

# Submission to the inquiry into claims made through the Transport Accident Commission

June 2026





## Message from the CEO

The Transport Accident Commission (TAC) welcomes the opportunity to contribute to the Legislative Council's Legal and Social Issues Committee Inquiry into claims made through the TAC ('Inquiry').

The TAC views this Inquiry as an important opportunity to listen and reflect on the TAC's efforts to provide Victorians with the support and care they need after a transport accident. It comes at a significant point in the organisation's current strategic journey, offering a valuable moment to assess progress, understand what is working well, and identify where further improvements could strengthen outcomes for clients and the Victorian community.



**Tracey Slatter**  
**Chief Executive Officer**



## TERMS OF REFERENCE

This submission is structured to provide a clear overview of the TAC's role and responsibilities, followed by information addressing the Terms of Reference of the Inquiry as defined by the Legislative Council Legal and Social Issues Committee.

This being issues related to claims made through the Transport Accident Commission (TAC), including but not limited to:

- (1) processes around legitimate claims, including disputed claims
- (2) circumstances and systems related to fraudulent claims
- (3) private provider discretion to set fees exceeding the Medicare Benefits Schedule Rate
- (4) interactions with other services, such as the National Disability Insurance Scheme (NDIS), and how TAC clients have been impacted by federal reforms to:
  - (a) the National Disability Insurance Agency and the NDIS
  - (b) restrictions on health privacy and information sharing between state and federal agencies.

Each section of this submission addresses the Terms of Reference outlined above and is organised as follows:

- Introduction
- Legislative framework
- Current practice
- Continuous improvement.

All data is accurate as at April 2026. The TAC's data systems apply ongoing quality and integrity processes, which means figures reproduced at a later point in time may differ marginally.



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## EXECUTIVE SUMMARY

For nearly 40 years, the TAC has administered a no-fault compensation scheme in Victoria that provides access to treatment, rehabilitation and financial support for people injured in transport accidents. The TAC scheme is designed to balance timely, individualised support for clients with the responsible and sustainable use of public funds.

As the operating environment evolves, the TAC is managing increasing complexity across claims. This includes a rise in psychological injuries, more clients with pre-existing or co-morbid conditions, increasing healthcare costs, and growing community expectations regarding access, transparency and service quality. These factors contribute to more complex decision-making, particularly for liability determinations, treatment approvals, and work capacity assessments.

This submission addresses the Terms of Reference of the Inquiry and outlines both current practice and areas of ongoing improvement.

### 1. Processes around legitimate claims, including disputed claims

The TAC's claims processes are designed to provide prompt access to support for legitimate claims while ensuring all decisions are fair, transparent and consistent with the *Transport Accident Act 1986* ('the Act'). Most claims are accepted quickly while a smaller proportion involves more complex circumstances, such as unclear accident details, evolving injuries, or differing clinical opinions, which can extend decision timeframes.

Disputes most commonly relate to injury causation, treatment necessity, work capacity, income assessments, and interpretation of clinical evidence. While disputes represent a small proportion of overall decisions, their impact on individual clients can be significant. The TAC provides several review pathways to support fair and timely resolution, including internal reconsideration, dispute resolution and independent review.

Under the 'Make Every Day Matter' corporate strategy ('the TAC Strategy'), the TAC is strengthening early triage and continuity of case management, improving the clarity and timeliness of decisions, and enhancing communication with clients at key points in the claims process. These initiatives aim to reduce avoidable disputes, improve client experience and outcomes, and ensure decisions remain robust and consistent with legislative requirements.

### 2. Circumstances and systems related to fraudulent claims

The TAC maintains a high-integrity, low-friction compensation scheme, ensuring public funds are protected while legitimate clients access the care they need. Its prevention first, proportionate approach ensures controls operate in the background, clearly distinguishing routine verification from genuine fraud risk. Whilst the TAC has strong legislative powers to support this work, these are exercised with restraint and oversight to maintain fairness and public accountability.

Fraud represents a very small proportion of TAC claims, but strong controls are essential to protect scheme integrity and prevent growth in fraudulent activity. The TAC uses verification processes, monitoring, and data analytics to detect and respond to potential fraud, whilst minimising unnecessary burden on legitimate clients. Prosecution is only pursued where there is a reasonable prospect of conviction and it is in the public interest. This approach protects scheme sustainability and fairness, without creating unnecessary barriers to treatment or recovery.



### **3. Private provider discretion to set fees above the Medicare Benefits Schedule**

The TAC operates within a complex private healthcare market in which providers have discretion to set their own fees, including charging above the Medicare Benefits Schedule. Within this environment, the TAC seeks to balance provider autonomy, client access and choice, and responsible stewardship of public funds. To support consistency and transparency, the TAC publishes fee schedules that set benchmarks for reasonable costs.

In recent years, divergence between TAC fee schedules and private market rates has increased, driven by broader healthcare cost pressures and practitioner pricing practices. This has created challenges for both clients and the TAC, including the risk of out-of-pocket costs and variability in access to providers.

The TAC is actively working to ensure fee structures remain fair, transparent and sustainable, while supporting client access to appropriate care and maintaining alignment with broader market conditions.

### **4. Interactions with other services, including the NDIS, and restrictions on health privacy and information sharing between state and federal agencies**

A small number of TAC clients may interact with multiple service systems, including the National Disability Insurance Scheme (NDIS). Whilst these systems are intended to operate in parallel, differences in eligibility criteria, funding models and administrative processes can create complexity for shared clients.

Recent federal reforms, including changes to the NDIS and restrictions on information sharing, have not affected TAC clients' entitlements under the Act but have made existing challenges in coordinating support and ensuring continuity of care more pronounced.

The TAC continues to work with government partners to improve system alignment, clarify roles and responsibilities, and reduce administrative complexity for clients navigating multiple schemes.

#### **Continuous improvement and future focus**

The TAC is committed to ongoing improvement in how it delivers services to injured Victorians. Under the TAC Strategy, this includes strengthening claims management capability, improving early decision-making, enhancing clinical support, and making better use of data and technology to deliver more timely and consistent outcomes.

This work is grounded in the objectives of the Act, which require the TAC to deliver appropriate compensation as quickly as possible, support effective rehabilitation, and manage the scheme efficiently, effectively and economically.

The TAC welcomes this Inquiry as an opportunity to consider the Committee's findings and recommendations that may further strengthen the TAC – supporting better outcomes for people impacted by road trauma while maintaining fairness and long-term sustainability for the Victorian community.



# About the Transport Accident Commission

The TAC is a cornerstone of Victoria's response to road trauma, established under the [Transport Accident Act 1986 \(Vic\)](#) to administer a proven, high-performing scheme that has delivered consistent outcomes for Victorians for nearly four decades.

The TAC's core purpose is to care for the lives of everyone who travels on Victoria's roads. It does this by promoting road safety, helping Victorians injured in transport accidents, and supporting the families of those who have lost loved ones – while delivering this care in an efficient and financially responsible way.

