public confidence, transparency and accountability in decision-making within the scheme. It provides guidance and education to scheme stakeholders including claimants, insurers and representatives. This helps to improve claims management, insurer decision making and minimises disputes in the scheme. DRS operates under a legislative presumption in favour of publishing the decisions of merit reviewers and claims assessors, which may include:

(a) publication of a decision in full

(b) publication of a decision in part

(c) publication of a de-identified and anonymised version of a decision.

7.143 A claimant may request that DRS withhold its decision from publication at any time up to 14 days after the decision is issued. DRS may withhold from publishing all or part of a decision, regardless of whether or not a claimant requests that DRS does so, if it is desirable to do so because of the confidential or sensitive nature of the information, or for any other reason.

7.144 DRS may publish decisions of merit reviewers and claims assessors on the DRS EDM system, on the Authority's website (www.sira.nsw.gov.au) and/or on the Australasian Legal Information Institute (AustLII) website (www.austlii.edu.au) or by other means.

7.145 Further information about publication of decisions can be found in the Authority's *Policy for publication of decisions by the Dispute Resolution Service.*

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Merit review

Guideline powers

7.146 This Part of the Motor Accident Guidelines, in relation to merit reviews by DRS, is made under the Act, including under Division 7.4, section 7.12 of the Act.

Requesting a merit review

7.147 A merit review application may be made after:

(a) the decision has been the subject of an internal review by the insurer

(b) the insurer has failed to complete an internal review and notify the claimant of the internal review decision within the required timeframe

(c) the insurer has declined to conduct an internal review.

7.148 The Regulation prescribes a number of merit review matters where an internal review is not required before an application may be made for a merit review, under Part 5, Division 1, clause 10.

Time for requesting a merit review

7.149 An application for merit review must be made within 28 days of the claimant receiving the insurer's decision, meaning:

(a) for merit review matters where an internal review is required before a merit review, the merit review application must be made:

- within 28 days of the claimant receiving the insurer's internal review of the reviewable decision
- within 28 days of the claimant receiving the insurer's decision to decline to conduct the internal review
- if the insurer has failed to complete the internal review and notify the claimant of the outcome within the period required under section 7.9(4)-(5) and 'The insurer review decision' section of this Part of the Motor Accident Guidelines, within 28 days of that date.

(b) for merit review matters prescribed by the Regulation not to require an internal review before a merit review, the merit review application must be made within 28 days of the claimant receiving the insurer's reviewable decision.

7.150 If a claimant applies for a merit review more than 28 days after receiving the insurer's decision, DRS may accept a late application for a merit review, consistent with section 1.3 of the Act, if an officer of DRS believes the exercise of that discretion would best promote the objects of the Act.

Application requirements

7.151 A claimant may apply for a merit review by making an application to DRS in accordance with the standard DRS application requirements set out in the 'Lodging an application with DRS' section of this Part of the Motor Accident Guidelines.

7.152 In addition to the standard DRS application requirements, an application for merit review must also include details of:

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(a) the decision of the insurer that is referred for merit review

(b) the alternative decision sought in the merit review

(c) issues under review – the elements of the original decision that the party wishes to be reviewed

(d) the reasons the decision should be changed

(e) any additional documentation or materials that the party considers relevant to a review of the decision

(f) any regulated costs sought.

7.153 DRS may decline to conduct a merit review if the application does not comply with the above clause.

Replying to a merit review application

Time for replying to a merit review application

7.154 An insurer may lodge a reply to an application for a merit review according to the timeframes listed in Table 7.2 (below) for each of the different types of merit review matters:

Table 7.2: Merit review notification period

Merit review matter types	Reply period
Damages claim merit review matters (Schedule 2, clause 1(w) to (z)(1))	14 days
Other merit review matters not listed above (Schedule 2, clause 1)	7 days

7.155 If an insurer lodges a reply later than the period allowed, DRS may consider a late reply to an application for merit review.

Reply requirements

7.156 An insurer may reply to an application for a merit review by making a reply to DRS in accordance with the standard DRS reply requirements set out in the 'Lodging a reply with DRS' section of this Part of the Motor Accident Guidelines.

7.157 In addition to the standard DRS reply requirements, the insurer's reply to an application for merit review must also include details of the following information:

(a) the response to the alternative decision sought in the merit review application

(b) the response to the reasons the claimant believes the decision should be changed

(c) the response to any regulated costs sought (if applicable).

7.158 DRS may decline to consider a reply to an application for a merit review if the reply does not comply with the above clause.

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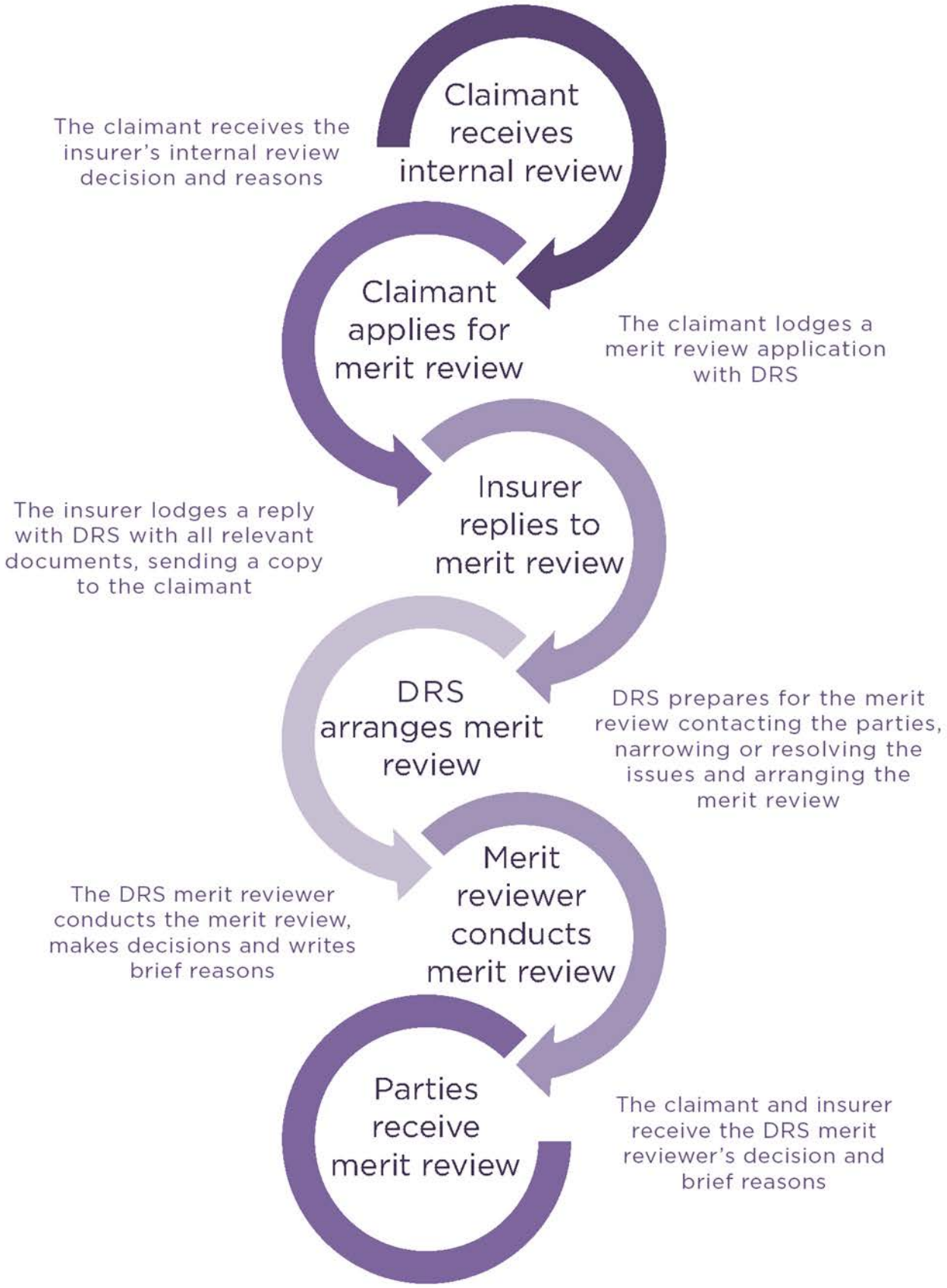
Figure 7.2: The merit review process



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The merit review

Managing the merit review

7.159 The application for merit review will be managed in accordance with the provisions set out in the 'Managing applications made to DRS' section of this Part of the Motor Accident Guidelines.

7.160 In addition to the standard application management provisions, DRS may also arrange for the merit review application to be dealt with by a merit reviewer, under section 7.12(2) of the Act.

The merit reviewer

7.161 The merit review will be dealt with by a merit reviewer who has been appointed by the Authority, under Division 7.2, section 7.4 of the Act.

7.162 DRS will advise the parties of the merit reviewer who has been allocated to deal with the merit review.

The merit review process

7.163 The merit review must be determined in line with section 7.13 of the Act.

7.164 The merit review must be dealt with in the way that best supports the objects of the Act, given the facts and circumstances of the particular claim and the particular merit review, which may include undertaking the review on the papers, using teleconferences, video conferences or face-to-face meetings as appropriate.

7.165 The merit reviewer may determine the merit review procedure, is not bound by the rules of evidence and may inquire into any matter relevant to the issues in dispute in such manner as they think fit.

7.166 The merit reviewer must act with as little formality as the circumstances of the claim permit and according to equity, good conscience and the substantial merits of the matter, without regard to technicalities and legal forms.

7.167 The merit reviewer must ensure that relevant material is available so as to enable all of the relevant facts in issue to be determined.

7.168 The merit reviewer may consider material that was not provided to the original decision-maker. The merit reviewer is required to decide what the correct and preferable decision is having regard to the material before the reviewer, including any relevant factual material, and any applicable written or unwritten law, under section 7.13(1) of the Act.

The merit review decision

7.169 The merit reviewer is to issue the parties with a certificate as to their determination, including a brief statement of reasons for the determination, under section 7.13(4) of the Act.

7.170 An obvious error in the merit reviewer's certificate, or statement of reasons attached to the certificate, may be corrected at the request of either party, or as a result of the merit reviewer's identification of an obvious error. Any such application is to be made to DRS in writing, setting out details of the obvious error and the terms of the suggested correction.

7.171 The party making the application is to send a copy of the application to the other party.

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7.172 Examples of obvious errors in the certificate include, but are not limited to:

(a) a clerical or typographical error in the certificate

(b) an error arising from an accidental slip or omission

(c) a defect of form

(d) an obvious inconsistency between the certificate and the reasons explaining the certificate.

Merit reviewer's assessment of legal costs

7.173 Statutory benefits costs disputes (where there is no other merit review matter before the merit reviewer):

(a) a dispute about the legal costs and other costs and expenses incurred by the claimant in a statutory benefits claim may be referred to DRS to be dealt with by a merit reviewer as to whether the costs and expenses incurred by the claimant are reasonable and necessary, under section 8.10(1) and Schedule 2, clause 1(aa) of the Act

(b) a dispute about the apportionment of legal costs between two Australian legal practitioners, in relation to a statutory benefits claim, may be referred to DRS to be dealt with by a merit reviewer, under Part 6, Division 2, clause 22(4)(a) of the Regulation.

7.174 Costs in a merit review application:

(a) when making a determination and issuing a certificate under section 7.13(4) of the Act about a merit review matter arising in a statutory benefits claim, the merit reviewer may include an assessment of the legal costs relating to that merit review in the merit reviewer's certificate and reasons, under Part 8, sections 8.10(3) and (4) of the Act.

7.175 A merit review decision is binding on the parties under section 7.14(3) of the Act, subject to the right of review that exists under section 7.15 of the Act.

The effect of the merit review decision

7.176 When a merit review decision takes effect depends on the nature of the merit review decision that is made, as established in section 7.14(1)-(2) of the Act.

7.177 The insurer must give effect to the merit review decision as quickly as is practicable after receiving notice of the decision.

7.178 If the merit review decision results in an increase in weekly payments of statutory benefits, under section 7.14(4)-(5) of the Act, the insurer must commence payment of the increased weekly payments within seven days of the issue of the certificate as to the merit reviewer's determination.

7.179 Where a merit review decision requires the insurer to make payments to the claimant for entitlements for prior periods which have not been paid, the insurer must make that payment as quickly as is practicable.

