McCabes

PIC Dispute Ready Reckoner

Dispute Resolution – Internal Review

Internal review

Section 7.9(1) provides that a claimant may request an insurer to review decisions about:

- A merit review matter,
- A medical assessment matter (except WPI disputes),
- A miscellaneous claims assessment matter.

What constitutes a merit review matter, a medical assessment matter or a miscellaneous claims assessment matter is set out in Schedule 2 to MAIA.

Pursuant to s 7.9(2), the claimant must provide the insurer with such information as the insurer may reasonably require and request for the purposes of an internal review. Section 7.9(6) confirms that the information may be considered in an internal review which was not before the original decision maker.

An internal review, pursuant to s 7.9(7) does not operate to stay the decision under review.

The MAGs impose the following time limits for internal review:

Clause	Action	Time Limit
Clause 7.4	Claimant requests internal review	Within 28 days after receiving insurer's decision
Clause 7.5	Insurer may exercise discretion to accept late requests for internal review if doing so will promote the objects of MAIA	N/A
Clause 7.9	Insurer acknowledges application for internal review	Within two working days of receiving application
Clauses 7.12 and 7.13	Insurer advises the claimant whether or not it has power to conduct internal review	Within seven days of receiving application
Clause 7.24	Insurer advises the claimant of the outcome of the internal review	Within 14 days of receiving application

According to clause 7.6 of the MAGs, a claimant may request an internal review by:

- application form,
- online process,
- letter, or
- telephone

Clause 7.15 of the MAGs provides that the person conducting the internal review:

- must have the required skill, experience, knowledge, training, capacity and capability,
- must not be somebody involved in the initial decision,
- may be somebody who has previously conducted an internal review in the same claim.

Pursuant to clause 7.23 of the MAGS, the insurer may:

- affirm the original decision,
- vary the original decision, or
- set aside the original decision and make a decision in substitution for the original decision.

Clause 23 of the MAIR provides that no costs are payable to a claimant or an insurer in connection with an application for internal review by the insurer.

Dispute Resolution – Merit Review

Merit review - Overview

Statutory framework

Section 7.12(1) provides that a claimant who is aggrieved by a *"reviewable decision"* made by an insurer may apply to the Personal Injury Commission (**PIC**) for a merit review.

Subject to reviewable decisions excluded by clause 10 of MAIR, s 7.11 mandates that a merit review may not take place until the insurer has conducted an internal review.

A merit review may take place, however, without an internal review, where the insurer has failed to complete the internal review when required to do so or where the insurer has declined to conduct a review – s 7.11(2).

Merit review matters

Statutory framework

The following table sets out:

- The disputes which, according to Sch 2 of MAIA, are *"merit review matters";*
- The disputes which, according to clause 10 of MAIR, require internal review by the insurer before they proceed to merit review by PIC; and
- The costs which the parties are entitled to recover, pursuant to Sch 1 of MAIR, for acting for a party in a merit review.

Sch 2 Cl 1	Provision	Reviewable Decision	Internal review required	Costs for merit review
(a)	S 3.4	The amount of statutory funeral benefits payable by the insurer.	Yes	$Nil
(a)	Div 3.3	The amount of statutory weekly benefits payable.	Yes	$Nil
(b)	S 3.12	Whether statutory weekly benefits can be ceased or whether there is a claim for damages pending.	Yes	$Nil
(c)	S 3.13	Whether statutory weekly benefits can be terminated because the injured person has reached retirement age.	Yes	$Nil
(d)	S 3.14	Whether the insurer may suspend payments because the claimant has failed to provide authorisations and medical evidence.	Yes	$Nil
(d)	S 3.15	Whether the insurer may suspend payments because the claimant has failed to provide evidence regarding fitness to work.	Yes	$Nil
(d)	S 3.17	Whether the insurer may suspend payments because the claimant has failed to undergo treatment, rehabilitation and vocational training.	Yes	$Nil
(e)	S 3.19	Whether the insurer has given the required notice period under before discontinuing or reducing weekly payments.	Yes	$Nil