The TAC's integrated approach, which brings together prevention, rehabilitation and compensation, is distinctive in Australia and underpins its effectiveness and long-term sustainability:

- Prevention – working with Victoria's Road Safety Partners to reduce the incidence and severity of transport accidents through sustained, evidence-based investment in behaviour change, infrastructure and system-wide safety initiatives.
- Rehabilitation – supporting people to rehabilitate and recover, return to work and regain independence after injury, through timely access to effective treatment and rehabilitation services.
- Compensation – providing fair, timely and appropriate financial support to reduce the economic impact of injury on individuals and families.



Since its inception in January 1987, the TAC has delivered critical support to **over 620,000 people** impacted by road trauma in Victoria.

Over this same period, Victoria has seen a substantial reduction in road trauma. In **1987, 776 people were killed** on Victorian roads; by **2025** this figure had **reduced to 290**.

In 2025, Victoria recorded 4.10 lives lost per 100,000 population, a rate lower than every other Australian state or territory aside from the ACT.

This represents significant progress; however, there is still more to do. Together with Victoria's Road Safety Partners, the TAC continues to pursue further reductions in road trauma through a system-wide focus on safer roads, safer vehicles, safer speeds and safer behaviours, as outlined in the Victorian Road Safety Strategy.

## 2024-25 at a glance

<b>Clients supported</b>	<b>Around 43,255 clients</b> , ranging from those with short-term injuries to clients with severe injuries requiring complex and lifelong rehabilitation supports. Includes 14,654 new clients in 2024-25
<b>Annual funding for treatment and services</b>	<b>\$1.87 billion to fund treatment, services, benefits, and compensation</b> for TAC clients
<b>Provider network</b>	Paid <b>41,692 providers for health, disability, vocational</b> and other support services
<b>Road safety initiatives</b>	<b>\$176 million in road safety prevention</b> , including infrastructure, enforcement, and the promotion of safe road behaviours
<b>Legislative basis</b>	<i>Transport Accident Act 1986 (Vic)</i>
<b>Funding mechanism</b>	Transport Accident Charge ('TAC Charge') collected through vehicle registration fees.



## LEGISLATIVE FRAMEWORK

The TAC is established under [s 10](#) of the Act and its functions per [s 12](#), include:

- to administer the Transport Accident Fund
- to receive and assess, and accept or reject, claims for compensation
- to determine transport accident charges
- to promote the prevention of transport accidents and safety in use of transport.

The Act sets out a comprehensive no-fault scheme, that is bound by the objects of the Act in [s 8](#), and general entitlement provisions commencing at [s 35](#). The no-fault nature of the compensation scheme ensures Victorians injured or killed in transport accidents receive support regardless of who caused the accident.

TAC support may be available in situations where:

- a person is injured or dies as a result of a transport accident in Victoria
- pedestrians and cyclists are injured or die in an accident caused by the driving of a motor vehicle, motorcycle, bus, train or tram
- cyclists collide with a stationary motor vehicle
- a person is injured or dies in an interstate accident involving a Victorian registered vehicle.

The Act also preserves the right of a client to seek common law damages where a transport accident results in death or serious injury and another person is at fault.

The objectives of the Commission, as outlined in [s 11](#) of the Act are:

- to manage the transport accident compensation scheme as effectively, efficiently and economically as possible
- to ensure appropriate compensation is delivered in the most socially and economically appropriate manner, and as quickly as possible
- to ensure that the transport accident scheme emphasises accident prevention and effective rehabilitation.

These objectives sit alongside the broader legislative framework that defines the organisation's functions, governance, accountability and financial management requirements.

This framework reflects the objectives of the Act in supporting the scheme to be managed with consistency, transparency and discipline, while balancing responsiveness to individual needs with safeguards that protect long-term sustainability and fairness for future generations.



# TAC clients

People involved in transport accidents vary widely in age, pre-existing health circumstances, cultural backgrounds and recovery needs. Many require only limited support to return to health and independence, while some experience more complex medical, psychosocial or cultural factors that call for more specialised and sustained support.

## Demographics

In 2024–25, **89%** (12,978) of people requiring TAC support **lived in Victoria** and **64% (9,300)** were employed at the time of their accident.

Their demographics at the time their TAC claims were accepted were as follows:

### Gender

- **Male – 53.7%** (7,871)
- **Female – 44.9%** (6,584)
- **Prefer not to say – 1.08%** (159)
- **Nonbinary or gender diverse – 0.27%** (40).

### Age

- **Under 18 years – 4.8%** (700)
- **18-21 years – 6.1%** (898)
- **22-50 years – 54.1%** (7,932)
- **51-69 years – 23.3%** (3,413)
- **70 years or over – 11.3%** (1,659)
- **Unknown – 0.4%** (52).

### Geographic residence

- **Metropolitan – 64.9%** (9,505)
- **Regional/Rural – 23%** (3,371)
- **Unknown – 12.1%** (1,778).

Behind these statistics is a person whose life may be changed by their transport accident. More than half of clients in 2024–25 required hospital treatment, one in five underwent surgery, and around half accessed allied health services as part of their recovery and rehabilitation. One in seven also accessed mental health support.



People impacted by road trauma represent every part of the community including younger drivers, older pedestrians, children, and families. Each turned to the TAC after an accident they never expected and never chose.

Although transport accidents affect people across all demographics, evidence shows that pre-existing health and psychosocial factors can influence both the likelihood of being involved in an accident and the complexity of a person's recovery. A 2022 study of 400 people involved in a serious-injury crash found that:

- 14.5% of drivers had a pre-existing physical medical condition
- 12.5% had a pre-existing mental health condition
- 7.8% had pre-existing substance use.

Older clients are more likely to have pre-existing chronic health conditions or disabilities that can interact with accident-related injuries, potentially slowing recovery and complicating assessments of injury-related liability.

Recovery from a transport accident can touch every part of a person's life: their ability to work, their relationships, their sense of self. Within its obligations under the Act, the TAC's role is to support a pathway to recovery and independence, and that pathway looks different for every person who enters the scheme.

This diversity shapes how the TAC must respond and adapt. For example, a 24-year-old with a severe spinal injury faces decades of life ahead and a recovery journey measured in years, not weeks. A regional client navigates their recovery with fewer local services and a greater travel burden. A client with pre-existing mental health conditions may find that a physical injury destabilises more than just their body.

Recovery and independence trajectories can also be impacted by changes in a person's age and health over time. Clients may develop new conditions or sustain unrelated injuries, each of which can interact with their accident-related injuries.

This reinforces the need for individual rehabilitation planning, timely access to quality services, and evidence-based decision making.



# Financial structure and sustainability

The TAC operates a fully funded, long-term scheme that is designed to meet the needs of injured Victorians now and into the future. The Act provides the framework that supports the scheme's financial sustainability, while also emphasising injury prevention, effective rehabilitation and efficient administration. This balance helps ensure that people injured in transport accidents can access the support they need, while keeping the scheme affordable and sustainable for the community over time.

Financial sustainability is not an end in itself; it is what protects equitable access to support over the long term. By safeguarding the scheme's viability, the TAC helps ensure that future clients can receive the same level of care and recovery support as those accessing services today.