7.180 On receiving the merit review certificate, the insurer must advise the claimant about the effect of the decision within 7 days, providing the claimant with details of:

(a) how and when the insurer will give effect to the merit review decision

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(b) the impact of the merit review decision on the claimant and their claim.

Legal costs for merit reviews

7.181 Schedule 1, Part 1, clause 1(1) of the Regulation makes provision for the maximum costs for legal services provided to a claimant or an insurer in connection with a merit review under Division 7.4 of the Act.

7.182 Where costs for legal services are payable by the insurer, the insurer must pay the invoice within 20 days of its receipt.

Requesting a review of a merit review decision by a review panel

7.183 A claimant or an insurer may apply under section 7.15(1) of the Act to the proper officer to refer a decision of a single merit reviewer to a review panel of merit reviewers for review by making an application to DRS.

7.184 An application for the referral of a decision of a single merit reviewer to a review panel may only be made on the grounds that the decision was incorrect in a material respect under section 7.15(2) of the Act.

Time for requesting a review

7.185 This Part of the Motor Accident Guidelines makes provision for limiting the time within which an application for review of a decision of a single merit reviewer may be made, under section 7.15(6) of the Act.

7.186 An application for review of a decision of a single merit reviewer must be made within 28 days of the date of the decision was sent by DRS.

7.187 The proper officer may decline an application for review if it is made more than 28 days after the date the decision was sent by DRS.

Application requirements

7.188 A party may apply for a review by making an application to DRS in accordance with the standard DRS application requirements set out in the 'Lodging an application with DRS' section of this Part of the Motor Accident Guidelines.

7.189 In addition to the standard DRS application requirements, an application for a review must also include details of:

(a) the decision of the single merit reviewer that is the subject of the application for review

(b) the reasons why the decision is incorrect in a material respect.

7.190 DRS may decline to accept the application if it does not comply with the above clause.

Replying to an application for review of a merit review decision by a review panel

Time for replying to a review application

7.191 A respondent may lodge a reply within seven days of receiving the application, by lodging that reply with DRS.

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7.192 If the respondent lodges a reply later than seven days of receiving the application, DRS may consider a late reply.

Reply requirements

7.193 A respondent may reply to an application for a review by lodging a reply with DRS in accordance with the standard DRS reply requirements set out in the 'Lodging a reply with DRS' section of this Part of the Motor Accident Guidelines.

7.194 In addition to the standard DRS reply requirements, a reply to an application for a panel merit review must also include a response to the reasons given in the application.

7.195 DRS may decline to consider a reply to an application for a panel review of a decision if the reply does not comply with the above clause.

The review of a merit review decision by a review panel

Managing the review application

7.196 DRS must arrange for a proper officer to consider the application and make a determination under section 7.15(3) of the Act on whether there is reasonable cause to suspect that the decision of the single merit reviewer was incorrect in a material respect.

7.197 The proper officer will advise the parties as soon as practicable, and preferably within 14 days of the expiry of the period for reply, whether they are satisfied that there is reasonable cause to suspect that the merit review decision was incorrect in a material respect, and whether the application is to be referred to a review panel.

The review panel

7.198 The review panel will be comprised of at least two merit reviewers who have been appointed by the Authority under section 7.4 of the Act. The single merit reviewer whose decision is under review will not be part of the panel.

7.199 DRS will advise the parties of the individual merit reviewers who have been allocated to the merit review panel.

The review panel process

7.200 The review panel must be conducted in the way that best supports the objects of the Act, given the facts and circumstances of the particular claim and the particular merit review. This may include undertaking the review on the papers, using teleconferences, video conferences or face-to-face meetings as appropriate.

7.201 The review panel may determine the review procedure, is not bound by the rules of evidence and may inquire into any matter relevant to the issues in dispute in such manner as it thinks fit.

7.202 The review panel may consider material that was not before the single merit reviewer.

7.203 The review panel must issue the parties with a certificate as to the panel's determination, attaching a brief statement of reasons for the determination.

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7.204 The review panel must determine the application as soon as practicable, and preferably within 28 days of the proper officer's decision. A review panel determination is not invalid if it is made after that period expires.

7.205 The effect of a review panel decision under Division 7.4, section 7.15(5) of the Act is the same as the status and effect of a review decision under Division 7.4, section 7.14 of the Act, and the provisions of this Part of the Motor Accident Guidelines relating to merit review decisions apply equally to review panel decisions.

Legal costs for review panel matters

7.206 Schedule 1, Part 1, clause 2(3) of the Regulation makes provision for the maximum costs for legal service provided to a claimant in connection with a matter relating to the assessment of a medical dispute.

7.207 Where costs for legal services are payable by the insurer, the insurer must pay the invoice within 20 days of its receipt.

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Medical assessment

Guideline powers

7.208 This Part of the Motor Accident Guidelines, in relation to medical assessments by the DRS, is made under the Act, including under Division 7.5, section 7.29 of the Act.

7.209 Schedule 2, clause 2 of the Act declares that there are a number of medical assessment matters that may be the subject of an application for a medical assessment by DRS.

Requesting a medical assessment

7.210 A medical dispute about a decision of an insurer may not be referred for assessment by a claimant until either:

(a) the decision has been the subject of an internal review by the insurer

(b) the insurer has failed to complete an internal review and notify the claimant of the internal review decision within the required period

(c) the insurer has declined to conduct a review.

Time for requesting a medical assessment

7.211 An application for a medical assessment may be lodged at any time, and should be lodged as soon as practicable after the claimant receives either:

(a) the insurer's internal review of the reviewable decision

(b) the insurer's decision to decline to conduct the internal review

(c) if the insurer has failed to complete the internal review and notify the claimant of the internal review within the required period, as soon as practicable after that due date.

Application requirements

7.212 This Part of the Motor Accident Guidelines makes provisions relating to the procedures for the referral of disputes for assessment, under section 7.29 of the Act.

7.213 A referral for medical assessment is made by making an application to DRS in accordance with the standard DRS application requirements set out in the 'Lodging an application with DRS' section of this Part of the Motor Accident Guidelines.

Replying to a medical assessment application

Time for replying to a medical assessment application

7.214 A party who receives an application for medical assessment lodged with DRS by another party or by a merit reviewer, claims assessor or the court will be given the opportunity to respond.

7.215 The respondent may lodge a reply to an application for a medical assessment according to the timeframes listed in Table 7.3 for each of the different types of medical assessment matters:

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Table 7.3: Medical assessment notification period

Medical assessment matters	Reply period
1. Permanent impairment medical assessment matters (Schedule 2, clause 2(a))	14 days
2. Treatment and care medical assessment matters (Schedule 2, clause 2(b) and (c))	14 days
3. Earning capacity impairment medical assessment matters (Schedule 2, clause 2(d))	14 days
4. Minor injury medical assessment matters (Schedule 2, clause 2(e))	14 days
5. Further medical assessments (section 7.24)	14 days
6. Review of a medical assessment (section 7.26)	14 days
7. Non-binding opinion medical assessments (section 7.27)	7 days

7.216 If the respondent lodges a reply later than the period allowed in Table 7.3 above, DRS may decline to consider the reply.

Reply requirements

7.217 A party may reply to an application for a medical assessment by making a reply to DRS in accordance with the standard DRS reply requirements set out in the 'Lodging a reply with DRS' section of this Part of the Motor Accident Guidelines.

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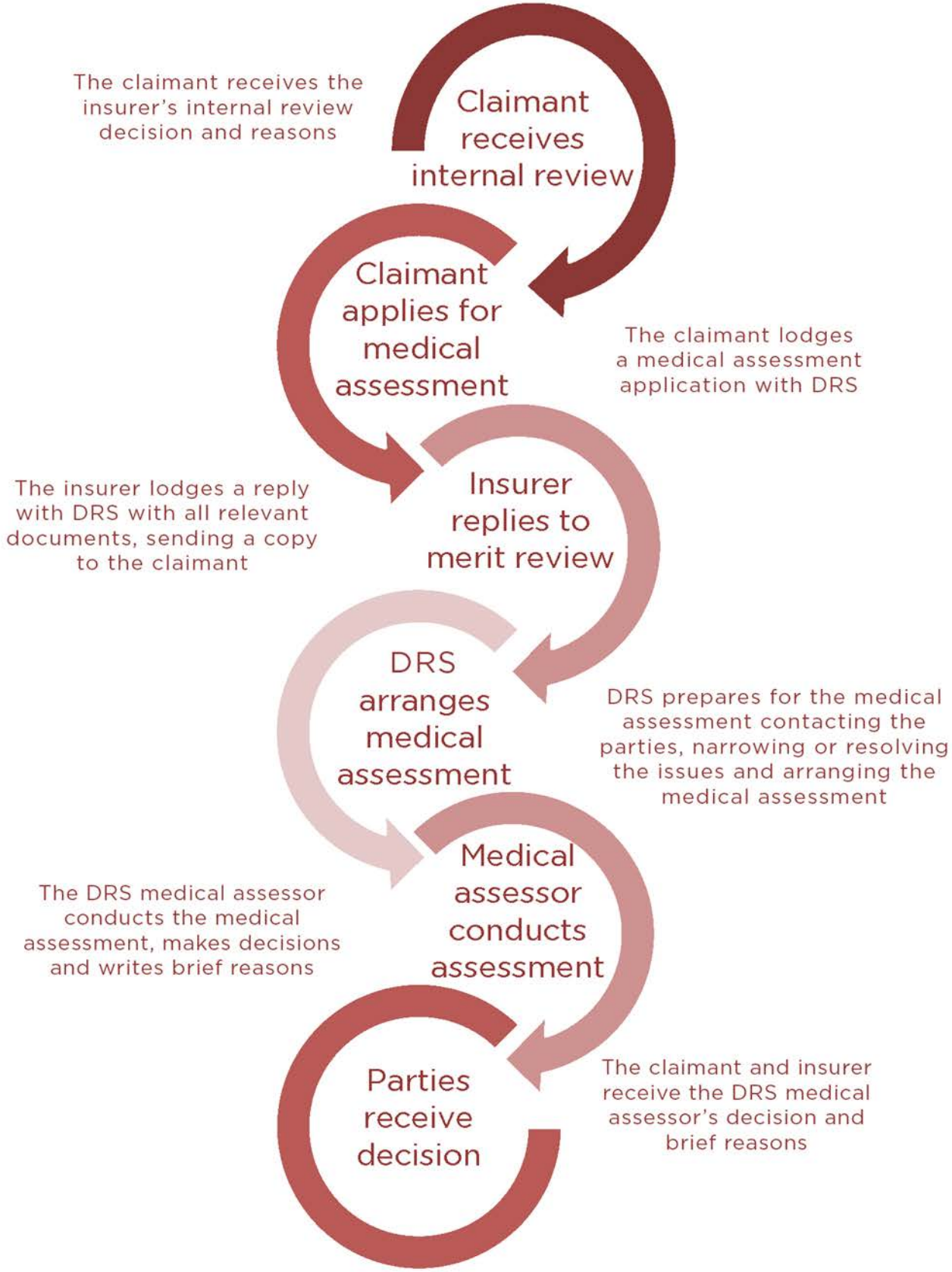
Figure 7.3: The medical assessment process



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The medical assessment

Managing the medical assessment

7.218 The application for a medical assessment will be dealt with in accordance with the provisions set out in the 'Managing applications made to DRS' section of this Part of the Motor Accident Guidelines and Part 7, Division 7.5 of the Act.

7.219 In addition to those standard application management provisions, DRS may also:

(a) arrange for the medical assessment application to be dealt with by one or more medical assessors, under section 7.20(2) of the Act

(b) provide to the medical assessor/s a copy of any certificates and reasons previously issued by DRS in relation to the same claimant, not limited to the same matter, after the parties have been provided a copy of these documents.

The medical assessor/s

7.220 The medical assessment will be conducted by a medical assessor who has been appointed by the Authority, under Division 7.2, section 7.4 of the Act.

7.221 DRS will advise the parties of the individual medical assessor or medical assessors who have been allocated to conduct the medical assessment.

The medical assessment process

7.222 The medical assessment must be conducted in the way that best supports the objects of the Act, given the facts and circumstances of the particular claim and the particular medical assessment. This may include undertaking the assessment on the papers, using teleconferences, videoconferences, face-to-face meetings or medical examinations as appropriate.

7.223 The medical assessor may determine the medical assessment procedure, is not bound by the rules of evidence, and may inquire into any matter relevant to the issues in dispute in such manner as they think fit.

7.224 Medical assessments are conducted in private and are not open to the public. An examination may not be recorded by the claimant or any other person unless with the prior agreement of the proper officer, the medical assessor and the consent of the claimant.