Sch 2 Cl 1	Provision	Reviewable Decision	Internal review required	Costs for merit review
(f)	S 3.19(3)	Whether an amount of statutory benefits is recoverable by the injured person and the amount of statutory benefits.	Yes	$Nil
(g)	S 3.21	Whether an injured person is or has been residing outside Australia.	Yes	$Nil
(h)	S 3.22	Whether the insurer is required to index an amount of a weekly payment of statutory benefits.	Yes	$Nil
(i)	S 3.24(1)(a)	Whether the cost of treatment and care provided to the claimant is reasonable.	Yes	$Nil
(j)	S 3.26	Whether statutory benefits for loss of capacity to provide gratuitous domestic services are payable and the amount of those benefits.	Yes	$Nil
(k)	S 3.27	Whether expenses have been properly verified.	Yes	$Nil
(l)	S 3.28	Whether treatment and care expenses have been incurred after the expiration of the period during which statutory benefits are payable.	Yes	$Nil
(m)	S 3.28	Whether treatment or care is authorised by the *Motor Accident Guidelines* beyond 26 weeks (except in circumstances referred to in clause 2(c)).	Yes	$Nil
(n)	S 3.29	Whether treatment and care expenses have been overpaid and may be recovered.	Yes	$Nil
(p)	S 3.31	Whether the cost of treatment and care exceeds any limit imposed by the Motor Accident Guidelines.	Yes	$Nil
(q)	S 3.32	Whether treatment and care provided to the injured person is treatment and care needs or excluded treatment and care.	Yes	$Nil
(r)	S 3.33	Whether treatment and care provided to an injured person has been provided while the person is residing outside Australia.	Yes	$Nil
(s)	S 3.34	Whether the insurer is entitled to refuse payment of statutory benefits where the injured person has died.	Yes	$1,992
(s)	S 3.35	Whether the insurer is entitled to refuse payment of statutory benefits where the injured person is receiving workers compensation payments.	Yes	$1,992
(s)	S 3.36	Whether the insurer is entitled to refuse payment of statutory benefits where the injured person was the at-fault driver or an uninsured vehicle.	Yes	$1,992
(t)	S 3.39	Whether the insurer is entitled to refuse payment of statutory benefits in accordance with Part 3 of the *Civil Liability Act 2002.*	Yes	$1,992
(t)	S 3.40	Whether the insurer is entitled to refuse payment of statutory benefits because damages have been recovered.	Yes	$1,992
(w)	S 6.22	Whether the insurer is entitled to delay making an offer of settlement.	Yes	$1,992

Sch 2 Cl 1	Provision	Reviewable Decision	Internal review required	Costs for merit review
(x)	S 6.24	Whether a request made of the claimant is reasonable or whether the claimant has a reasonable excuse for failing to comply.	No	$1,992
(y)	S 6.25	Whether the claimant has provided the insurer with all relevant particulars about a claim.	No	$1,992
(z)	S 6.26	Whether the insurer is entitled to give a direction to the claimant to provide relevant particulars.	No	$1,992
(za)	S 6.5	Whether the insurer is entitled to suspend weekly payment because the Claimant failed to minimise loss.	Yes	$Nil
(aa)	St 8.10	Whether the costs and expenses incurred by the claimant are reasonable and necessary.	No	$Nil

Determination of merit review

Statutory framework

In determining a merit review, according to s 7.13(1), the merit reviewer appointed by the PIC is to decide what the *"correct and preferable decision"* should be according to the material then before the reviewer.

Essentially, the merit reviewer is given the power to step into the shoes of the insurer and make their own decision on the merits of the dispute – s 7.13(2).

Pursuant to s 7.13(3), the merit reviewer may:

- affirm the reviewable decision, or
- vary the reviewable decision, or
- set aside the reviewable decision and make a decision in substitution for the reviewable decision, or
- set aside the reviewable decision and remit the matter for reconsideration by the insurer in accordance with any direction made by the merit reviewer.

The merit reviewer is obligated by s 7.13(4) to issue a certificate with a brief statement or reasons. By virtue of s 7.13(5), the merit reviewer is required to determine the application within 28 days, but the decision is not invalid if made outside the 28-day period.

Merit reviewer powers in medical disputes

Statutory framework

Should a medical dispute arise in a merit review, a merit reviewer has the following powers:

- to refer a medical dispute to the PIC for assessment – s 7.20(1),
- to refer a medical dispute for a further medical assessment – s 7.24, and
- to request a non-binding opinion from a medical assessor, on a medical assessment matter - s 7.27.

Effect of merit review decision

Statutory framework

Pursuant to s 7.14(1), a merit reviewer's decision takes effect on the day it is given or such later date as decided by the merit reviewer.

However, given s 7.14(2), where a merit reviewer's decision varies, or substitutes, an insurer's decision, the decision of the merit reviewer is taken:

- to be a decision of the insurer, and
- to take affect from the date of the insurer's actual initial decision (unless the merit reviewer directs otherwise).

Review of merit review decisions

Statutory framework

Section 7.15(1) allows both the claimant and the insurer to apply to have a merit reviewer's decision reviewed by a merit review panel.

Pursuant to s 7.15(2), however, a reviewable decision may only be referred to the merit review panel on the grounds that *"the decision was incorrect in a material respect".* As such, the merit review panel's role is to assess whether the merit reviewer could have made the decision they did, rather than whether they should have made that decision on the merits.