Built on strong actuarial foundations and informed by lessons from the former Motor Accident Board, the TAC operates what other jurisdictions would recognise as a compulsory third party (CTP) scheme, but one of Australia's most comprehensive. Its no-fault model means entitlements to treatment, rehabilitation and income support apply regardless of who caused the accident, with access to impairment and common law damages for those with more serious injuries. This contrasts with the at-fault or hybrid models used in some other states and delivers greater equity and consistency for injured people.

The TAC is primarily funded through the TAC Charge, included in vehicle registration fees, and through returns from a diversified investment portfolio aligned to meeting the TAC's long-term claims cost obligations. The TAC has consistently maintained the TAC Charge at or below the Consumer Price Index (CPI), reflecting a strong commitment to affordability for the Victorian community. For 2025-26 the average annual premium is \$449 (inc. GST).

This level of pricing is broadly comparable to other jurisdictions with similar compensation benefits. For example, in New South Wales, the average premium for all vehicles is around \$536 (inc. GST), set by competing licensed insurers within a regulated market overseen by the State Insurance Regulatory Authority (SIRA).

Under the Act, the TAC charge is indexed annually by CPI, unless the Governor in Council, on recommendation of the TAC, determines otherwise through a Charges Order to suppress, increase or decrease indexation. Indexation of premiums and benefits supports the long-term sustainability of the TAC by ensuring revenue keeps pace with rising costs, particularly healthcare, which continues to increase faster than general inflation.

Australian Institute of Health and Welfare National Health Accounts data shows that health sector prices rose by an average of 2.56% per annum over the ten years to 2023-24, while TAC premium increases averaged 1.56% per annum over the same period. Without appropriate indexation over time, the gap between revenue and the cost of supporting future injured Victorians would widen.

Investment in road safety is a defining feature of the TAC model. Since 2010, Victoria's sustained investment in road safety has contributed to an estimated **2,500-2,600** lives saved and prevented around **22,000** serious injuries. Fewer accidents means less trauma, faster community recovery, and a scheme that remains sustainable for the Victorians who will need it in the future.



# Strategic direction and priorities

The TAC's corporate strategy, 'Make Every Day Matter' (the TAC Strategy), launched in 2024 and was developed in response to changing community expectations, evolving needs and increasing complexity across both the transport and healthcare systems. TAC data showed that more people were presenting with complex injuries after a transport accident and facing challenges returning to work or regaining independence, with an increasing reliance on long term care.

These insights highlighted an opportunity for the TAC to modernise its systems and services, strengthen frontline capability and improve coordination for clients, supporting them to navigate the scheme and progress their recovery and independence more easily through more responsive and tailored services.

As part of this strategy, the TAC has begun major technology and system reforms that enhance client experience, improve outcomes and equip employees with modern tools to deliver more personalised and targeted support. This investment will make it easier for people to access assistance with clearer guidance, simpler processes and more proactive, intuitive communication across all channels.

The TAC is committed to continually strengthening the claims management capability of its people. As a founding member of the Personal Injury Education Foundation (PIEF), which is recognised as the national peak body for Australia's personal injury and disability management sector, the TAC actively participates in and contributes to PIEF's national program. This includes building alignment to PIEF's new [National Standards](#) in best-practice claims service delivery.

The TAC Strategy is grounded in a commitment to TAC clients achieving the best possible recovery and independence outcomes, evidence-based decision-making, strong partnerships and continuous improvement – ensuring the TAC continues to deliver for Victorians now and into the future.

TAC clients are already experiencing improvements from changes introduced through this strategy, including:

- enhancements to payment processes that have increased first-time payment rates and reduced repeat contact, contributing to an 11% reduction in call volumes
- significantly improved call responsiveness, with average wait times reducing from 11 minutes to approximately two minutes, reducing delays and improving access to support
- a streamlined Independent Medical Examination (IME) process to accelerate the delivery of benefits and entitlements to injured clients, with the objective of reducing appointment wait times from around 68 days to between 21 and 28 days
- early adoption of AI tools to improve the quality and consistency of record-keeping, supporting clearer communication and more efficient client follow-up.



Recent insights from the TAC's biannual Client Experience Survey (April 2026) show that clients are reporting improvements in their experience with the TAC, with positive sentiment rising consistently over the last eight biannual waves of the survey since November 2022. For the last wave conducted in April 2026, clients rated the TAC 7.06 out of 10 across service delivery, communication and the quality of decisions relating to treatment and support. This is an increase from 6.98 out of 10 in October 2025.

These early outcomes and insights under the TAC Strategy reflect targeted investments in process simplification, technology uplift and new ways of working that focus on what matters most to clients. Importantly, this work represents a foundation rather than an end state.

Further information can be found in the Best Client Outcomes section of the ['Make Every Day Matter' strategy](#) on the TAC website.



# 1. Processes around legitimate claims, including disputed claims

The TAC's claims processes are designed to provide timely access to support while ensuring decisions are consistent with the requirements of the [Transport Accident Act 1986 \(Vic\)](#) and the TAC's claims framework.

This framework aims to:

- recognise and support clients with accepted claims as quickly as possible
- promote injury rehabilitation and the recovery of independence
- identify, prevent and respond to ineligible claims
- provide fast, clear, consistent and evidence-informed decisions around entitlements and rehabilitation supports
- reduce the burden of disputes and resolve them efficiently when they arise
- use scheme resources responsibly to ensure support for Victorians now and into the future.

Within this framework, there are two key categories of decision-making. First, the TAC determines whether a person is eligible to receive support after lodging a claim (*a decision on eligibility for compensation*). If the claim is accepted, the person becomes a 'TAC client'.

From that point, the TAC makes separate and ongoing decisions about payment for TAC-funded treatments, services or other benefits, and where the law provides for it, fair compensation for losses suffered.



## LEGISLATIVE FRAMEWORK

The Act sets out the TAC's responsibilities related to administering the compensation scheme, as well as providing the requirements for entitlement to benefits or compensation for people injured in transport accidents, and how decisions must be made and explained.

Parts 3 and 4 of the Act provide who is eligible for compensation, circumstances where compensation is not payable, and how decisions are made and reviewed. It includes:

- [Section 35](#) – Who is entitled to compensation
- [Section 39](#) – Circumstances in which a person is not entitled to compensation
- [Section 70](#) – Decision on eligibility for compensation
- [Section 74](#) – Cessation or review of liability to pay compensation in certain circumstances.

The objectives set out in [s 11](#) ensure that the scheme emphasises effective rehabilitation, and under [s 60](#) the TAC must pay for the *reasonable cost* of medical and like services where those services are required because of a transport accident injury.

The Act defines what “reasonable” means in [s 3](#). Reasonableness is assessed by reference to the necessity of that service in the circumstances. In practical terms, this requires the TAC to determine whether the treatment is necessary, supports a person's recovery and independence, is clinically appropriate, and is directly related to the transport accident injury when deciding whether it should be funded.