Contacting treatment providers

7.225 A medical assessor may, at their discretion, communicate with any of the claimant's treating health practitioners in relation to health or safety issues noted by a medical assessor as being of an urgent or serious nature, where necessary to prevent or lessen a serious or imminent threat to life or health, or with the consent of the claimant. Any such communication may be considered personal health information and should not form part of the medical assessment application, decision, reasons or any certificate.

Support persons at medical assessments

7.226 If the person being assessed is a person under legal incapacity, a parent, tutor, next friend, legal guardian, carer or other support person or appointed personal representative may be present during an assessment.

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7.227 If the person being assessed is not a person under legal incapacity, a support person may only be present during an assessment if the medical assessor conducting the assessment is satisfied it is reasonable in the circumstances. During the conduct of such an assessment, any person other than the claimant who has been permitted to be present may not respond to questions or speak on behalf of the claimant, unless invited to do so by the medical assessor.

7.228 Legal, medical or other representatives of the claimant or any other party may not be present during an assessment unless the proper officer gives prior approval and is satisfied that the circumstances warrant it.

Cancelling a medical assessment

7.229 A claimant must notify DRS as soon as they become aware that they will be unable to attend a medical assessment or medical review panel assessment arranged for them.

7.230 If the claimant has given DRS at least 72 hours or more notice before the scheduled time for an assessment, the claimant will not be required to pay any cancellation fees.

7.231 If the claimant, without a reasonable excuse, gives DRS less than 72 hours' notice before the scheduled time for an assessment , or fails to attend an assessment, or attends an assessment late that results in a cancellation, the claimant will be required to pay a cancellation fee equal to the amount of any cancellation fee that DRS is required to pay to the medical assessor or interpreter.

7.232 DRS will send a notification to the claimant seeking payment of any such cancellation fee.

7.233 A new date for an assessment will only be scheduled if the proper officer is satisfied that the claimant has provided to DRS either:

(a) a reasonable excuse for the late attendance or non–attendance

(b) evidence that payment of the cancellation fee would cause the claimant financial hardship

(c) a signed Irrevocable Authority and Direction in a form acceptable to DRS, addressed to the insurer, directing the insurer to pay the cancellation fee from the claimant's damages claim settlement monies

(d) payment of the cancellation fee.

The medical assessment decision

7.234 The medical assessor to whom a medical dispute is referred must give a certificate as to the matters referred for assessment as soon as practicable, and preferably within 14 days of the medical examination of the claimant, or where there is no medical examination of the claimant, preferably within 14 days of the medical assessor receiving the application for assessment. However, a medical assessor's decision is not invalid because it is made after that period has expired.

7.235 An obvious error in the medical assessor's certificate, or statement of reasons attached to the certificate, may be corrected at the request of either party, or as a result of the medical assessor's identification of an obvious error. Any such application is to be made to DRS in writing, setting out details of the obvious error and the terms of the suggested correction.

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7.236 The party making the application is to send a copy of the application to the other party.

7.237 If the medical assessor is satisfied that the certificate issued under section 7.23 contains an obvious error, the medical assessor may issue a replacement certificate to correct the error under section 7.23(9) of the Act.

7.238 On receiving the medical assessment decision in the certificate, the insurer is to advise the claimant about the effect of the decision, providing the claimant with details of:

(a) how and when the insurer will give effect to the medical assessment decision; and

(b) the impact of the medical assessment decision on the claimant and their claim.

Other matters relating to medical assessments

Combined certificate of impairment

7.239 If a combined certificate is required under section 7.23(8) of the Act, a medical assessor nominated by the Authority must make an assessment of the total degree of permanent impairment resulting from all the injuries and must give a combined certificate as to that total degree of permanent impairment. This must be issued to the parties as soon as practicable, and preferably within three business days of receiving all of the single medical assessors' certificates.

Non-binding opinions

7.240 The medical assessor to whom a medical assessment matter has been referred for the purpose of providing a non–binding opinion under section 7.27 of the Act must give the parties and the merit reviewer or claims assessor a statement of their opinion as soon as practicable, and preferably within seven days of any medical examination of the claimant, or where there is no medical examination of the claimant, preferably within seven days of receiving the referral for a non–binding opinion.

7.241 The medical assessor's statement of their opinion must set out the reasons for their opinion on the matters referred.

Incomplete certificates

7.242 A certificate is incomplete when it does not comply with the requirement of section 7.23(7). If a medical assessor or review panel provides an incomplete certificate, DRS may refer the matter back to the medical assessor or review panel to ensure it complies with section 7.23(7).

7.243 Either party may request that the matter be referred back to the medical assessor or review panel due to an incomplete certificate by making an application to DRS.

7.244 Examples of incomplete certificates include, but are not limited to where:

(a) disputes and/or injuries are not referred to

(b) submitted documentation is not referred to

(c) a certificate is unsigned

(d) a certificate or parts of the certificate are omitted.

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7.245 In considering whether or not the certificate is incomplete, DRS may seek submissions from the parties.

7.246 After being notified of an incomplete certificate, the medical assessor must issue a complete certificate to the parties. To do this, the medical assessor may require a claimant to attend further examination.

Medical assessment applications about permanent impairment

7.247 In addition to the standard DRS application requirements, an application for a medical assessment about the degree of permanent impairment must also include evidence in support of the degree of permanent impairment asserted by the party.

7.248 DRS may refuse to accept the application if it does not comply with the above clause, under section 7.20(3) of the Act.

Medical assessment applications about minor injury

7.249 In addition to the standard DRS application requirements, an application for medical assessment about a minor injury must also include evidence in support of the injury asserted by the party.

7.250 DRS may refuse to accept the application if it does not comply with the above clause.

Further medical assessment

7.251 A medical assessment referred for assessment may be referred again for assessment, under section 7.24 of the Act. The grounds for further medical assessment are set out in Part 5, Division 3 of the Regulation.

Time for requesting a further medical assessment

7.252 An application for a further medical assessment may be made at any time under section 7.24(1)-(2) of the Act.

Managing the further medical assessment

7.253 The application for a further medical assessment will be managed in accordance with the DRS dispute application management approach set out in the 'Managing applications made to DRS' section of this Part of the Motor Accident Guidelines.

7.254 In addition to the standard application management provisions, DRS must arrange a proper officer to consider the application and make a determination under section 7.24(5) of the Act, on whether they are satisfied that the application meets the requirements for referral under section 7.24 of the Act and Part 5, Division 3, clause 13 of the Regulation.

7.255 The proper officer will advise the parties of that determination, providing brief reasons for the determination, within 14 days of the expiry of the period for the respondent to lodge a reply.

Scope of a further medical assessment

7.256 The matters in dispute in a further medical assessment can be limited by an agreement between the parties as to the degree of permanent impairment of an injured person that has resulted from a particular injury, or whether a particular injury was caused by a motor accident, under section 7.25 of the Act.

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Requesting a review of a medical assessment by a review panel

7.257 This Part of the Motor Accident Guidelines sets out how a claimant or an insurer may apply for a review of a decision of a single medical assessor, under section 7.26(1) of the Act.

7.258 Either party may apply under section 7.26(1) of the Act to the proper officer to refer a medical assessment by a single medical assessor to a review panel of medical assessors for review.

7.259 A combined certificate assessment cannot be the subject of review under this section, except by way of the review of any of the assessments of the single medical assessor on which the combined certificate assessment is based, under section 7.26(4) of the Act.

7.260 An application to refer a medical assessment of a single medical assessor to a review panel may only be made on the grounds that the decision was incorrect in a material respect, under section 7.26(2) of the Act.

7.261 A medical assessment may not be referred for review on more than one occasion, under section 7.26(3) of the Act.

Time for requesting a review

7.262 This Part of the Motor Accident Guidelines makes provision for limiting the time within which an application for review of a medical assessment of a single medical assessor may be made, under section 7.26(10) of the Act.

7.263 An application for review of a medical assessment of a single medical assessor must be made within 28 days of the date of the certificate is sent by DRS.

7.264 If a party applies for a review of a medical assessment more than 28 days after the date the certificate is sent by DRS, DRS may decline the application.

Application requirements

7.265 A party may apply for a review by making an application to DRS in accordance with the standard DRS application requirements set out in the 'Lodging an application with DRS' section of this Part of the Motor Accident Guidelines.

7.266 In addition to the standard DRS application requirements, an application for a review must also include details of:

(a) the decision of the single medical assessor that is the subject of the application for review

(b) the reasons why the decision is incorrect in a material respect.

7.267 DRS may decline to accept the application if it does not comply with the above clause.

Replying to an application for review of a medical assessment by a review panel

Time for replying to a review application

7.268 A respondent who receives an application for a review of a decision of a single medical assessor may lodge a reply within 14 days of receiving the application.

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7.269 If a respondent lodges a reply more than 14 days after receiving the application, DRS may decline to consider a reply.

Reply requirements

7.270 A respondent may reply to an application for a review by making a reply to DRS in accordance with the standard DRS reply requirements set out in the 'Lodging a reply with DRS' section of this Part of the Motor Accident Guidelines.

7.271 In addition to the standard DRS reply requirements, a reply to a review application must also include a response to the reasons given in the review application.

7.272 DRS may decline to consider a reply to a review application if the reply does not comply with the above clause.

The review of a medical assessment by a review panel

Managing the application

7.273 The application for a review will be managed in accordance with the provisions set out in the 'Managing applications made to DRS' section of this Part of the Motor Accident Guidelines.

7.274 In addition to those standard application management provisions, DRS must arrange for a proper officer to consider the application and make a determination under section 7.26(5) of the Act on whether there is reasonable cause to suspect that the medical assessment was incorrect in a material respect.

7.275 The proper officer will advise the parties as soon as practicable, and preferably within 14 days of the expiry of the period for a reply, whether they are satisfied that there is reasonable cause to suspect that the medical assessment was incorrect in a material respect, and whether the application is to be referred to a medical review panel, providing brief reasons for the decision.

The medical review panel

7.276 The medical review panel will be conducted by at least two medical assessors who have been appointed by the Authority under Division 7.2, section 7.4 of the Act. The single medical assessor whose medical assessment is under review will not be on the panel.

7.277 DRS will advise the parties of the individual medical assessors who have been allocated to conduct a particular medical review panel.

Scope of the medical review

7.278 The matters in dispute before a medical review panel can be limited by an agreement between the parties as to the degree of permanent impairment of an injured person that has resulted from a particular injury, or whether a particular injury was caused by a motor accident, under section 7.25 of the Act.

The medical review panel process

7.279 The review panel must be conducted in the way that best supports the objects of the Act, given the facts and circumstances of the particular claim and the particular medical assessment, which may include undertaking the panel

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review on the papers, using teleconferences, video conferences, face-to-face meetings or medical examinations as appropriate.

7.280 The medical review panel may determine the review procedure, is not bound by the rules of evidence, and may inquire into any matter relevant to the issues in dispute in such manner as it thinks fit. This may include seeking the assistance of a merit reviewer or claims assessor to assist the panel to inquire into any matter relevant to the issues in dispute.

7.281 The review panel may consider material that was not provided before the medical assessment being reviewed was made.

The medical review panel decision

7.282 The medical review panel must confirm the single medical assessor's certificate, or revoke that certificate and issue a certificate as to the medical review panel's determination, under section 7.26(7) of the Act, including a statement of reasons for the determination.

7.283 The medical review panel is also to issue a new combined certificate to take account of the results of the review when required, under section 7.26(8) of the Act.

7.284 The review application will be determined as soon as practicable, and preferably within 28 days of the proper officer's decision under section 7.26(5) of the Act. However, a medical review panel decision is not invalid if it is made after that period expires.

7.285 The status and effect of a medical review panel certificate under section 7.26(7) and section 7.26(8) of the Act is the same as the status and effect of a medical assessment under section 7.23 of the Act, and the provisions of this Part of the Motor Accident Guidelines relating to medical assessments apply equally to medical review panel certificates.

Costs and medical assessments

Expenses for attending a medical assessment

7.286 The insurer must pay the reasonable and necessary costs and expenses incurred by the claimant, and by a parent or other carer of the claimant in order to accompany the claimant, in attending a medical examination, under section 7.28 of the Act.

Legal costs for medical assessment matters

7.287 Schedule 1, Part 1, clause 2 of the Regulation makes provision for the maximum costs for legal services provided to a claimant or an insurer in connection with a matter relating to the assessment of a medical dispute.

