Australian Capital Territory

Motor Accident Injuries (Internal Review) Guidelines 2022

Disallowable instrument DI2022–219

made under the

Motor Accident Injuries Act 2019, section 487 (MAI guidelines)

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1 Name of instrument

This instrument is the *Motor Accident Injuries (Internal Review) Guidelines 2022.*

2 Commencement

This instrument commences on the 7th day after its notification.

3 Guidelines

I make the guidelines attached to this instrument.

4 Revocations

The *Motor Accident Injuries (Internal Review) Guidelines 2019* (DI2019-244) is revoked.

Lisa Holmes
MAI Commissioner
MAI Commission

9 September 2022

Internal Review Guidelines

Contents

1. INTRODUCTION

The internal review guidelines (guidelines) are part of the MAI guidelines made under section 487 of the Motor Accident Injuries Act 2019 (MAI Act). The purpose of the guidelines is to make provision for matters in relation to applications and provide advice about applications and the conduct of internal reviews for decisions about defined benefit entitlements.

An insurer's duty to act in good faith (see section 20 of the MAI Act) includes a duty to give an applicant written reasons for all decisions that have a material effect on an entitlement to defined benefits and to tell an applicant about the right of review of a decision of an insurer. An insurer should have their own procedures to identify and provide reasons for all internally reviewable decisions, and to inform applicants about the process for seeking an internal review of an internally reviewable decision. This includes giving the applicant information so they can be assisted to understand the basis for making the decision, including relevant details from any medical/technical reports or clinical guidelines relied upon in making the decision.

By way of an example, an applicant could be informed that a stated treatment expense will not be paid because the treatment and care is not reasonable and necessary. In providing reasons as to why the treatment and care is not reasonable and necessary an insurer should set out any relevant factors from section 120 of the MAI Act and the Treatment and Care Guidelines which were considered in making the decision and detail any evidence the insurer relied upon to support the decision.

An insurer should discuss any unfavourable decisions regarding defined benefits with an applicant and provide the applicant with any further information they may need to understand the decision. Examples of an unfavourable decision include denial of liability for the motor accident; denial of a particular treatment because it is not reasonable and necessary; or stopping income replacement payments. If the discussion identifies an error has been made, the insurer must correct the decision and not put an applicant to the effort of an application for internal review to obtain the same or similar outcome on internal review.

The guidelines, which are set out in sections 3 to 5, are not intended to be exhaustive. An internal review process is to operate together with other procedures an insurer has in place to manage complaints as part of the insurer's MAI licence. The adoption of simple and accessible arrangements by an insurer for the making of complaints, together with timely responses or resolution, may avoid a person needing to apply for an internal review of a decision.

2. STATUTORY FRAMEWORK

Division 2.10.2 of the MAI Act enables a person to apply for the internal review of a decision the insurer has made about an application for defined benefits. A table detailing the decisions that are internally reviewable is set out in Part 1.1, Schedule 1 of the MAI Act. A regulation may also prescribe decisions that are internally reviewable. The table covers a range of decisions an insurer must make in relation to an application for defined benefits

including about accepting liability for an application, assessing entitlements to defined benefits such as treatment and care expenses and calculating the amount of any defined benefit.

Subsection 187(2) of the MAI Act sets out the timeframe to make an internal review application. An application must be made within 28 days after:

- the date of the internally reviewable decision; or
- if the insurer has not made the internally reviewable decision within the time allowed under this Act – the end of the time for making the decision.

MAI guidelines may make provision for the period to make a late application for an internal review, applications for and the conduct of the internal review, and circumstances for extending the period to make a review decision.

The legislative framework for the internal review of decisions about defined benefit includes:

- the MAI Act;
- the Motor Accident Injuries Regulation 2019 (the Regulation); and
- these Guidelines.

3. LATE APPLICATIONS (Section 187)

3.1 Subsection 187(3) of the MAI Act allows a late application for the internal review of a decision to be made after 28 days from the date of an internally reviewable decision, if the applicant satisfies an insurer that they have a full and satisfactory explanation for the delay and the guidelines provide for the late application to be made within a longer period. The late application must then be made within the longer period.