Where a client disputes a TAC decision, Part 4 Division 3 provides a review framework:

- [Section 77](#) – Right to apply to the VCAT for merits review
- [Section 78](#) – Obligation on the TAC to reconsider its decision upon application
- [Section 80](#) – Power of the TAC to vary a decision following reconsideration

Part 6 of the Act governs access to common law damages for clients with serious injuries.

Where another party was at fault, a client may pursue common law damages if their level of impairment is determined at 30% or more, where the TAC issues a Serious Injury Certificate under [s 93](#), or where the client obtains leave from the County Court to bring common law proceedings.

In addition, the [TAC Protocols](#) are an alternative dispute resolution framework designed to resolve claims for compensation and disputes efficiently.



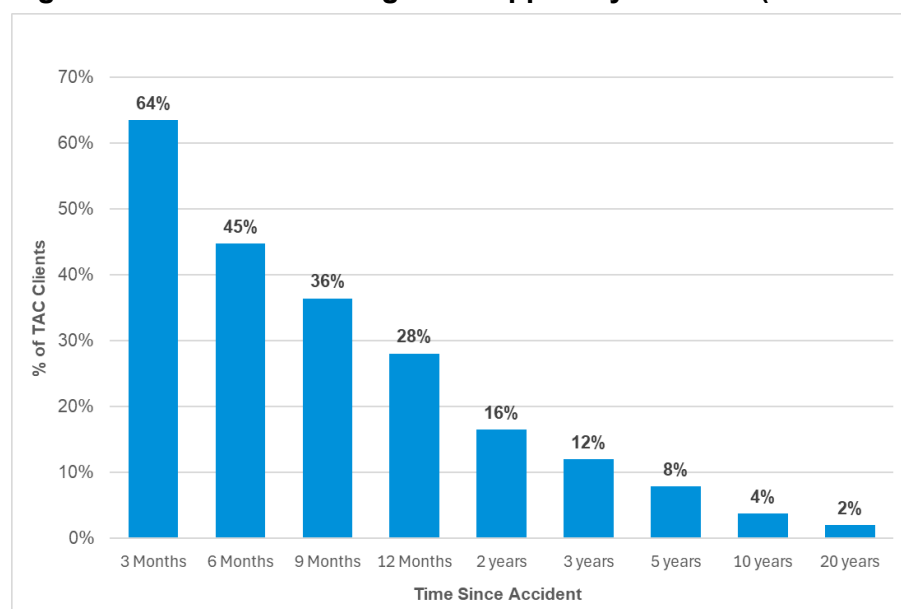
## Current practice

In 2024-25, the TAC actively supported **43,255 clients** and paid **\$1.87 billion in treatment, services, benefits and compensation**. This included supporting **14,654 new clients** during the year – approximately 40 new clients every day.

As shown in the graph below, most clients require TAC support only within the first 12 months after their accident. A smaller group with more complex injuries needs sustained support across several years, and a small number with the most severe or complex injuries will require TAC support for the rest of their lives.

The TAC is designed to support all clients throughout their recovery and path to independence, for as long as that journey takes.

**Figure 1: Clients continuing TAC support by duration (as at 30 June 2025)**



The TAC pays for a comprehensive range of benefits designed to support each person's rehabilitation, independence and long-term wellbeing after a transport accident.

During 2024-25, the TAC provided support to clients through the funding of:

- **medical and like services:** Funding for treatment and supports to rehabilitate and maintain independence – approximately **\$782.6 million**
- **income benefits:** Financial support for clients unable to work due to their transport accident injuries – approximately **\$200.4 million**
- **dependency:** Support for dependents when a person dies as a result of a transport accident, including funeral costs – approximately **\$62 million**
- **impairment:** A no-fault lump-sum payment recognising permanent physical or psychological injury – approximately **\$101.9 million**

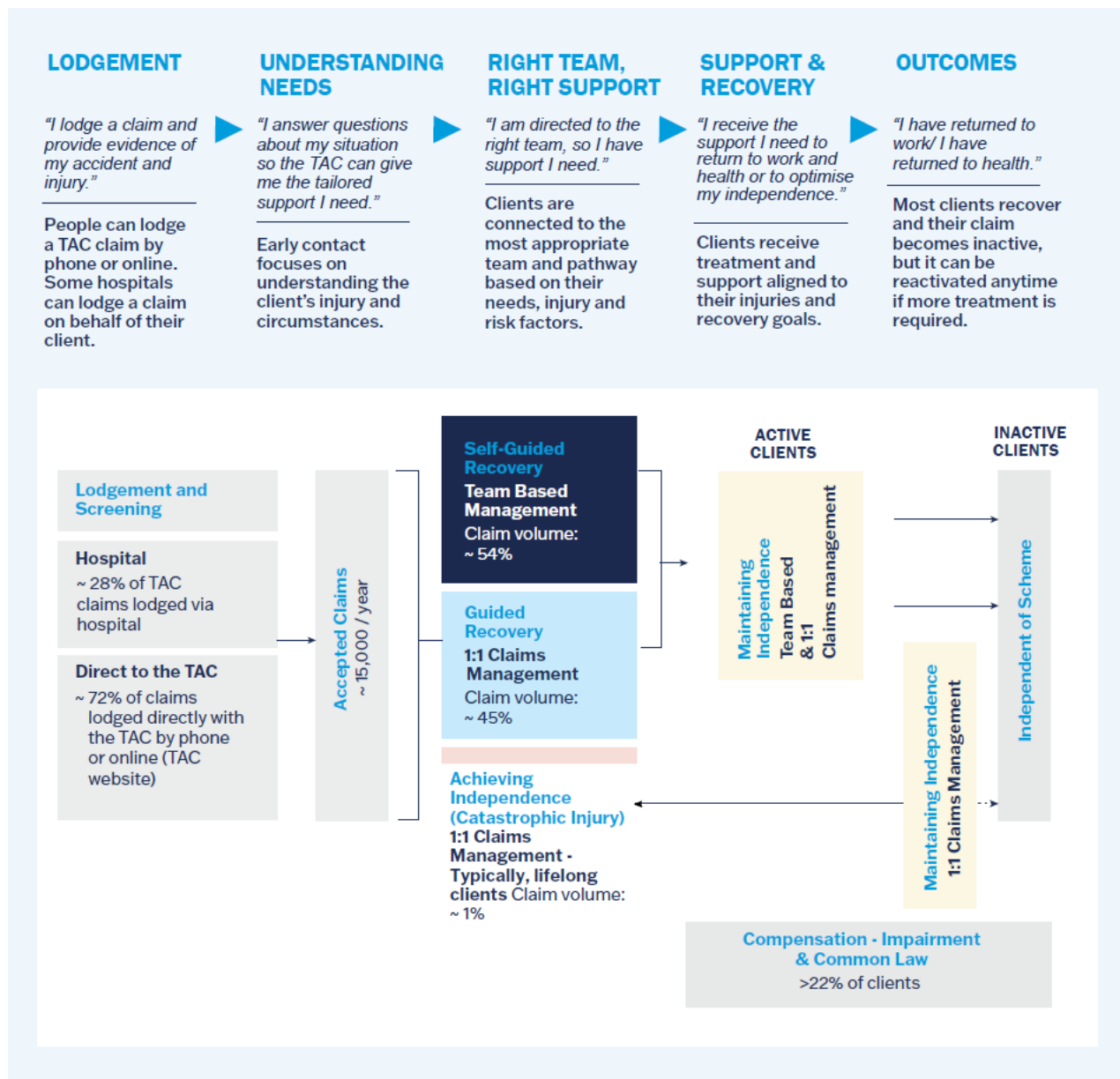


- **common law:** Compensation for seriously injured clients where another party was at fault – approximately **\$530 million**. This is more than a quarter of TAC’s total expenditure.