7.288 Where an invoice for legal services is payable by the insurer, the insurer must pay the invoice within 20 days of its receipt.

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Claims assessment

Guideline powers

7.289 This Part of the Motor Accident Guidelines, in relation to claims assessments by DRS, is made under the Act, including under Division 7.6, section 7.39 of the Act.

Damages settlement approval

Settlements requiring approval

7.290 If a claimant is not represented by an Australian legal practitioner, a claim for damages cannot be settled unless the proposed settlement is approved by DRS, under Division 6.4, section 6.23(2)(b) of the Act.

Requesting settlement approval

Time for requesting settlement approval

7.291 Division 6.4, section 6.23(1) of the Act provides for the timeframe to approve a settlement.

7.292 If a claimant and insurer have agreed to a proposed damages settlement, and the claimant is not represented by an Australian legal practitioner, the insurer must make an application to DRS on behalf of both the claimant and the insurer seeking a damages settlement approval, which the insurer must lodge as quickly as is practicable, and preferably within seven days of reaching that proposed agreement, in accordance with its duties under Section 6.4 of the Act.

Application requirements

7.293 A request for a settlement approval is made by making an application to DRS in accordance with the standard DRS application requirements set out in the 'Lodging an application with DRS' section of this Part of the Motor Accident Guidelines.

7.294 In addition to the standard DRS application requirements, an application for a settlement approval lodged by the insurer must also include details of:

(a) the amount of the proposed damages settlement, including a breakdown of the amount allowed for each head of damage and how each amount allowed has been calculated

(b) the amount of any reductions in the proposed damages settlement including for contributory negligence or any other reduction, including brief reasons for that reduction and how any reductions have been calculated

(c) the amount of any advance payments that the insurer has made in advance of the settlement and the dates of those advance payments, including brief reasons explaining why those advanced payments were made

(d) the evidence, documents and materials relevant to an assessment of the damages settlement.

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7.295 DRS may decline to accept the settlement approval application if it does not comply with the above clause.

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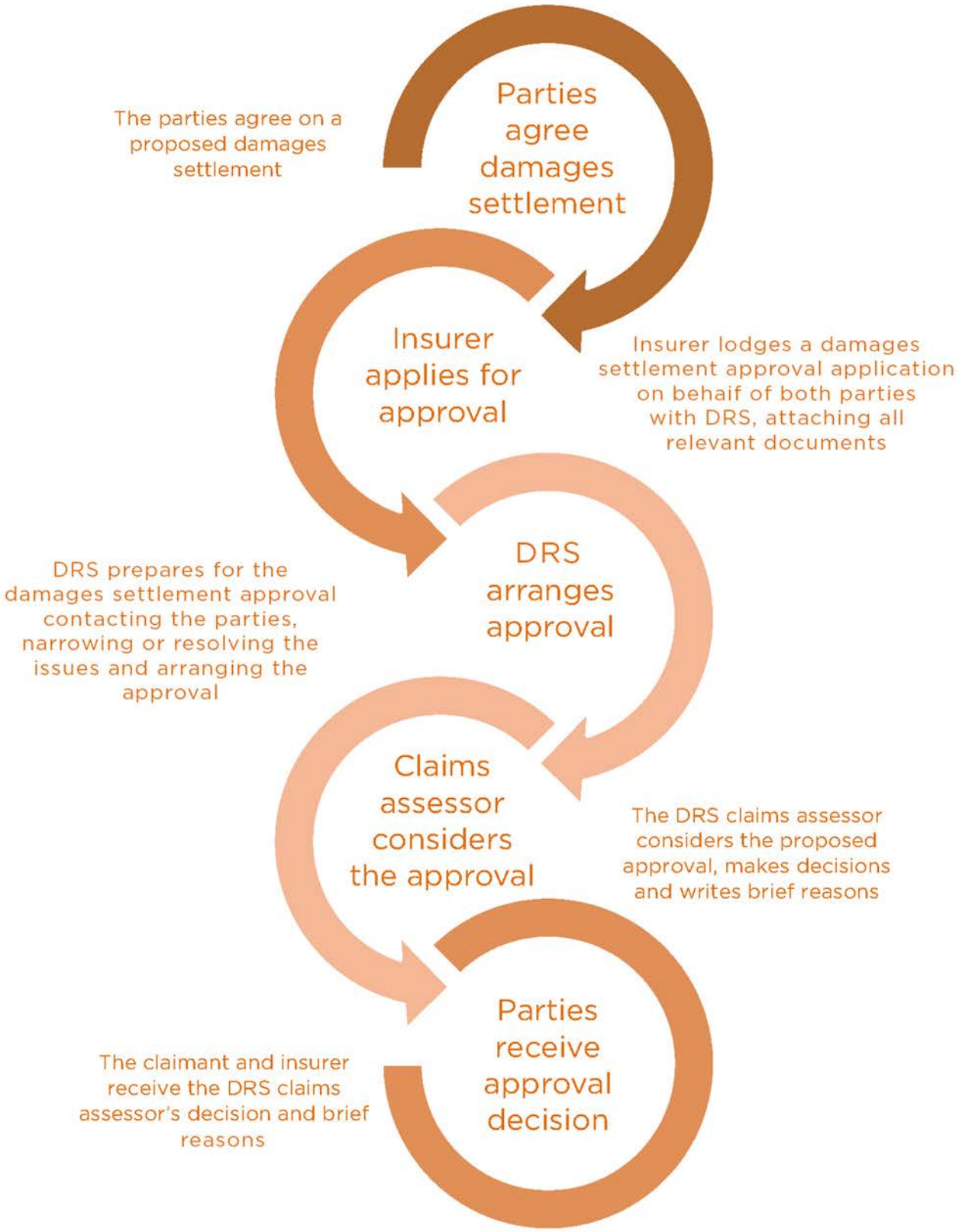
Figure 7.4: The damages settlement approval process



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Settlement approval

Managing the settlement approval

7.296 The application for a settlement approval will be managed in accordance with the provisions set out in the 'Managing applications made to DRS' section of this Part of the Motor Accident Guidelines.

7.297 In addition to the standard application management provisions, DRS may also arrange for the settlement approval application to be referred to a claims assessor for determination, under Division 6.4, section 6.23 of the Act.

7.298 The settlement approval will be considered and determined by a claims assessor who has been appointed by the Authority, under Division 7.2, section 7.4 of the Act.

7.299 DRS will advise the parties of the claims assessor who has been allocated to determine a particular settlement approval.

The settlement approval process

7.300 The settlement approval must be conducted in the way that best supports the objects of the Act, given the facts and circumstances of the particular claim and the particular damages settlement, which may include undertaking the assessment on the papers, using teleconferences, videoconferences or face-to-face meetings as appropriate.

7.301 The claims assessor may determine the settlement approval procedure, is not bound by the rules of evidence, and may inquire into any matter relevant to the issues in dispute in such manner as they think fit.

7.302 The claims assessor may request additional information from the parties for the purpose of considering the settlement approval.

7.303 The claims assessor is not to approve the settlement of the claim unless satisfied that the settlement complies with any applicable requirements of or made under Division 6.4, section 6.23(3) of the Act, or this Part of the Motor Accident Guidelines.

7.304 The proposed settlement must comply with the following requirements of this Part of the Motor Accident Guidelines, made under section 6.23(3) of the Act:

(a) timeliness – the proposed settlement satisfies the timing requirements in section 6.23(1) of the Act

(b) appropriateness – the proposed settlement is just, fair and reasonable and within the range of likely potential damages assessments for the claim were the matter to be assessed by a claims assessor, taking into account the nature and extent of the claim and the injuries, disabilities, impairments and losses sustained by the claimant, and taking into account any proposed reductions or deductions in the proposed settlement

(c) understanding – the claimant understands the nature and effect of the proposed settlement and is willing to accept the proposed settlement.

7.305 The claims assessor may receive information from the claimant in confidence during the settlement approval process. This information may include the reason given by the claimant for agreeing to the proposed settlement. The claims assessor is not required to disclose this information to the insurer, except where the information suggests that the claimant may have made a

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fraudulent claim or may have otherwise contravened the Act or the Motor Accident Guidelines.

The settlement approval decision

7.306 The claims assessor may decide to:

(a) reject the proposed settlement as submitted in the application, with or without recommendations to the parties about the further conduct of the claim,

(b) approve the proposed settlement as submitted in the application

(c) approve an amended proposed settlement agreed by the parties during the course of the consideration of the proposed settlement approval.

7.307 The claims assessor must issue the parties with a certificate as to the determination of the settlement approval application, attaching a brief statement of reasons for the determination.

7.308 The settlement approval application will be determined as soon as practicable by the issuing of the claims assessor's certificate, and preferably within 14 days of the application being made; however, a determination is not invalid if it is made after that period expires.

The effect of the settlement approval decision

7.309 A settlement approval decision is effectively binding on the parties under Division 6.4, section 6.23 of the Act.

When does an approved settlement take effect?

7.310 The insurer should apply and give effect to the settlement approval decision as quickly as is practicable, in accordance with any agreed terms of the settlement, and the insurer's responsibilities under the principles in 'Part 4 of the Motor Accident Guidelines: Claims'.

7.311 On receiving the settlement approval decision, the insurer must advise the claimant about the effect of the decision within 7 days, providing the claimant with details of:

(a) how and when the insurer will give effect to the settlement approval decision

(b) the impact of the settlement approval decision on the claimant and their claim.

Miscellaneous claims assessment

Miscellaneous claims assessment matters

7.312 Schedule 2, clause 3 of the Act declares that there are a number of miscellaneous claims assessment matters that may be the subject of an application for a miscellaneous claims assessment by DRS.

7.313 A dispute about a decision of an insurer may not be referred for a miscellaneous claims assessment unless either:

(a) the decision has been the subject of an internal review by the insurer

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(b) this Part of the Motor Accident Guidelines provides that an internal review is not required for the decision about the miscellaneous claims assessment matter to which the insurer's decision relates

(c) the insurer has failed to complete an internal review and notify the claimant of the internal review decision within the required timeframe

(d) the insurer has declined to conduct an internal review.

7.314 A miscellaneous claims assessment may be made without an internal review, under section 7.41(2)(a) and 7.41(3) of the Act, this clause of the Guidelines and Part 5, Division 1, clause 11 of the Regulation, if the dispute is about which insurer is the insurer of the at-fault motor vehicle for the purposes of section 3.3 ('Determination of relevant insurer'), as listed in Schedule 2, clause 3(c) of the Act.

Requesting a miscellaneous claims assessment

7.315 This Part of the Motor Accident Guidelines may make provisions with respect to any aspect of the procedures to be followed under Division 7.6, section 7.39 of the Act.

Time for requesting a miscellaneous claims assessment

7.316 The application for a miscellaneous claims assessment may be made to DRS at any time by any party to the dispute.

Application requirements

7.317 A referral for a miscellaneous claims assessment is made by making an application to DRS in accordance with the standard DRS application requirements set out in the 'Lodging an application with DRS' section of this Part of the Motor Accident Guidelines.

7.318 In addition to the standard DRS application requirements, an application for a miscellaneous claims assessment must also include:

(a) the decision that is referred for a miscellaneous claims assessment

(b) the alternative decision sought in the miscellaneous claims assessment

(c) the reasons the decision should be changed

(d) any regulated costs sought (if applicable).

7.319 DRS may decline to conduct a miscellaneous claims assessment if the application does not comply with the above clause.

Replying to a miscellaneous claims assessment application

Time for replying to a miscellaneous claims assessment application

7.320 A party who receives an application for a miscellaneous claims assessment lodged with DRS by another party will be given the opportunity to respond.

7.321 The responding party may lodge a reply to an application for a miscellaneous claims assessment within a period of time after receiving the application for a miscellaneous claims assessment as listed in Table 7.4 for the various types of medical assessment matters.

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Table 7.4: Miscellaneous claims assessment notification period

Miscellaneous claims assessment matters	Reply period
Statutory benefits payments matters (Schedule 2, clause 3(b), (f) and (k))	7 days
Procedural claims matters (Schedule 2, clause 3(h), (i), (j), (l), and (m))	14 days
Fault and contributory negligence matters (Schedule 2, clause 3(a), (a1), (c), (d), (e) and (g))	21 days

7.322 If the respondent lodges a reply later than the period allowed above, DRS may decline to consider the reply.

7.323 DRS may also proceed in the absence of a reply.

Reply requirements

7.324 A party may reply to an application for a miscellaneous claims assessment by making a reply to DRS in accordance with the standard DRS reply requirements set out in the 'Lodging a reply with DRS' section of this Part of the Motor Accident Guidelines.