3.2 These guidelines specify the longer period as 14 days, after an insurer makes a decision that, given the full and satisfactory explanation and the circumstances of the delay, a longer period should apply.

3.3 The longer period should only apply if the full and satisfactory explanation for the delay is consistent with the main objects of the MAI Act, such as the object to promote and encourage the quick, cost effective and just resolution of disputes.

3.4 For example, it would be appropriate to apply a longer period to an application that relates to an issue or complaint that the applicant has previously taken steps to resolve with the relevant insurer. This could include matters the applicant has raised informally with their usual contact at the insurer (such as through an email or telephone call with an applications manager) or through any other arrangements the insurer has in place to manage complaints. This will encourage applicants to first raise any issues or complaints about decisions directly with an insurer and avoid many relatively simple matters, such as errors in calculations, being progressed through internal review.

3.5 To streamline the process for making a late application, the applicant should provide both the full and satisfactory explanation for their delay together with an application for the decision to be reviewed. This is intended to ensure there is no delay between the insurer making a decision on whether the longer period applies and the decision to accept the internal review application.

4. CONDUCT OF INTERNAL REVIEW (Section 188)

These guidelines make provision for applications for internal review and the conduct of an internal review by an insurer.

4.1 Applying for an internal review

4.1.1 An application for an internal review should be made in writing to an insurer. The application may be given to an insurer through the post or by electronic means and may also be lodged using an online application process (if provided by the insurer). A complete application must include:

- name and contact details of the applicant;
- the decision of an insurer being requested for an internal review (noting this may include several decisions of a related type) and the alternative decision sought by the applicant;
- the date of the decision (or if not known, the approximate date);
- brief details of issues for review - elements of the original decision the applicant wishes to be reviewed;
- reason(s) the applicant believes the decision made should be changed; and
- any additional information the applicant considers is reasonably required for the review of the decision, and if this information is being obtained from a third party, a final date, for the provision of this information to the insurer.

4.1.2 If an application is not made in writing, an insurer must ensure they document their conversation with an applicant, and the applicant is given the opportunity to provide all information required to confirm acceptance of a complete application. Similarly, if a written application does not include all of the required information for a complete application, an insurer must immediately contact the applicant so the applicant can provide any further details required to confirm acceptance of a complete application. This is to include details of whether the applicant considers additional information is required for the review, and a final date for any third-party information to be provided. The insurer must retain written records of all contact with the applicant about completing the application. If the application is a late application, a full and satisfactory explanation for a delay is to be given to the insurer together with the application.

4.1.3 An application for an internal review may be withdrawn by an applicant at any time prior to an internal review decision being made. An insurer is to confirm the withdrawal of an application in writing.

4.2 Actions an insurer must take on receiving an application

4.2.1 An insurer that receives an application for internal review must give the applicant a confirmation notice for the application within 3 business days of a complete application being received or recorded by the insurer. The notice is to be given in writing and may be given by electronic means or by post. For the purposes of these guidelines a notice will be taken to be given on the day it is posted by the insurer, and not on the day it would have been delivered to the applicant.

4.2.2 The notice is to include the following information if applicable:

- the decision or elements of a decision covered by the application;
- the date the complete application for internal review was received or recorded by the insurer;
- confirmation that the applicant does not consider that additional information is required for the review of the decision; or alternatively details of any additional information which the applicant considers is required for the review, and a final date for any outstanding third-party information to be provided;
- whether or not the insurer has accepted the application for internal review;
- if the insurer has accepted the application, the date a review decision is expected and information about circumstances in which this date may be extended;
- if the application is declined, brief reasons for this decision and details of any options available to the applicant if they do not agree with the decision; and
- details of how to contact the insurer about the internal review.

4.2.3 An application for an internal review may be declined if:

- the application is not complete and the applicant is unable to be contacted by the insurer within 3 business days of receiving the incomplete application;
- the application is for a matter or an element of a matter that is not an internally reviewable decision;
- an application is made outside application time frames;
- an insurer is not satisfied with the full and satisfactory explanation for the delay in making an application; or
- the circumstances for a late application are not in accordance with these guidelines.