Common law payments reflect that TAC benefits, however comprehensive, do not fully account for future economic loss or pain and suffering for people with serious injuries. The common law pathway provides Victorians with an additional avenue that can help meet those needs.

## Client journey

The following graphic shows a more detailed overview of the client journey from lodging a claim to achieving outcomes.



Annual figures based on 12-month data (Sep 24 to Aug 25)  
Active clients - Claims with any payment in the last 6 months



## TAC access and eligibility

Timely access to TAC support is critical to recovery outcomes after a transport accident, enabling injured people to commence treatment and services as early as possible. At the same time, the TAC must ensure that claims meet the eligibility requirements set out in [s 35](#) of the Act, so that scheme resources are directed appropriately to those entitled to support.

The TAC operates within a clear legislative and policy framework for claim eligibility. As outlined in the TAC's '[Making a claim for compensation](#)' policy, claims can be lodged online, by phone or via authorised third parties, including hospitals. The TAC assesses eligibility for compensation in accordance with the requirements of the Act and the TAC's '[Eligibility for benefits](#)' policy, supported by objective written third party evidence including police reports and medical certification.

In 2024-2025:

- **16,670 TAC claims were lodged**
- **14,654 TAC claims were accepted.**

A total of 51 denied claims were disputed on eligibility grounds, with 14 subsequently overturned.

Under [s 70](#) of the Act the TAC must respond to a lodged claim within 21 days. In 2024-25, the TAC met this obligation in 99.1% of cases, with 80% of claims accepted within just four days.

Strong manual controls underpin the eligibility process. Every claim is reviewed by a Lodgement Officer to verify that the circumstances meet the statutory definition of a transport accident and that all legislative and policy requirements are satisfied.

Additional verification may be required when:

- **the accident circumstances are unclear** (for example, it is uncertain whether a motor vehicle was involved)
- **the accident occurred interstate** and further information is needed to confirm which scheme is responsible
- **injury causation is uncertain** and additional medical information is required to confirm that the injury is related to the transport accident
- **documentation is incomplete or inconsistent** (for example, missing police reports or inconsistent medical certification).

Claims may be denied where the circumstances do not meet legislative definitions or eligibility criteria, or where responsibility sits with another compensation scheme (for example, WorkSafe Victoria).

When a claim is denied, the TAC communicates its decision in writing and provides the client with their appeal rights. If they choose to do so, the client has access to options to have their TAC decision reviewed. Further details on review options can be found in the TAC's '[Reviewing a decision](#)' policy, as well as on [page 27](#) of this document.



**Figure 2: Simplified view of the TAC claim lodgement process**



## Early support and triage

When an eligible claim is accepted, the TAC undertakes a brief assessment to understand the client's injury, recovery needs, and any risk factors that may affect their recovery.

Clients are then allocated to the most appropriate claims management model:

- **One-to-one model:** Clients are supported by a dedicated claims manager who provides consistent, proactive and coordinated support. This model is particularly effective for clients with complex injuries or changing rehabilitation needs, enabling early issue identification and timely adjustments to supports.
- **Team-based model:** Clients have access to a group of claims advisors and customer service officers. This structure efficiently manages high volumes of client and provider requests, ensuring timely decisions and responsive support. It enables the TAC to deliver services at scale while maintaining a focus on funding supports that promote effective rehabilitation.

This approach is designed to ensure that support is proportionate to need, while enabling efficient service delivery across a large client population.

Through its current strategy, the TAC is enhancing its ability to identify client needs even earlier, more accurately and throughout the life of a claim. This will support more timely allocation of one-to-one support where needed, improving recovery outcomes while maintaining responsible stewardship of the scheme.



## Recovery outcomes

Data below from 2024–25 provides insight into how long clients typically require TAC support following a transport accident:

- 36.5% (3,545) no longer needed TAC support within three months of their accident
- 55.3% (5,701) no longer needed TAC support within six months of their accident
- 72% (8,245) no longer needed TAC support within twelve months of their accident
- <1% (115) of clients sustained catastrophic injuries requiring lifelong support

These figures reflect the important role of early intervention for clients with straightforward recovery needs, alongside longer-term support for clients with more complex injuries.

## TAC-funded treatment and services

In the early stages after an accident (within the first 90 days), clients can access a range of [TAC funded treatments and services](#) without needing individual approval. This supports timely care during a critical period of recovery.

Where a treatment or service is requested beyond this phase, providers submit treatment plans or requests outlining clinical need and recovery progress. The TAC then considers whether it can fund the treatment or service, with decision-making guided by [s 60](#) of the Act and the following four core principles:

- **Entitlement** – Is the treatment required because of a transport accident injury, and is it payable under the Act?
- **Reasonableness** – Are the fees consistent with the TAC fee schedule or other relevant considerations, and is the service necessary given the client’s circumstances and existing supports?
- **Clinical justification** – Is the treatment clinically appropriate for the client at this stage of recovery? How is progress being measured, and what does the evidence show?
- **Outcome focused** – What outcomes will this treatment support, and how will it help the client progress?

## Payment for TAC-funded treatment and services

The TAC pays for the reasonable cost of approved treatments and services in line with its published fee schedules, typically reimbursing providers directly. Where providers charge above the scheduled rate, clients may incur a gap payment (see [section 3](#) of this submission for further detail).

Eligible TAC service providers can invoice the TAC for treatment and services either by sending an invoice by post/email or by submitting and receiving payment online via [HICAPS Digital](#).

Where a provider asks a TAC client to pay for a treatment or service upfront and then seek reimbursement, clients can claim reimbursement by uploading receipts and proof of treatment through the [myTAC portal](#).



In 2024–25, the TAC paid 1.2 million invoices for treatment and services funded by the TAC. Of these:

- **87.8%** were **payments directly to providers** following invoicing
- **12.2%** were **payments to clients** following a request for reimbursement.

## Treatment and service decision outcomes

In 2024–25, the TAC made almost **100,000 treatment and service decisions, averaging approximately 8,300 decisions per month.**

These decisions are broken down as follows:

- **Approved: 89,519** (92%)
- **Approved with conditions: 3,664** (3.8%) – includes partial approvals (where only some of what was requested was funded) and approvals with a cease date (after which no further requests for that service will be considered)
- **Denied: 3,770** (3.8%)
- **Other: 319** (0.4%) – includes suspensions and request withdrawals.