7.325 In addition to the standard DRS reply requirements, a reply to an application for a miscellaneous claims assessment must also include the following information:

(a) the response to the alternative decision sought in the application for miscellaneous claims assessment

(b) the response to the reasons the other party believes the decision should be changed

(c) the response to any regulated costs sought.

7.326 DRS may decline to consider a reply to an application for a miscellaneous claims assessment if it does not comply with the above clause.

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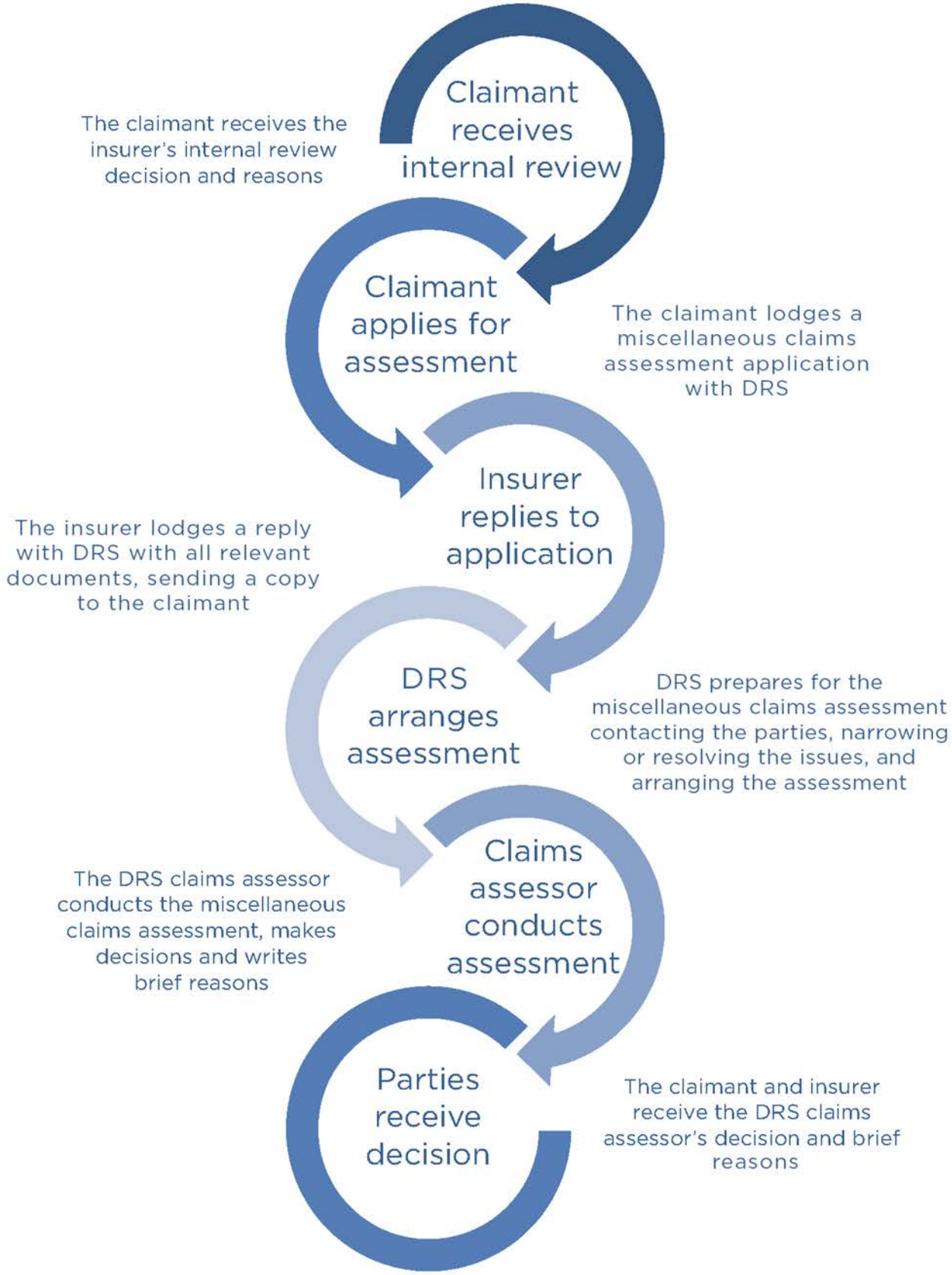
Figure 7.5: The miscellaneous claims assessment process



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The miscellaneous claims assessment

Managing the miscellaneous claims assessment

7.327 The application for a miscellaneous claims assessment will be managed in accordance with the provisions set out in the 'Managing applications made to DRS' section of this Part of the Motor Accident Guidelines.

7.328 In addition to those standard application management provisions, DRS may also arrange for the miscellaneous claims assessment application to be referred to a claims assessor, under section 7.32(2) of the Act.

7.329 The provisions of Division 7.6, Subdivision 2 'Assessment of claims for damages', also apply to the assessment of a miscellaneous claims assessment under Subdivision 3 'Miscellaneous claims assessments' due to the operation of section 7.42(2) of the Act.

The claims assessor

7.330 The miscellaneous claims assessment will be conducted by a claims assessor who has been appointed by the Authority, under Division 7.2, section 7.4 of the Act.

7.331 DRS will advise the parties of the claims assessor who has been allocated to conduct a particular miscellaneous claims assessment.

The miscellaneous claims assessment process

7.332 The miscellaneous claims assessment must be conducted in the way that best supports the objects of the Act, given the facts and circumstances of the particular claim and the particular miscellaneous claims assessment, which may include undertaking the assessment on the papers, using teleconferences, videoconferences or face-to-face meetings as appropriate.

7.333 The claims assessor may determine the miscellaneous claims assessment procedure, is not bound by the rules of evidence and may inquire into any matter relevant to the issues in dispute in such manner as the they think fit.

7.334 The claims assessor conducting the miscellaneous claims assessment may exercise the same claims assessor powers and apply the same procedures as for a claims assessments, subject to the modifications in Part 5, Division 5 of the Regulation.

The miscellaneous claims assessment decision

7.335 The miscellaneous claims assessment will be determined by the claims assessor within 21 days of receipt of all relevant information, or as soon as practicable, thereafter.

7.336 The claims assessor must issue the parties with a certificate as to the miscellaneous claims assessment, attaching a brief statement of reasons for the assessment, under section 7.36(5) of the Act.

7.337 An obvious error in the claims assessor's certificate, or statement of reasons attached to the certificate, may be corrected at the request of either party, or as a result of the claims assessor's identification of an obvious error. Any such application is to be made to DRS in writing, setting out details of the obvious error and the terms of the suggested correction.

7.338 The party making the application is to send a copy of the application to the other party.

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7.339 If the PCA is satisfied that the certificate or a statement of reasons attached to the certificate contains an obvious error, the PCA may issue, or approve of the claims assessor issuing, a replacement certificate or statement of reasons to correct the error, under section 7.36(6) of the Act.

The effect of the miscellaneous claims assessment decision

7.340 The insurer should apply and give effect to the miscellaneous claims assessment decision as quickly as practicable, in accordance with its duties under Section 6.4 of the Act.

7.341 On receiving the miscellaneous claims assessment decision, the insurer must advise the claimant about the effect of the decision within 7 days, providing the claimant with details of:

(a) how and when the insurer will give effect to the miscellaneous claims assessment decision

(b) the impact of the miscellaneous claims assessment decision on the claimant and their claim.

Legal costs for miscellaneous assessment matters

7.342 Schedule 1, clause 3 of the Regulation make provision for the maximum costs for legal services provided to a claimant in connection with matters relating to the assessment of a miscellaneous assessment matter.

7.343 Where costs for legal services are payable by the insurer, the insurer must pay the invoice within 20 days of its receipt.

Damages claims assessment

7.344 A claimant, insurer or both may refer a claim for damages for a claims assessment, under section 7.32(1) of the Act.

Claims that are exempt from assessment

7.345 The Regulation, under Part 5, Division 4, clause 14, lists those kinds of claims that are exempt from assessment.

7.346 A claim is also exempt from assessment if a claims assessor has made a preliminary assessment of the claim and has determined, with the approval of the PCA, that the claim is not suitable for assessment, under section 7.34(1)(b) of the Act.

7.347 In determining whether a claim is not suitable for a claims assessment, a claims assessor and the PCA will have regard to the objects of the Act, the objects of DRS and all of the circumstances of the claim at the time of considering the claim. This may include, but is not limited to whether:

(a) the claim involves complex legal or factual issues, or complex issues in the assessment of the amount of the claim

(b) the claim involves issues of liability, including issues of contributory negligence, fault and/or causation

(c) a claimant or a witness, considered by the claims assessor to be a material witness, resides outside New South Wales

(d) a claimant or insurer seeks to proceed against one or more non-CTP parties

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(e) the insurer alleges that a person has made a false or misleading statement in a material particular in relation to the injuries, loss or damage sustained by the claimant in the accident, giving rise to the claim.

Requesting a damages claims assessment

Time for requesting a damages claims assessment

7.348 The parties to a claim must use their best endeavours to settle the claim before referring it for damages claims assessment, under section 7.32(3) of the Act.

7.349 An application for a claims assessment, including for exemption from assessment, must be made within three years of the date of the accident, under section 7.33 of the Act.

7.350 If an application for a claims assessment, including for exemption from assessment, is made more than three years after the date of the motor accident, the applicant must provide a full and satisfactory explanation for the delay for a claims assessor. The claims assessor will determine whether to grant leave for the claim to be referred for assessment, including for exemption from assessment, under section 7.33 of the Act.

Application requirements

7.351 This Part of the Motor Accident Guidelines makes provisions relating to the procedures referring disputes for a damages claims assessment, including for exemption from a damages claims assessment, under section 7.39 of the Act.

7.352 A claim for damages may be referred for a claims assessment, including for exemption from damages claims assessment, by making an application to DRS in accordance with the standard DRS application requirements set out in the 'Lodging an application with DRS' section of this Part of the Motor Accident Guidelines.

7.353 In addition to the standard DRS application requirements, an application for a damages claims assessment, including for exemption from assessment, must also include details of:

(a) the best endeavours that the parties have used to attempt to settle the claim before referring it for assessment, including for exemption from assessment

(b) the issues in dispute between the parties.

7.354 DRS may decline to conduct a claims assessment if the application does not comply with the above clause.

Replying to a damages claims assessment application

Time for replying to a damages claims assessment application

7.355 A party who receives an application for a claims assessment, including for exemption from assessment, lodged with DRS by another party will be given the opportunity to respond.

7.356 The responding party may lodge a reply to an application:

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(a) for exemption from damages claims assessment, within seven days of receiving the application

(b) for a damages claims assessment, within 21 days of receiving the application.

7.357 If the respondent lodges a reply later than the period allowed above, DRS may decline to consider the reply.

7.358 DRS may also proceed to make a decision in the absence of a reply.

Reply requirements

7.359 A party may reply to an application for a damages claims assessment, including for exemption from assessment, by making a reply to DRS in accordance with the standard DRS reply requirements set out in the 'Lodging a reply with DRS' section of this Part of the Motor Accident Guidelines.

7.360 In addition to the standard DRS reply requirements, a reply to an application for a claims assessment, must also include:

(a) the response of the party, including details of the best endeavours that the parties have used to attempt to settle the claim before referring it for assessment, identified in the claims assessment application

(b) the response of the party to the issues in dispute between the parties identified in the claims assessment application.

7.361 DRS may proceed to make a decision in the absence of a reply to an application for a claims assessment, including for exemption from assessment, if the reply does not comply with the above clause.