4.2.4 If an insurer accepts a complete application and subsequently determines a matter is not an internally reviewable decision, then the insurer should advise the applicant, in writing, as soon as practicable, that the application for internal review has been declined.

4.2.5 An insurer should also contact the applicant, as soon as practicable, after accepting a complete application if clarification is required about any element of the original decision that is to be subject to a review, or to request any additional information or documents reasonably required for the review.

4.3 Individual conducting the review

A review must be conducted by an individual appointed by the insurer who:

- has the required skills, experience, knowledge, training, and capacity to conduct the internal review in accordance with the main objects of the MAI Act, and the duties and obligations of an insurer under the MAI Act; and
- was not involved in making or advising on the decision subject to the review or was not the direct supervisor/manager of a person involved in making or advising on the decision subject to review.

4.4 Conducting an internal review

4.4.1 An internal review is to be conducted in a manner that best supports the main objects of the MAI Act having regard to the personal circumstances and any special needs of an applicant, and the facts and circumstances that gave rise to the application for the review. This may include a document review, informal discussions with an applicant, a teleconference, a video conference or a face to face meeting, as appropriate.

4.4.2 An insurer must document their own procedures for conducting internal reviews, including engaging with the applicant and preparing an index of documents/conversations considered during the review. These procedures must ensure that the insurer engages with the applicant so they understand and can provide input into the review process. The procedures should also ensure that an applicant is not placed at an unfair disadvantage. The applicant is to be assisted by the insurer to understand any legal issues relating to the decision (i.e. what is meant by 'reasonable and necessary'). The insurer should avoid relying on technicalities or requiring the applicant to call on their own resources to provide additional information for the internal review.

4.4.3 An internal review may consider additional information not provided before the decision being reviewed was made (see Section 190). This may include information which was not available or was overlooked at the time the original/internally reviewable decision was made. For example, additional evidence necessary to make findings on material questions of facts for the review. The request should be for information that is reasonably required for the review and may be obtained from the applicant or an external party.

4.4.4 Any request from an insurer for additional information must be made before the expiry of the initial period an insurer has to decide an internal review application in subsection 191(1) of the MAI Act. In the case of a medical or other assessment involving an examination of the injured person, the notice of the appointment is to be given to the applicant before the expiry of the initial period. The insurer and applicant must also agree to a final date for any report from a third-party provider to be received by the insurer.

4.4.5 An insurer is not liable for the costs of the applicant in making and pursuing an internal review application. This includes any legal services sought for the application. An insurer must not impose any fees or costs on an applicant for the conduct of an internal review.

4.4.6 The notice of the internal review decision should be organised and provide appropriate headings. The notice must document the insurer's findings on material questions of fact, including evidence or other material on which the findings are based and include particulars of the reasons for the insurer's decision. The notice is to include

- an index of all documents and information considered in the internal review;
- a chronology of all conversations and communications that occurred between the applicant and the insurer during the internal review process; and
- document the timeframe for which the decision was required to be made, including the dates of and details of any agreement to pause the internal review process in accordance with section 5 of the Guidelines.

Information must also be provided in the notice about how the applicant may apply for an external review of the decision (Part 1.2, Schedule 1 of the MAI Act).

5. INTERNAL REVIEW DECISION - EXTENDING TIME (Section 191)

5.1 These guidelines make provision for the particular circumstances for extending the timeframe for a decision on an internal review. Under section 191 of the MAI Act an insurer must within 10 business days of receiving an application for internal review, either affirm, amend or set aside the decision.

5.2 A further extension period of 10 business days applies, if required, to allow the insurer to consider any additional information not available at the time of the original decision being reviewed. If the insurer has been given the additional information after the original decision, but before or with a complete application, then the extension period will automatically apply. The parties may also agree to pause the process to enable additional information to be provided after the complete application is received. The process will resume, and the extension period will apply from the later of the following dates:

- when the additional information is received by the insurer, or
- a final date agreed between the insurer and applicant for any additional information being sought from a third-party, to be received by the insurer.

If the parties cannot agree to pause the process, or on a final date for information to be provided, then the application will need to be decided within the existing timeframes.