## Decision timeframes – current snapshot: Quarter 3 2025–26

- **70% of decisions** made within **10 days**
- **17.5% of decisions** made in between **11-20 days**
- **4.5% of decisions** made in between **21-30 days**
- **8% of decisions** made over **30 days.**

## Income support

Loss of Earnings payments (the TAC’s term for income support payments) assist clients who are unable to work as a result of their injury, helping them maintain financial stability while they focus on their recovery.

Eligible clients may receive Loss of Earnings payments for up to 18 months after their accident, generally covering 80% of their pre-accident weekly earnings (up to the statutory maximum of \$1,690 per week as at 1 July 2025). This provides timely financial support during what is often the most challenging stage of recovery.

Eligible clients with ongoing reduced work capacity may transition to Loss of Earning Capacity benefits. Further information can be found on the [TAC website](#).

Eligibility for Loss of Earnings payments is set out in [ss 44-45](#) the Act and requires a valid [Certificate of Capacity](#) and evidence that the client was an “earner” prior to their accident.

There are significant health, financial and social benefits for clients who are supported to return to the workplace. The TAC works closely with clients, employers and treating health teams through active claims management, employer engagement and vocational rehabilitation services to facilitate safe and sustainable return-to-work outcomes.



In 2024–25:

- **5,848 TAC clients** received **Loss of Earnings** payments.
- **2,953 clients began Loss of Earnings payments during that year**, and **1,948 of these clients** returned to work and transitioned off this support within 12 months.

## Impairment benefits

The TAC provides a no-fault lump sum payment to clients with a permanent physical or psychological impairment as the result of a transport accident, assessed at 11% or more.

An impairment rating is measured as a percentage that reflects how much permanent impact a person's injury has on their overall functioning, this can only be clinically assessed once an injury or injuries have stabilised.

This benefit payment is intended to compensate for a permanent loss of function. The method for assessing and calculating impairment benefits is set out in [ss 47–48](#) the Act, and indexed payments currently range from \$9,580 to \$437,830. More information is available on the [TAC website](#).

The TAC continues to improve its timeliness in finalising impairment assessments, reducing the time clients wait for certainty about their entitlements.

In 2024–25, **2,748 clients** received impairment benefits, with **79% of decisions made within 18 months** of initiation. This represents an increase from 71.8% in 2023–24.

## Decision-making and use of clinical evidence

How the TAC makes decisions about a person's claim, including what treatment and benefits can be funded, is guided by the requirements of the Act and relevant [TAC policies](#).

Under [s 76](#) of the Act, the TAC must be provided with information it requires to determine whether a treatment, service or expense is reasonable, necessary and related to the transport accident. The TAC aims to make this process as transparent as possible by clearly explaining what information is required and how it will be used.

Understanding which injuries are, and are not, attributable to a transport accident is central to the TAC's statutory obligations to make fair and accurate decisions about TAC entitlements. Where a claim involves ongoing treatment, services, or income support, additional clinical information or specialist input may be needed before a decision can be made.

To support sound decision-making, the TAC may seek specialist advice or assessment at different stages of a claim. This can include:

- **TAC Clinical Panel** – the [Clinical Panel](#) is made up of experienced medical and allied health professionals who provide independent, evidence-informed clinical advice to TAC claims managers. They offer best-practice peer review and clinical guidance.

While claims managers may seek advice from the Clinical Panel within their area of expertise, the Panel does not make decisions on behalf of the TAC – final decisions remain the responsibility of the TAC claims manager.



The Clinical Panel can also support treating providers by discussing effective treatment options, recommended care pathways, and approaches to managing complex presentations. In addition, they may recommend [outcome measures](#) that help assess a person's health status and demonstrate whether the treatment is effective.

- **Joint Medical Examinations (JME)** – a [JME](#) is an independent medico-legal assessment jointly requested by the TAC and a client's lawyer. JME's are designed to reduce the number of examinations a client needs to attend and are only used when existing records and treating evidence are insufficient to make a decision.
- **Independent Medical Examinations (IME)** – IMEs are used in select cases when further clinical clarity is required, particularly in impairment, and complex or legally contested matters. These examinations are conducted by qualified independent practitioners who are not involved in the client's treatment. IMEs form part of the broader clinically justified evidence base considered when determining entitlements. [s 71](#) of the Act empowers the TAC to arrange these examinations as required.

Seeking specialist input or assessment may extend decision timeframes, but can be necessary to ensure decisions are accurate, clinically justified, procedurally fair, and aligned with a client's recovery needs.



## CASE STUDY

### Specialist input to support decision making

A 48-year-old woman was involved in a low-speed motor vehicle accident and sustained four rib fractures. Several months later, she began reporting lower back pain – a symptom not reported in the first four months following the accident.

As her presentation became more complex, involving multiple treating practitioners and investigations, her pain specialist requested that the TAC fund sacroiliac joint injections. At this time, imaging identified pre-existing degenerative disease of the lumbar spine. Her pain was ultimately attributed to the sacroiliac joints and this pre-existing disease.

Given the delay between the accident and the reported symptoms, the presence of pre-existing spinal degeneration predating her accident and differing clinical opinions about the cause of the lower back pain, the claims manager sought impartial advice from the TAC Clinical Panel.

The Panel member reviewed the medical information available on the client's file, then contacted the pain specialist directly to discuss the request, understand the clinical reasoning behind the causation opinion, and clarify how the pre-existing lumbar degeneration and the delayed onset of symptoms had been factored into the treatment recommendation.

Based on this review, the Panel member advised the claims manager of their opinion that the lumbar spine condition was not related to the transport accident but instead was caused by the underlying degenerative disease.

This case highlights how initially straightforward claims can evolve in complexity, and the importance of careful clinical assessment to ensure treatment decisions are appropriately linked to transport accident-related injuries and remain fair and consistent with the TAC's legislative obligations.

Beyond the advice to the TAC, the Panel member's direct engagement with the pain specialist also provided an opportunity to share expertise in transport accident injury presentation, supporting the practitioner's capacity to identify and document causation more effectively in future claims.



## Support for severely injured clients

The TAC's most severely injured clients require intensive, long-term support for catastrophic injuries, sometimes over a lifetime. Severe injury is defined in [s 3](#) of the Act, and includes acquired brain injury, quadriplegia, paraplegia, major burns and limb amputations.

In the 12 months to December 2025, the TAC provided **\$256 million** in essential supports to **1,511 severely injured clients**. These supports, including nursing and attendant care, to help clients live safely, participate in rehabilitation, and promote independence.

The total estimated outstanding liability for all severely injured clients is approximately **\$10 billion**. This represents more than half of the TAC's outstanding claim liability of \$17.93 billion.

## Communicating decisions

Clear and timely communication is a central component of the TAC's decision-making approach. Most requests are approved, but when a request is denied or only partly approved, the TAC aims to speak with the client by phone to explain the outcome, outline the reasons for the decision, and respond to any immediate questions.