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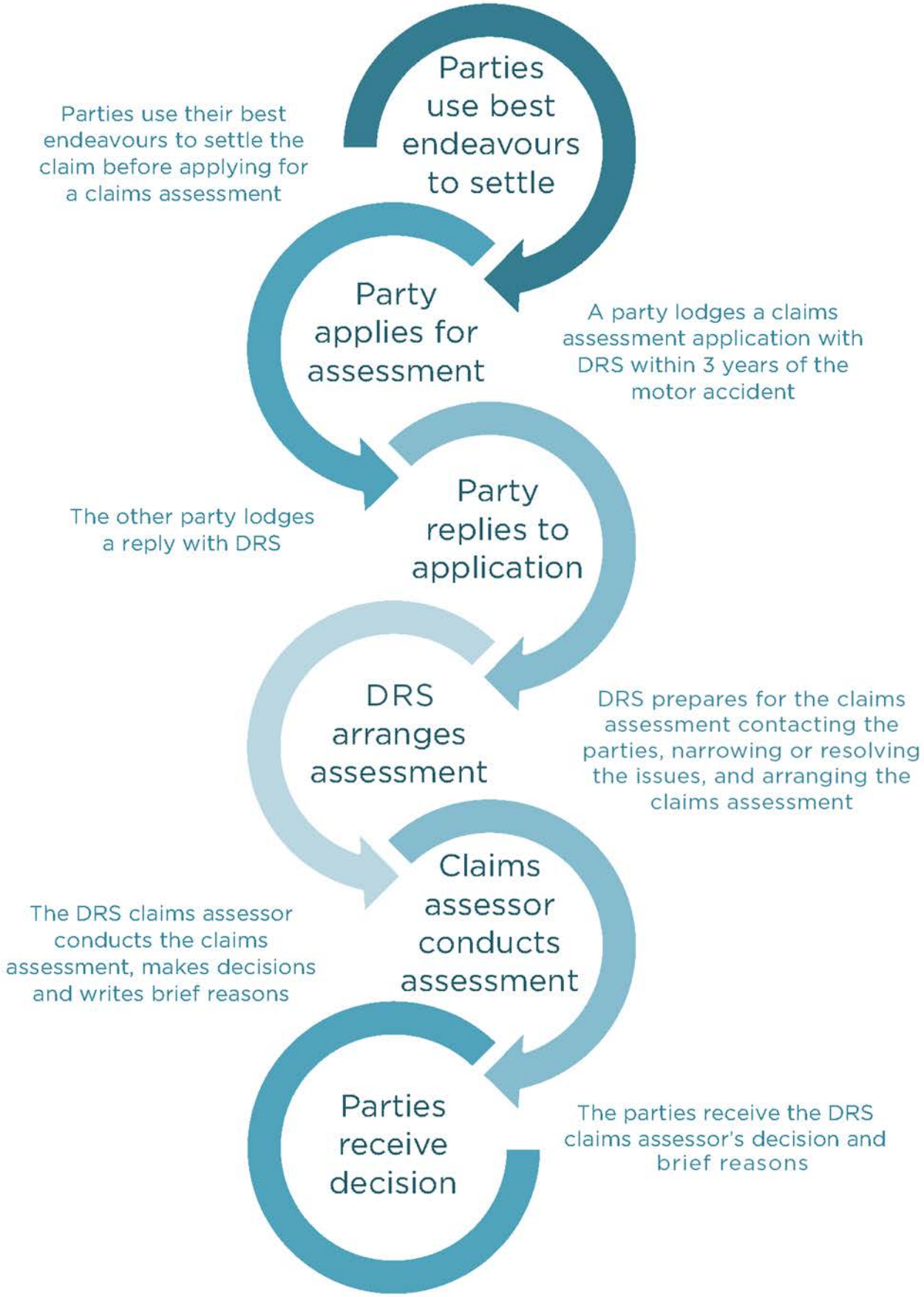
Figure 7.6: The claims assessment process



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The damages claims assessment

Managing the damages claims assessment

7.362 The application for a claims assessment, including for exemption from assessment, will be managed in accordance with the provisions set out in the 'Managing applications made to DRS' section of this Part of the Motor Accident Guidelines.

7.363 In addition to those standard application management provisions, DRS may also:

(a) make exemption assessment arrangements – arrange for an exemption application under section 7.34(1)(a) of the Act, to be referred to the PCA, under section 7.32(2) of the Act

(b) make claims assessment arrangements – arrange for a damages claims assessment application, including any exemption application under section 7.34(1)(b) of the Act for matters claimed to be not suitable for assessment, to be referred to a claims assessor, under section 7.32(2) of the Act.

7.364 If a claim is exempt from assessment under section 7.34(1)(a) of the Act for matters specified in the Regulation as exempt, the PCA must, as soon as practicable, and preferably within seven days of the due date for the reply to the application, arrange for a certificate to that effect to be issued to the insurer and the claimant under section 7.34(2) of the Act.

7.365 If a claims assessor has determined (with the approval of the PCA) that a claim is not suitable for assessment under section 7.34(1)(b) of the Act, the PCA must, as soon as practicable, and preferably within seven days of the claims assessor's determination, arrange for a certificate to that effect to be issued to the insurer and the claimant under section 7.34(2) of the Act.

The claims assessor

7.366 The claims assessment will be conducted by a claims assessor who has been appointed by the Authority, under section 7.4 of the Act, and who may assess that particular class of claim under section 7.35 of the Act.

7.367 DRS will advise the parties of the claims assessor who has been allocated to conduct a particular claims assessment.

The damages claims assessment process

7.368 The claims assessment must be conducted in the way that best supports the objects of the Act, given the facts and circumstances of the particular claim and the particular claims assessment, which may include undertaking the assessment on the papers, using teleconferences, videoconferences or face-to-face meetings, as appropriate.

7.369 The claims assessor may determine the claims assessment procedure, is not bound by the rules of evidence, and may inquire into any matter relevant to the issues in dispute in such manner as they think fit.

7.370 The claims assessor must act with as little formality as the circumstances of the claim permit and according to equity, good conscience and the substantial merits of the matter, without regard to technicalities and legal forms.

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7.371 The claims assessor must ensure that relevant material is available so as to enable all of the relevant facts in issue to be determined.

7.372 During the course of an assessment, the claims assessor will not inquire about the amount of any offers made by either party.

7.373 A claims assessor will not be disqualified from assessing a matter if they become aware in any manner of the amount of any offer. If the claims assessor becomes aware of any offer, they will disregard that information for the purpose of assessing the claim.

The damages claims assessment decision

7.374 The claim assessor will determine the claims assessment as soon as practicable and preferably within 21 days of the assessment, under section 7.36(4) of the Act; however, a determination is not invalid if it is made after that period expires.

7.375 The claims assessor must issue the parties with a certificate as to the claims assessment, attaching a brief statement of reasons for the assessment, under section 7.45(1) of the Act.

7.376 An obvious error in the claims assessor's certificate, or statement of reasons attached to the certificate, may be corrected at the request of either party, or as a result of the claims assessor's identification of an obvious error. Any such application is to be made to DRS in writing, setting out details of the obvious error and the terms of the suggested correction.

7.377 The party making the application is to send a copy of the application to the other party.

7.378 If the PCA is satisfied that the certificate, or a statement of reasons attached to the certificate, contains an obvious error, the PCA may issue, or approve of the claims assessor issuing, a replacement certificate or statement of reasons to correct the error, under section 7.36(6) of the Act.

7.379 A request by a party to have an obvious error corrected must be made within 21 days after the certificate of the claims assessment is issued.

The effect of the damages claims assessment decision

7.380 The insurer should apply and effect to the claims assessment decision as quickly as is practicable, in accordance with its duties under section 6.4 of the Act.

7.381 The Regulation prescribes the time for payment of assessed damages at Part 5, Division 4, clause 16(1).

7.382 On receiving the claims assessment decision, the insurer must advise the claimant about the effect of the decision within 7 days, providing the claimant with details of:

(a) how and when the insurer will give effect to the claims assessment decision

(b) the impact of the claims assessment decision on the claimant and their claim.

Legal costs in damages claims assessment matters

7.383 Schedule 1 clause 2(5) and Table E of the Regulation makes provision for the maximum costs for legal services to a claimant in connection with a claims assessment matter.

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7.384 Where costs for legal services are payable by the insurer, the insurer must pay the invoice within 20 days of its receipt.

Further assessments of damages claims

7.385 This Part of the Motor Accident Guidelines makes provisions relating to the procedures for the referral of disputes for assessment, under section 7.39 of the Act.

7.386 A claim for damages may be referred for a further claims assessment by making an application to DRS in accordance with the standard DRS application requirements set out in the 'Lodging an application with DRS' section of this Part of the Motor Accident Guidelines.

7.387 The further claims assessment will be dealt with under the same guideline provisions that apply to claims assessments, and the 'Assessment of claims for damages' section also applies to applications for further claims assessment.

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Part 8 of the Motor Accident Guidelines: Authorised Health Practitioners

State Insurance Regulatory Authority 204

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Authorised Health Practitioners

Introduction

8.1 This Part of the Guidelines provides for the appointment of health practitioners for the purposes of authorisation under Division 7.7, section 7.52 of the Act.

8.2 This Part of the Guidelines applies to all appointments commencing on or after 1 December 2019.

8.3 A health practitioner may be appointed as a decision-maker in the Dispute Resolution Service and as an authorised health practitioner at the same time. However, a health practitioner may not act in both roles in the same claim.

Health practitioners authorised to give evidence

8.4 Section 7.52 of the Act provides for the admissibility of evidence in certain proceedings. A health practitioner, other than the injured person's treating health practitioner, is authorised to give evidence in proceedings for the purposes of section 7.52 by:

(a) an agreement between the parties for the health practitioner to conduct a joint medical assessment, or

(b) appointment by the Authority to its list of authorised health practitioners, or

(c) appointment by the Authority for a specific purpose and duration on application by a claimant or insurer.

8.5 A health practitioner is not authorised to give evidence in proceedings unless the practitioner is authorised under these Guidelines at the time the evidence is given. For evidence given by written report, this means that the health practitioner must be authorised at the time they examine the claimant and write the report.

8.6 If evidence given by the health practitioner is admitted in the proceedings, the practitioner is always authorised to give further evidence on cross-examination and re-examination of that evidence during proceedings.

Joint medical assessments

8.7 In a claim, where a legally-represented claimant and an insurer agree to a health practitioner conducting a joint medical assessment, that health practitioner is authorised under section 7.52(1)(b) of the Act for the purposes of that claim.

8.8 The parties must instruct the health practitioner in writing to conduct the joint medical assessment. The joint instruction letter must state that:

(a) the health practitioner is to perform a joint medical assessment, and

(b) the health practitioner must send the report and any supplementary reports to both parties on completion.

8.9 If a party identifies an error in the report, it may request the health practitioner to re-issue the report with the correct information. The party must send the request and supporting evidence to the health practitioner in writing within 7

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calendar days of receiving the initial report and provide a copy of the request and supporting evidence to the other party.

8.10 No supplementary reports can be requested unless agreed to by both parties. A report issued by the health practitioner to correct an error is not considered supplementary.

8.11 The insurer must meet the cost of the joint medical assessments, including the initial report and any supplementary reports.

Appointment by the Authority to its list

8.12 A health practitioner seeking appointment to the Authority's list of authorised health practitioners must apply to the Authority by completing and submitting the application form available on the Authority's website (https://www.sira.nsw.gov.au/).

8.13 As far as reasonably practicable, the Authority will ensure that there are authorised health practitioners appointed in the regional areas of NSW.

8.14 The Authority will determine the application for appointment against the eligibility requirements and notify the applicant in writing of its decision.. If the Authority declines to appoint a health practitioner, the Authority's decision will include:

(a) brief reasons for that decision

(b) a period of time, if any, before the health practitioner may re-apply for appointment and the reasons for that nominated period.

8.15 A health practitioner seeking to re-apply must complete a new application form.

8.16 If the health practitioner disagrees with the Authority's decision, they may ask the Authority to review its e decision by writing to the Authority within 14 days of receipt of the decision, and provide any relevant information as to why their application should be accepted. The Authority will undertake the internal review and notify the health practitioner of the outcome within 21 days after receiving the request for review or after receiving the last document or information the Authority may request from the health practitioner.

8.17 The Authority will publish on its website (www.sira.nsw.gov.au) the names of all authorised health practitioners, their contact details, practice locations, and other information relevant to their role as an authorised health practitioner.

8.18 Health practitioners appointed to the Authority's list must continue to meet the eligibility requirements and comply with the terms of appointment to remain authorised under this section.

8.19 The NSW Medical Board Policy 'Guidelines for medico-legal consultations and examinations' (File reference DD10/10871 revised December 2005, on SIRA's website) applies to all health practitioners appointed under this section. Where the Policy refers to the NSW Medical Board's Code of Professional Conduct: *Good Medical Practice*, this only applies to health practitioners who are medical practitioners under the *Medical Practice Act 1992.*

Eligibility requirements

8.20 The Authority may appoint a health practitioner to its list of authorised health practitioners if it is satisfied that the health practitioner:

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(a) has at least five years of full-time equivalent relevant clinical experience, including an understanding of the treatment and/or management of motor accident related injuries

(b) holds current General or Specialist registration with the Australian Health Practitioner Regulation Agency (AHPRA) with no conditions, undertakings, reprimands, limitations or restrictions on registration as a result of a disciplinary process

(c) is not subject to supervisory requirements, or does not have any provisions on their registration that may adversely impact their performance in the role

(d) has high-level communication skills, such that they would be able to comply with the requirements for consultations, examinations and reports outlined in the NSW Medical Board Policy titled 'Guidelines for medico-legal consultations and examinations' (File reference DD10/10871 revised December 2005, on SIRA's website).