Section 7.15(4) provides that the review panel may confirm the decision of the single merit reviewer or set aside the decision and substitute their own decision.

Schedule 1, cl 2(3) of MAIR provides that:

- where the proper officer approves the application to refer the reviewable decision to the merit review panel, the maximum costs are $1,992;
- where the proper offer refused the application, the maximum costs for the respondent are $996, but the unsuccessful applicant may not charge for their legal services.

Dispute Resolution – Miscellaneous Disputes

Assessment of miscellaneous disputes

Statutory framework

Section 7.42(1) provides that the parties may refer a miscellaneous dispute to the PIC for assessment at any time.

Pursuant to s 7.41, a miscellaneous dispute cannot be referred to the PIC for assessment unless the insurer has conducted an internal review.

Clause 11 of MAIR provides, however, that there is one exception; the insurer is not required to conduct an internal review prior to a miscellaneous assessment by the PIC regarding which insurer is the insurer of the at-fault vehicle.

The following table sets out:

- the disputes which, according to Sch 2 of MAIA, are *"miscellaneous assessment matters";*
- The status of miscellaneous assessments according to s 7.42(3); and
- The costs which the parties are entitled to recover, pursuant to Sch 1 of MAIR, for acting for a party in a miscellaneous assessment.

Sch 2 Cl 3	Provision	Miscellaneous Dispute	Status of assessment	Costs for misc assessment
(a)	S 2.30	Whether there has been due inquiry and search to establish the identity of an unidentified motor vehicle.	Not binding in damages claim	$1,992
(aa)	S 2.31	Whether the Nominal Defendant has lost the right to reject a claim for failure to conduct due inquiry and search.	Not binding in damages claim	$1,992
(b)	S 3.1	Whether the death or injury to a person has resulted from a motor accident in NSW.	Binding	$1,992
(c)	S 3.3	Which insurer is the insurer of the at-fault motor vehicle.	Binding	$Nil
(d)	S 3.11	Whether the motor accident was caused by the fault of another person.	Binding	$1,992
(e)	Ss 3.28 and 3.36	Whether the motor accident was caused mostly by the fault of the injured person.	Binding	$1,992
(f)	S 3.37	Whether the insurer is entitled to refuse payment of statutory benefits because the injured person committed a serious driving offence.	Binding	$1,992
(g)	S 3.38	Whether the insurer is entitled to reduce statutory benefits for the injured person's contributory negligence.	Binding	$1,992
(h)	Part 6	Whether the claimant has given a full and satisfactory explanation for non-compliance with a duty or for delay.	Binding in claim for statutory benefits	$1,992

Sch 2 Cl 3	Provision	Miscellaneous Dispute	Status of assessment	Costs for misc assessment
(i)	Ss 6.9 and 6.10	Whether the motor accident verification requirements have been satisfied.	Binding in claim for statutory benefits	$1,992
(j)	S 6.12	Whether notice of the claim for statutory benefits has been properly given.	Binding	$1,992
(k)	S 6.13	Whether the insurer is entitled to refuse payment of weekly payments for breach of the statutory benefits time limits.	Binding	$1,992
(l)	S 6.14	Whether a late claim for damages may be made.	Not binding	$1,992
(m)	S 6.15	Whether a claim may be rejected for failure to give proper notice.	Binding in claim for statutory benefits	$1,992

Dispute Resolution – Medical Assessment

Internal review before medical assessment

Pursuant to s 7.19 a medical dispute about a decision made by an insurer cannot be referred by a claimant for assessment until the insurer has conducted an internal review.

Section 7.19(2A), however, provides that internal review is not necessary in WPI disputes.

Unlike merit review matters, MAIR does not provide for an exception to the internal review pre-condition.

A medical dispute may, however, be referred for assessment, under s 7.19(2) where the insurer fails to complete the interview review when required to do so or declines the conduct the review.

Referral for medical assessment

Section 7.20(1) provides that a medical dispute may be referred to the PIC by the claimant, the insurer, a merit reviewer, a claims assessor or the court.

Section 7.20(3) is a new provision which has no equivalent in the 1999 Act. It provides that the PIC can refuse to accept a medical dispute about the degree of permanent impairment if the applicant has not provided sufficient evidence to support their position.

That is, a claimant is at risk of having an application rejected in the absence of evidence that the claimant's impairment exceeds 10%. Similarly, an insurer's application may be rejected if the insurer fails to provide evidence that the claimant's impairment is below the threshold.

Medical dispute matters

Statutory framework

The following table sets out:

- the disputes which, according to Sch 2 of MAIA, are *"medical dispute matters";*
- the status of medical assessments according to s 7.23; and
- the costs which the parties are entitled to recover, pursuant to Sch 1 of MAIR, for acting for a party in a medical dispute.