All decisions are then formally confirmed in writing. For decisions that can be reviewed – including denials, partial approvals, reductions, and cessations – written notices clearly set out the reasons for the decision and explain the available review options, so clients understand their options and how to exercise them.

The TAC is progressing enhancements to its technology and processes to support timely communication, clearer and more accessible language, and clearer guidance on next steps, helping ensure clients fully understand their options and what to do next.

## Review of TAC decisions

Under [s 77](#) of the Act, people have a legal right to ask for a review of decisions made about their TAC claim or any request for treatments, services or other benefits.

The TAC recognises that review processes can take time and this may have an impact on clients. Wherever possible, the TAC aims to resolve issues early. Clients are encouraged to first speak with a TAC representative to discuss their concerns and see whether the matter can be resolved. Where this is not possible – typically due to differing clinical opinions, complex injuries or unclear eligibility – the TAC provides several formal review options to ensure decisions can be reconsidered fairly and transparently.

All review requests must be made within 12 months of the date the person became aware of the decision. There are three review pathways available: informal review, dispute resolution, and application to the Victorian Civil and Administrative Tribunal (VCAT).



## Informal review

Clients may request an internal review (known as an [‘informal review’](#)). This is conducted by a TAC review officer who was not involved in the original decision. Clients can provide additional information, including medical evidence, to support the review. There is no cost to seek informal review, and clients do not need a lawyer to represent them.

The review officer considers all available information and has authority to uphold, compromise, or overturn the original decision.

## Dispute resolution

Clients can access an alternative dispute resolution process pursuant to the [No Fault Dispute Resolution Protocol 2026](#). This pathway is recognised in [s 77\(1A\)\(b\)](#) of the Act as a ‘pre-issue review’ and, if commenced, the timeframe to apply to VCAT is extended to three months after the dispute resolution outcome.

This process is designed to resolve disputes as efficiently as possible through an early exchange of information, assessment of evidence, and narrowing of issues. Clients must be legally represented to access this pathway.

As part of the current TAC Strategy, a fast-track process for urgent matters was introduced in March 2025. This pathway provides significantly quicker outcomes for clients and is available where a dispute is lodged within one month of the decision and relates to TAC claim eligibility (i.e. access to the scheme), income entitlements, surgery scheduled within three months of the decision date, or urgent hospital admission.

The fast-track process ensures urgent matters receive prompt attention as a built-in feature of the Protocols, not as an exception to them. Where circumstances fall outside these criteria, lawyers may contact the TAC directly to discuss escalation options.

## Victorian Civil and Administrative Tribunal (VCAT)

Clients may also apply to VCAT for a merit review of a TAC decision. This is a formal dispute resolution process, and clients may choose to be represented by a lawyer or to represent themselves.

When an application is made to VCAT, [s 78](#) of the Act requires the TAC to first reconsider the decision, then under [s 80](#) the TAC must advise the Tribunal whether it affirms, varies, or revokes its original decision. The Tribunal may then hold a compulsory conference to give both parties an opportunity to resolve the dispute. If the matter remains unresolved, VCAT will set a hearing date at which both parties may call witnesses, give evidence and make submissions. A VCAT Member will then issue a decision, which is binding on the TAC.

If VCAT decides in favour of the TAC, a client may seek leave to appeal if they believe VCAT made an error in how it applied the law. Appeals may be made to the Court of Appeal or the Trial Division of the Supreme Court of Victoria.



## Review outcomes

In 2024-25, the TAC made 100,185 decisions, of which 7,434 were subject to review (comprising denials and approvals with conditions).

In the same period the TAC received 583 requests for informal review, 2,278 disputes, and 335 applications to VCAT.

In total, 2,790 matters were resolved, with 334 withdrawn by the client.

The numbers for decisions subject to review, reviews received, and reviews resolved don't align within a single year, and that is expected. Clients have up to 12 months to request a review after a decision is made, and the time it takes to resolve a review can vary depending on the circumstances. As a result, each number reflects a different stage in an ongoing review process rather than a single point in time.

**In 95% of resolved matters, the original decision was either upheld or settled by compromise, and 5% were overturned.**

When a matter is settled by compromise, which means it is resolved through a negotiated agreement, it is usually because new information has been provided that was relevant to the original decision. In some cases, this reflects a genuine change in the client's circumstances in the period since the original decision was made - particularly given that clients have up to 12 months to request a review. This demonstrates that the review and dispute processes are giving clients a real chance to have decisions reconsidered and to provide further evidence in support of their claim. Insights from these outcomes also inform improvements to TAC policies and future decision-making.

In 2024-25, the TAC improved the timeliness of **informal reviews**, with **93% finalised within four months**. The median resolution time reduced to 62 days, down from 75 days in 2023-24.

For urgent matters such as income replacement and surgery, the introduction of a fast-track pathway for **TAC Protocols disputes** has significantly reduced median resolution times from 220 days in 2023 to 43 days for the same period in 2025, enabling clients with the most immediate needs to receive outcomes in weeks rather than months.

The TAC remains focused on resolving matters as early and appropriately as the circumstances of each case allows.

## Common law damages

Where another party was at fault in a transport accident, an injured person may be eligible to bring a claim for common law damages against that party. Common law damages recognise both the financial impact of the injury and the pain and suffering a person has experienced.

Under the Act, the TAC is required to indemnify the at-fault party. This means that if a court awards damages, the TAC pays the compensation – not the at-fault party. It also means the TAC takes responsibility for conducting the court proceedings on behalf of the at-fault party.

To be eligible for a common law claim, there must be evidence of both serious injury and negligence. Most common law claims are resolved without going to court, usually within 12 months of initiation. More complex matters may take longer to resolve.



**Table 1: Key TAC common law compensation caps as at 1 July 2025:**

Common Law Claim	Amount
Threshold (minimum amount)	\$67,980
Pecuniary Loss - loss of past and / or future earnings (maximum amount)	\$1,530,470
Pain/Suffering (maximum amount)	\$680,160

To give clients greater certainty and earlier closure, the TAC takes a proactive approach to common law claims. Where possible, the TAC identifies clients who may be eligible rather than waiting for a claim to be initiated by the client or their lawyer.

Where a client is eligible, the TAC facilitates interim payments and works to resolve claims as early as possible. This client-centred approach helps ease financial pressure and allows clients to focus on their recovery. It is unique among compulsory third-party schemes in Australia and is highly regarded by other jurisdictions.

In 2024-25 the TAC:

- **settled 1,440 Victorian common law settlements** – meaning a payment was made. This is an increase of nearly 5% from the previous year.
- **resolved 1,901 Victorian common law cases, 72.8% within 18 months** of commencement – exceeding the corporate target by 4.8%. This broader measure includes both settlements and matters where no payment was made (for example, where a serious injury was not established).

The TAC’s proactive approach is reflected in the **142 early common law payments made in 2024-25**. These payments provide earlier certainty and help reduce financial pressure for clients as the common law process progresses. This represents a significant increase on previous years, up from 51 in 2022-23 and 128 in 2023-24.