8.21 The Authority will consider all relevant information available to assess whether a health practitioner meets the eligibility requirements and may request additional information from the applicant or third parties. This may include:

(a) information related to complaints, compliance, or breaches of legislation, guidelines, or fee schedules within the last 10 years

(b) conditions on registration or current disciplinary proceedings that may affect the practitioner's registration, ability to undertake the role, or integrity of the motor accident insurance scheme of NSW if appointed

(c) if the practitioner has any pending criminal charges or has, within the last 10 years, been convicted of any criminal offence or demonstrated behaviour that may affect the practitioner's ability to undertake the role with impartiality and fairness., or may affect the integrity of the motor accident insurance scheme of NSW.

Restrictions

8.22 The Authority may appoint an authorised health practitioner to its list subject to restriction

8.23 Without limiting the above clause, a restriction may include limiting the authorisation to give evidence in:

(a) specified medical matters, or

(b) medical matters in specified claims, or

(c) medical matters related to specified claimants or kinds of claimants.

8.24 The Authority may also restrict a health practitioner's appointment to a defined period or for the duration of a specific claim.

8.25 The Authority may impose a restriction on a health practitioner's appointment at any time during the period of authorisation, after first notifying the health practitioner.

Terms of appointment

8.26 Appointment as an authorised health practitioner requires that during the term of appointment the health practitioner must:

(a) act without bias and in a way that does not give rise to an apprehension of bias in the performance of their responsibilities

(b) comply with the relevant law, including the *Motor Accident Injuries Act 2017*, the *Motor Accident Injuries Regulation 2017*, and these Guidelines, including the Expert Witness Code of Conduct in Part 7 and, promptly notify the Authority of any compliance breaches

(c) act in an ethical, professional and considerate manner when examining injured persons

(d) agree to the Authority publishing on its website (www.sira.nsw.gov.au) the health practitioner's name, contact details, practice location(s), and other information relevant to the terms and extent of their appointment

(e) notify the Authority within 14 calendar days of any change to name or details

(f) have access to the necessary resources and infrastructure to do all administrative activities necessary for the role

(g) comply with all legal requirements for practice, including relevant policies and codes of conduct

(h) comply with the standards and conduct for medico-legal consultations, examinations and reports, as set out in the NSW Medical Board Policy titled 'Guidelines for medico-legal consultations and examinations' (File reference DD10/10871 revised December 2005, on SIRA's website). Where the Policy refers to the NSW Medical Board's 'Code of Professional Conduct: Good Medical Practice', this only applies to health practitioners who are medical practitioners under the *Medical Practice Act 1992*

(i) establish and maintain appropriate and secure record management systems to manage work and maintain records and data lawfully and efficiently

(j) comply with all privacy obligations including under the *Health Records and Information Privacy Act 2002* (NSW) and the *Privacy Act 1988* (Cth)

(k) participate in the Authority's performance framework for authorised health practitioners, including complying with any mandatory training required by the Authority for authorisation, and the Authority's data reporting and training requirements

(l) co-operate with the Authority's complaints-handling framework, including responding to complaints with full and accurate details and, when indicated by the Authority, taking remedial action.

8.27 Appointment as an authorised health practitioner requires that during the term of their appointment by the Authority to its list of authorised health practitioners, the health practitioner must not:

(a) provide treatment advice and/or services to injured persons referred to the health practitioner for examination or assessment in their capacity as an authorised health practitioner

(b) accept a referral or examine an injured person if the authorised health practitioner has a conflict of interest

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(c) ask for or accept any inducement, gift, or hospitality from individuals or companies, or enter into arrangements that could be perceived to provide inducements, that may affect, or be seen to affect, their ability to undertake the role of an authorised health practitioner in an impartial and unbiased manner

(d) engage in activities or publicly express opinions that might be perceived to compromise the practitioner's ability to undertake the role of an authorised health practitioner in an impartial and unbiased manner

(e) undertake medico-legal assessments in claims made under the *Motor Accident Injuries Act 2017* outside of their area(s) of expertise.

8.28 A health practitioner who is appointed as an authorised health practitioner should accept all referrals whether made on behalf of an injured person or an insurer, but should decline a request for examination or assessment if:

(a) they are not adequately qualified or experienced

(b) the request relates to a medical matter for which the health practitioner is not authorised to give evidence

(c) they have a conflict of interest (personal, work-related, or financial)

(d) for any other reason they are unable to complete the task within the terms specified by the requesting party.

Cessation of appointment

8.29 The Authority may revoke a health practitioner's appointment at any time. The Authority will notify the health practitioner in writing of its revocation and the reasons for the revocation.

8.30 If the health practitioner disagrees with the Authority's decision, they may request areview of the decision by within 14 days of receipt of the decision and provide any relevant information as to why the appointment should not be revoked. The Authority will undertake the review and notify the health practitioner of the outcome within 21 days after receipt or after receiving the last document or information the Authority may request from the health practitioner.

8.31 A health practitioner may cease their appointment at any time during the term of the appointment by notifying the Authority in writing.

8.32 If a health practitioner's appointment is revoked or ceased, the evidence given by the health practitioner in the period that they were authorised remains admissible for the purposes of section 7.52 of the Act and any cross-examination and re-examination of that evidence during proceedings is not affected.

Appointment by the Authority on application by the parties

8.33 Where a claimant or insurer proposes to obtain evidence from a health practitioner not appointed by the Authority to its list of authorised health practitioners, a claimant or insurer may apply by writing to the Authority to seek the appointment of that health practitioner to be authorised.

8.34 The application to the Authority must include:

(a) reasons why the applicant party cannot obtain evidence from a health practitioner on the Authority's list

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(b) reasons why a joint medical assessment cannot be arranged

(c) the name, address and qualifications and/or experience of the health practitioner the applicant party requests the Authority to appoint

(d) evidence that the health practitioner agrees to be bound by the Expert Witness Code of Conduct outlined in Part 7, and the guidelines relating to consultations and reports outlined in the NSW Medical Board Policy titled 'Guidelines for medico-legal consultations and examinations' (File reference DD10/10871 revised December 2005, on SIRA's website)

(e) details of the specific claim or claims for which the evidence is being sought, including claim number, claimant name, and other identifying information.

8.35 For the purposes of section 7.52, the Authority may appoint the nominated health practitioner if the Authority is satisfied that:

(a) the applicant party cannot obtain the required evidence from a health practitioner on the Authority's list, and

(b) the health practitioner has suitable qualifications and skills to give the evidence.

8.36 The Authority will determine the application for appointment and notify the applicant in writing of its decision. Where the Authority accepts the appointment, the Authority will also notify the health practitioner that they are authorised to give evidence and outline the terms of their appointment including any restrictions.

8.37 The claimant or insurer relying on evidence by a health practitioner appointed under this clause must provide to the other party a copy of the Authority's notification of authorisation at the time the report is served or relied on, whichever is the earlier.

8.38 Unless otherwise specified by the Authority, a health practitioner appointed under this clause is only authorised for the purposes and duration of the relevant claim or claims. The Authority may impose further restrictions on the appointment at any time during the period of authorisation.

(a) A health practitioner appointed under this clause must include in their report(s) a statement that they are authorised by the Authority and any restrictions on the appointment that apply.

8.39 The Authority may revoke a health practitioner's appointment at any time. The Authority will notify the applicant and the health practitioner in writing and advise the reasons for the revocation. The guidelines for 'Cessation of appointment' in this Part will apply.

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Part 9 of the Motor Accident Guidelines: CTP Care

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CTP Care

Introduction

9.1 This Part of the Guidelines is made under section 6.1 of the Act. It sets out the requirements to transition the payment of statutory benefits for treatment and care from a licensed insurer to the Lifetime Care and Support Authority (LTCSA) as the relevant insurer.

9.2 This Part applies to licensed insurers. It also applies to LTCSA in the exercise of its functions as the relevant insurer:

(a) for the payment of statutory benefits for treatment and care provided more than 5 years after a motor accident under section 3.2 of the Act, or

(b) when it enters into an agreement with a licensed insurer to assume responsibility for the payment of statutory benefits for treatment and care provided within 5 years after a motor accident under section 3.45 of the Act.

9.3 This Part is in two sections to reflect the key stages of the transition process:

(a) before LTCSA is the relevant insurer

(b) after LTCSA is the relevant insurer.

Principles

9.4 All parties must apply the following principles when transitioning the payment of statutory benefits for treatment and care from a licensed insurer to LTCSA:

(a) the injured person is kept informed of what is happening

(b) the injured person is not adversely affected by the transition process

(c) the licensed insurer and LTCSA work collaboratively to ensure proactive and timely support for the injured person to optimise their recovery and return to work or other activities

(d) customer service outcomes are prioritised along with efficient and responsible decision-making, including early resolution of claims where possible, and the quick, cost-effective and just resolution of disputes

(e) the transition does not adversely affect the quality of decision-making on whether statutory benefits are payable for the cost of treatment and care

(f) complete, accurate and up-to-date information relevant to the payment of statutory benefits for treatment and care is shared openly and transparently between the licensed insurer and LTCSA to support a smooth transition.

Before LTCSA is the relevant insurer

Data and information

9.5 The licensed insurer must provide LTCSA with accurate and up-to-date data in the manner determined by the Authority, including:

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(a) all claims likely to require treatment and care more than 5 years after the motor accident

(b) all claims where the injured person is receiving treatment and care more than 156 weeks after the motor accident and the only injuries resulting from the motor accident were minor injuries. For these claims, the licensed insurer must also provide the reason under section 3.28(3) of the Act that the payment for treatment and care is authorised.

9.6 The licensed insurer must provide LTCSA with copies of all data and information agreed between them to be relevant to the claim. The licensed insurer must provide the agreed data and information as early as possible.

9.7 If there is a disagreement between the licensed insurer and LTCSA about the provision of data and information that they cannot resolve, including timeliness in providing data, either one may refer the matter to the Authority for direction.

9.8 If LTCSA enters into an agreement with a licensed insurer to assume responsibility for the payment of statutory benefits for treatment and care during the period of 5 years after a motor accident, LTCSA and the licensed insurer must retain a copy of the executed agreement and provide it to the Authority on request.

Notification requirements

9.9 Unless a claim is finalised and closed, a licensed insurer must give the injured person notice that LTCSA will become the relevant insurer for the payment of statutory benefits for treatment and care.

9.10 The notice must be in writing and given at the following times:

(a) if there is an early assumption of responsibility by LTCSA during the period of 5 years after the motor accident — at least 2 weeks before the likely date that LTCSA becomes the relevant insurer, or

(b) if LTCSA becomes the relevant insurer for payment of treatment and care provided more than 5 years after the date of the motor accident — 4 years and 6 months after the date of the motor accident.

9.11 The notice must clearly and simply explain:

(a) the plan to transition to LTCSA as the relevant insurer for the payment of statutory benefits for treatment and care

(b) the relevant legislative provisions for that transition

(c) the ongoing responsibilities of the licensed insurer, including payment of weekly statutory benefits and/or management of any claim for damages

(d) that LTCSA will notify the injured person in writing to confirm that it is the relevant insurer and the contact details for the LTCSA contact officer

(e) contact details for SIRA's CTP Assist if the injured person has unresolved questions or concerns.

9.12 The licensed insurer must provide LTCSA with a copy of the notice at the same time the licensed insurer gives a copy of the notice to the injured person.

9.13 The licensed insurer must also notify the injured person's current treatment and care service providers that LTCSA will soon be the relevant insurer. This

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notice must be given at least 2 weeks before LTCSA becomes the relevant insurer. This clause does not apply for a licensed insurer if the injured person is an interim participant of the Lifetime Care and Support Scheme (LTCSA is responsible for notifying treatment and care service providers in this case).

After LTCSA is the relevant insurer

Data and information

9.14 After LTCSA is the relevant insurer, the licensed insurer must continue to provide LTCSA with copies of any new data and information relevant to the claim.

9.15 The licensed insurer must provide any new data and information to LTCSA as early as practicable after the licensed insurer receives it.