Sch 2 Item 2	Provision	Medical Dispute	Status of assessment	Costs for medical assessment
(a)	S 7.21	The degree of permanent impairment of an injured person that has resulted from any injury caused by a motor accident (including whether the degree of permanent impairment is greater than a particular percentage).	Conclusive evidence	$1,992
(b)	S 3.24	Whether any treatment and care provided to an injured person is reasonable and necessary in the circumstances or relates to an injury caused by a motor accident.	Conclusive evidence	$1,992

Sch 2 Item 2	Provision	Medical Dispute	Status of assessment	Costs for medical assessment
(c)	S 3.28	Whether treatment or care provided to an injured person will improve the recovery of the injured person.	Conclusive evidence	$1,992
(d)	S 4.8	The degree of impairment of the earning capacity of the injured person that has resulted from an injury caused by a motor accident.	Prima facie evidence only	$1,992
(e)	Ss 3.11 and 3.28	Whether an injury is a minor injury.	Conclusive evidence	$1,992

Interim medical assessment

Where a medical assessor declines to assess permanent impairment pending the impairment becoming permanent, s 7.22(1) mandates that the medical assessor must make an interim assessment where the assessment is for the purpose of determining the injured person's entitlement to statutory weekly benefits under Div 3.3 or their entitlement to statutory benefits for treatment and care under Div 3.4.

Section 7.22(2) provides that the purpose of the interim assessment is to assess the injured person's minimum degree of permanent impairment.

Importantly:

- the degree of permanent impairment is deemed to be greater than the minimum degree but only for the purpose of assessment the injured person's entitlement to statutory benefits – s 7.22(3)
- an interim assessment only operates pending the final assessment – s 7.22(4);
- an interim assessment is not relevant to a claim for damages – s 7.22(5); and
- the insurer cannot recover an overpayment if the final assessment falls below the interim assessment – s 7.22(6).

Further medical assessment

Statutory framework

Section 7.24 subtly modifies the further assessment regime which applied under the 1999 Act. In summary:

Section	Provision
S 7.24(1)	A court, a merit reviewer or a claims assessor may refer a medical dispute to the PIC for a further assessment at any time and, by inference, for any reason.
S 7.42(2) and clause 13 of MAIR	A claimant or an insurer may only refer a medical dispute to the PIC for further assessment on the grounds of deterioration of injury or additional relevant information about the injury which is capable of having a material effect on the outcome of the previous assessment.
S 7.24(3)	A claimant or an insurer may not refer a claim for further assessment more than once (presumably each).

Costs

Schedule 1, cl 2(2) of MAIR provides that:

- where the proper officer approves the application to refer the reviewable decision to the merit review panel, the maximum costs are $1,992;

- where the proper offer refused the application, the maximum costs for the respondent are $996, but the unsuccessful applicant may not charge for their legal services.

Review medical assessment

Statutory framework

Section 7.26(1) allows the claimant or an insurer to apply to have a medical assessment reviewed by a review panel.

The sole ground for review, under s 7.26(2) is that the medical assessment was incorrect in a material respect.

Importantly, s 7.26(3) provides that a medical assessment may not be referred for review on more than one occasion. In contrast to further assessments, it appears that only one review application, in total, is permitted as distinct from one application per party.

Section 7.26(6) provides that the review panel is to conduct the medical assessment refresh and is not limited to reviewing only one aspect of the assessment.

Carefully note, however, s 7.25 which allows the parties to agree to limit the scope of a review assessment.

Costs

Schedule 1, cl 2(3) of MAIR provides that:

- where the proper officer approves the application to refer the reviewable decision to the merit review panel, the maximum costs are $1,992;
- where the proper offer refused the application, the maximum costs for the respondent are $996, but the unsuccessful applicant may not charge for their legal services.

Agreement to limit scope of further or review assessment

Section 7.15 is a new provision, with no equivalent in the 1999 Act, which allows the parties to limit the scope of a further or review assessment by agreeing upon:

- the degree of an injured person's permanent impairment resulting from a particular injury, and
- whether a particular injury was caused by a motor accident.

Non-binding opinion

Section 7.27 is another new provision which allows a merit reviewer or a claims assessor to call upon the assistance of a medical assessor by requesting a non-binding opinion on a medical assessment matter.

It is not clear when a claims assessor or a claims assessor would prefer a non-binding opinion on a medical assessment matter under s 7.27 rather than an assessment under s 7.20 which is conclusive by virtue of s 7.23 (other than earning capacity assessments).

Further Information

For further details about the content in this publication please contact:

Peter Hunt Principal
peter.hunt@mccabes.com.au
+61 2 8231 6284
+61 414 425 879