Initial notification requirements

9.16 No later than 5 business days after LTCSA becomes the relevant insurer for the payment of statutory benefits for treatment and care, LTCSA must notify the injured person in writing of the following:

(a) confirmation that LTCSA is the relevant insurer for the payment of statutory benefits for treatment and care

(b) the date LTCSA became the relevant insurer for the payment of statutory benefits for treatment and care

(c) details of what LTCSA will be responsible for

(d) contact details of the LTCSA contact officer.

9.17 No later than 2 weeks after LTCSA becomes the relevant insurer for the payment of statutory benefits for treatment and care, LTCSA must notify the injured person's current treatment and care service providers that LTCSA is the relevant insurer, and provide contact details for the LTCSA contact officer.

Ongoing notification requirements

9.18 The licensed insurer must notify LTCSA within 7 days after a damages claim is settled that is related to a claim for which LTCSA is the relevant insurer for the payment of statutory benefits for treatment and care.

9.19 LTCSA must notify the Authority of the following:

(a) disputes under section 3.45(5) of the Act that are likely to be referred to the Dispute Resolution Service (DRS)

(b) applications for judicial review, such as where LTCSA or an injured person applies for a court to review a DRS decision

(c) any likely or actual dissolution of an agreement between a licensed insurer and LTCSA under section 3.45(2) of the Act

(d) Notifiable Data Breaches in accordance with the *Privacy Act 1988* (Cth)

(e) any funding issues identified relating to an early assumption of responsibilities by LTCSA under section 3.45 of the Act

(f) all significant breaches of any legislation relevant to the functions of LTCSA as relevant insurer under the Act.

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Communication with the injured person

9.20 When communicating with an injured person, LTCSA must:

(a) communicate directly with the injured person to deal with the claim (regardless of whether the injured person is legally represented)

(b) where a friend assists the injured person with the claim – communicate directly with that friend in addition to the injured person (or, instead of the injured person if appropriate in all the circumstances), regardless of whether the injured person is legally represented

(c) if requested in writing to do so by the injured person, friend or the injured person's legal representative, copy the injured person's legal representative into all written correspondence

(d) in this clause: ***friend*** means a person, including a family member, who is assisting the injured person with the claim and has authority from the injured person to give and receive information about the claim. It does not include a legal representative acting on instructions. The injured person can revoke that authority at any time by notifying LTCSA or can limit the friend's authority to a specified timeframe.

9.21 If a dispute arises between LTCSA and a legally represented injured person and is before the DRS, LTCSA is not to communicate with the injured person directly about the dispute and must communicate only with the injured person's legal representative.

Complaints

9.22 LTCSA must handle all complaints in a fair, transparent and timely manner.

9.23 LTCSA must have a documented internal complaint and review procedure and make the procedure and information on how to make a complaint readily available and accessible to all stakeholders. The procedures must refer to the rights of the customer to refer a complaint to the Authority if they are dissatisfied with LTCSA's response to their complaint.

9.24 LTCSA must acknowledge all complaints in writing within 5 business days of their receipt. The acknowledgement must include:

(a) if LTCSA can resolve the complaint to the satisfaction of the complainant within 5 business days from the receipt of the complaint – the LTCSA's written decision resolving the complaint

(b) if LTCSA cannot resolve a complaint to the satisfaction of the complainant within 5 days from the receipt of the complaint – a copy of the LTCSA's complaints procedure and the contact details of the representative(s) of LTCSA handling the complaint.

9.25 LTCSA must resolve all complaints within 20 days from the date of receipt and notify the complainant in writing of:

(a) the LTCSA's decision and the reasons for that decision

(b) the opportunity to have the complaint considered by a more senior representative of LTCSA who was not involved in making the original decision

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(c) information on the availability of external complaint or dispute resolution handling bodies (including the Authority) if the complainant is dissatisfied with the LTCSA's decision or procedures.

9.26 LTCSA must keep a record of all complaints it receives in a complaints register and provide a summary report to the Authority every six months. This report is due within 30 days of the end of the 30 June and 31 December reporting periods. It should be formatted as set out by the Authority and include a complaints trend analysis of the risks and potential issues.

9.27 If LTCSA receives a complaint regarding the conduct of a licensed insurer, then LTCSA must:

(a) forward the complaint to the licensed insurer within 5 business days

(b) confirm with the complainant that the complaint has been forwarded.

9.28 Where the complaint concerns the conduct of both LTCSA and a licensed insurer, then the party who received the complaint must:

(a) respond to the complaint in respect of its own conduct

(b) consult with the other party as required to investigate the complaint

(c) forward the complaint to the other party for its separate response within 5 business days

(d) advise the complainant of any action taken.

Information and data provision to the Authority

9.29 LTCSA must comply with the Authority's reasonable request to provide information or documents relevant to the payment of statutory benefits for treatment and care on a CTP claim.

9.30 If the Authority is satisfied that a document provided by LTCSA contains an error, the Authority may require LTCSA to amend the document.

9.31 LTCSA must:

(a) code the injured person's injuries by using appropriately trained coders applying the Abbreviated Injury Scale (AIS) 2005 Revision (or as otherwise prescribed by the Authority) and claims in accordance with the Authority's Motor Accident Insurance Regulation Injury Coding Guidelines and agreed timeframes and provide up-to-date and accurate claims data to the Motor Accidents Claims Register, in accordance with the Act and the claims register coding manual, as amended from time to time, or as otherwise required by the Authority

(b) maintain consistent information on the claim file and data submitted to the claims register, and record any changes in accordance with the claims register coding manual, as amended from time to time.

9.32 LTCSA must comply with any reasonable Authority requirements for data exchange and centralised claim notification.

9.33 LTCSA must update relevant Universal Claims Database (UCD) fields in a timely manner for all claims it manages as the relevant insurer.

Recovery plans

9.34 All injured persons must have a tailored recovery plan with the following exceptions:

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(a) where the injured person is performing their pre-accident work duties

(b) where the injured person is performing their usual pre-accident activities

(c) where the claim is denied

(d) where an injured person has returned to their pre-accident work duties and other activities within 28 days of the claim being made.

9.35 Where the transition to LTCSA as the relevant insurer for the payment of statutory benefits for treatment and care happens more than 5 years after the motor accident, LTCSA must:

(a) issue the recovery plan within 3 months after the date LTCSA becomes the relevant insurer

(b) review the recovery plan where significant changes occur.

9.36 When reviewing the injured person's recovery plan, LTCSA must consider:

(a) the nature of the injury and the likely process of recovery

(b) treatment and rehabilitation needs, including the likelihood that treatment or rehabilitation will improve earning capacity and any temporary incapacity that may result from treatment

(c) any employment engaged in by the injured person after the accident

(d) any certificate of fitness provided by the injured person

(e) the injured person's training, skills and experience

(f) the age of the injured person

(g) accessibility of services within the injured person's residential area.

9.37 If, following a review, LTCSA revises the injured person's recovery plan, LTCSA must send the revised recovery plan to both the injured person and their nominated treating doctor with the following details:

(a) name of injured person

(b) claim number

(c) date of injury

(d) current treatment being undertaken

(e) future treatment expected to be undertaken

(f) current fitness for work and/or usual activities

(g) expected fitness for work and/or usual activities with milestones

(h) obligations of the injured person

(i) consequences for the injured person if they do not adhere to the recovery plan

(j) contact details of all current insurers

(k) what action the injured person can take if they disagree with the recovery plan.

Treatment and care

9.38 If LTCSA has identified an injured person requiring treatment and care, it must facilitate referral to an appropriate treatment provider (including vocational

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provider, if appropriate) within 10 days of the identification, with the injured person's agreement.

9.39 LTCSA must refer the injured person to an appropriate service provider reasonably accessible to the injured person.

9.40 If the injured person expresses a preference for a particular provider, then LTCSA must refer the injured person to that provider subject to LTCSA being satisfied as to the suitability of that provider.

9.41 If the LTCSA determines that the injured person's preferred service provider is not suitable, it must notify the injured person of the reasons for its decision and refer the injured person to another service provider reasonably accessible to the injured person.

9.42 Where LTCSA is required to determine the injured person's request for treatment and care, it will:

(a) advise the injured person and service provider in writing of its decision as soon as possible but within 10 days of receipt of a request, and if approved

(b) state the costs LTCSA has agreed to meet

(c) pay the account as soon as possible but within 30 days of receipt of an invoice or expense.

9.43 LTCSA will advise the injured person of LTCSA's obligation to pay all reasonable and necessary treatment and care costs and expenses – including travel expenses to attend approved treatment, rehabilitation services or assessments, including all services or assessments conducted by DRS medical assessors – as soon as possible (no later than 20 days after receiving an account or request for reimbursement).

9.44 If LTCSA is determining an injured person's request for treatment and care that will potentially alter the injured person's minor injury decision, LTCSA must contact the licensed insurer related to the claim before the decision is made and within 5 business days of receiving the request.

Claims made more than 5 years from the date of accident

9.45 For claims made more than 5 years after a motor accident, LTCSA and the licensed insurer are responsible for making decisions about the claim as follows:

(a) LTCSA — in the case of the payment of statutory benefits for treatment and care

(b) licensed insurer — for all other claim-related decisions.

9.46 The licensed insurer must make all decisions relating to the claim, except concerning the payment of statutory benefits for treatment and care. These include:

(a) whether a late claim may be made

(b) whether the injury to a person resulted from a motor accident in NSW

(c) whether the motor accident was caused wholly or mostly by the fault of the person

(d) whether the person's only injuries resulting from the motor accident were minor injuries

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(e) assessing the degree of contributory negligence.

9.47 Where the licensed insurer accepts liability for the payment of statutory benefits, LTCSA must make all decisions relating to the payment of statutory benefits for treatment and care. These include:

(a) whether expenses were incurred in connection with providing treatment and care

(b) whether the cost of specific treatment and care was reasonable and necessary in the circumstances

(c) whether the requested treatment and care relates to the injury resulting from the motor accident concerned.

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Glossary

AF	At fault
CDR	Clinical dementia rating
AustLII	Australasian Legal Information Institute
CRPS	Complex regional pain syndrome
ABS	Australian Bureau of Statistics
CT scans	Computerized axial tomography scan
AMA	Australian Medical Association
CTP	Compulsory third party
AMA4	Guides to the Evaluation of Permanent Impairment, Fourth Edition (third printing, 1995) published by the American Medical Association
DSM	Diagnostic & Statistical Manual of Mental Disorders
DRE	Diagnosis-related estimates
DSM-5	Diagnostic & Statistical Manual of Mental Disorders, Fifth Edition, 2013, published by the American Psychiatric Association.
DCO	Diffusing capacity of carbon monoxide
MAF	Motor Accidents Operational Fund
DRO	Dispute Resolution Officer
MAITC	Motor Accident Injuries Treatment & Care Fund
DRS	Dispute Resolution Service
MRI scans	Magnetic Resonance Imaging Scan
DX box	Secure document exchange box
NAATI	National Accreditation Authority for Translators & Interpreters
ENT	Ear, nose and throat
NAF	Not at fault

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EEG	Electroencephalogram
APRA	Australian Prudential Regulation Authority
EDM	Electronic dispute management
PC	Personal care
EFT	Electronic funds transfer
PCA	Principal claims assessor
PIRS	Psychiatric impairment rating scale
eGreenSlip	Electronic notification of a third-party policy by an insurer to Roads & Maritime Services
ROM	Range of motion
REM	Risk equalisation mechanism
RMS	Roads & Maritime Services
FEV1	Forced expiratory volume
TAFE	Technical and Further Education
FVC	Forced vital capacity
TEMSKI	Table for the evaluation of minor skin impairment
Fund levy	The combined total of the Motor Accidents Operational Fund levy, Lifetime Care & Support Authority Fund levy and Motor Accident Injuries Treatment & Care Benefits Fund levy
SCI	Spinal cord injuries
SI	Superimposed inflation
SLR	Straight leg raising
ICD	International Statistical Classification of Diseases & Related Health Problems
UEL	Upper extremity impairment
VIN	Vehicle identification number
ITC	Input tax credit

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VO2 max	Measurement of exercise capacity
LTCS	Lifetime Care & Support Scheme
WPI	Whole person impairment
MAI	Motor accident injuries
WHO	World Health Organisation
MRC	Medical Research Council
WOVR	Written-off vehicles register

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Disclaimer

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However, to ensure you comply with your legal obligations you must refer to the appropriate legislation as currently in force. Up to date legislation can be found at the NSW Legislation website legislation.nsw.gov.au

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