## The TAC Protocols

The [TAC Protocols](#) are a formal agreement between the TAC, the Law Institute of Victoria and the Australian Lawyers Alliance, established in 2005 to give clients a clearer, faster and more supportive experience. They streamline how clients access their entitlements by providing defined processes for joint medical examinations, impairment benefit assessments, common law damages and dispute resolution, supporting consistent and timely outcomes across the scheme.

Over time, the TAC Protocols have continued to evolve to better meet TAC clients’ needs – helping identify serious injuries earlier, resolve claims more efficiently and reduce the time clients spend navigating complex legal steps. The most recent updates, released on 30 March 2026, further strengthen early-resolution pathways and enhance the overall client experience.



In practice, the updated TAC Protocols can enable eligible clients to bypass the impairment process entirely and proceed directly to a common law application – recognising that where an impairment lump sum would be deducted from any eventual common law settlement, the financial outcome is the same. For clients, this means fewer medical examinations and a faster path to finalising their claim. To avoid financial disadvantage while the common law claim is being finalised, interim payments are paid where appropriate.

To access the TAC Protocols, clients must have a lawyer to act on their behalf. The [TAC website](#) provides practical guidance on choosing a lawyer and understanding legal costs. When individuals are successful in their claim, the TAC pays fixed legal costs directly to lawyers, aimed at reducing financial barriers to legal representation.

The TAC Protocols are well established. VCAT's procedural guidance 26, [the County Court Common Law Division Practice Note](#), and the Supreme Court of Victoria's [Personal Injuries List Practice Note SC CL 3](#) expressly reference the TAC Protocols, with an expectation that parties attempt to resolve claims through the TAC Protocols before proceeding to litigation.

An independent evaluation by Deakin University of the TAC Protocols (2016-2024) identified measurable improvements for clients since the introduction of the TAC Protocols, including:

- the time it takes for the TAC to make an initial serious injury decision is **53% faster**
- time to fully resolve a serious injury claim is **39% faster**
- Joint Medical Examination (JME) time from application to final appointment is **14% faster**
- serious injury claims proceeding to court are **33% less likely**
- disputes proceeding to the VCAT are **74% less likely**.

## Service and experience

The TAC manages a high volume of client interactions every year and is focused on continually improving the accessibility, responsiveness and quality of its services. Each contact is an opportunity to support clients effectively and to learn from their experiences.

The TAC receives **around 380,000 calls** and **407,000 written** correspondences annually.

In 2024–25:

- **65%** (246,971) of **incoming calls** were **answered on first attempt**
- **86%** (348,872) of **written enquiries** were **responded to within 10 working days**
- of phone calls unable to be answered on first attempt, **21,469 (83%)** were **returned within one business day**.

The TAC is committed to providing a service that is accessible and continually improving based on feedback and insights. Alongside formal review rights, the TAC maintains dedicated channels for clients, providers and legal representatives to raise concerns, seek escalation and contribute to service improvement.



## Complaints

Clients can raise concerns about any aspect of the TAC or their claim. They may speak with their claims manager or escalate directly to the TAC Complaints Team via an online form, email or phone. Complaints can be anonymous and do not affect entitlements.

The complaints team records the issue, gathers information, works with the relevant area to resolve it, keeps the client informed, and provides an outcome. Written complaints are acknowledged and responded to within 28 business days.

If a client remains dissatisfied with how their complaint has been managed, they may also contact the Victorian Ombudsman, who can review the administrative actions of Victorian government bodies. Depending on the nature of the complaint, issues may also be raised with the Office of the Victorian Information Commissioner, the Victorian Equal Opportunity and Human Rights Commission, and the Victorian Legal Services Board and Commissioner. The TAC cooperates fully with any enquiries made by the Ombudsman and Commissioners.

In 2024–25, **647 formal complaints** were received, **89 fewer** than the previous year.

## Solicitor engagement

The TAC provides a [Solicitor Contact Guide](#) to streamline communication with legal representatives. It offers direct email contacts and instructions for common enquiry types, including access to team managers, so matters reach the right person quickly. This reduces unnecessary phone escalation, supports efficient use of the TAC Protocols, and minimises friction for clients who are legally represented.

The TAC also engages with legal representatives through structured forums. Clients don't always raise concerns with the TAC directly, and solicitors often have visibility across many clients' experiences. Engagements such as the No Fault Forum – which brings together members of the Australian Lawyers Alliance and the Law Institute of Victoria with senior TAC claims leaders – provide a channel for broader client feedback to be surfaced in a way the TAC can act on.

## Customer Insights Program

The TAC's Customer Insights Program regularly engages with clients to better understand their experiences with the TAC. This includes a biannual client survey, completed by approximately 1,000 clients, as well as real-time feedback collected after phone interactions.

The client survey explores clients' perceptions of the service they receive, how the TAC communicates with them, and the quality of decisions relating to treatments and services. Insights from this feedback are used to identify opportunities, drive continuous improvement, improve service design, communication and processes, and inform the TAC's customer experience metric.

Latest results from April 2026 highlight:

- The **TAC's client experience measure** continues to track upwards, reaching **7.06 out of 10** – a third consecutive annual increase.
- **Real-time call feedback** scores from clients averaged **8.33 out of 10**.

These indicators show positive momentum as the TAC continues to work toward ensuring its service and experience meets individual client needs and community expectations.



## CONTINUOUS IMPROVEMENT

The TAC Strategy is centred on achieving the best possible outcomes and experiences for TAC clients. It focuses on strengthening the organisation's claims management approach through targeted investment in digital capability, data and analytics, and support models designed to better respond to each client's individual needs.

A key focus of this work is improving the claims experience by:

- identifying clients with complex needs earlier to enable more proactive support
- improving triage and allocation so clients receive the right level of support
- streamlining clinical processes, including faster access to specialist input
- providing clearer communication about decisions and next steps
- reducing decision timeframes through process improvements and better use of technology.

Technology improvements and the introduction of artificial intelligence play an important enabling role, and the TAC is committed to using them responsibly – not to replace human judgement and empathy in decisions that matter to clients, but to reduce the administrative burden of routine tasks. This enables people to focus their expertise and time where it has the greatest impact: making nuanced clinical decisions, listening and responding to clients as individuals, and supporting them to achieve the best possible recovery outcomes.

### Claims model and early intervention

The TAC's claims model supports early intervention and targeted use of resources. Through the TAC Strategy, this approach is being strengthened with improved data and analytics, new service pathways and a modernised claims platform.

Automation of routine tasks enables people to focus on cases where human expertise makes the greatest difference. These changes support earlier identification of emerging needs and allow support to be more responsive as circumstances evolve, improving both timeliness and client outcomes. Together, these enhancements reinforce a more proactive, consistent and client-centred claims experience.

### Improved decision-making

The TAC has taken proactive steps to improve decision-making for complex claims, with a clear focus on timeliness and consistency. Targeted process improvements, including more collaborative clinical advice models, streamlined referral pathways and better use of data, are reducing delays, enabling earlier decisions and improving consistency while maintaining safety and quality.

In 2022, following collaboration between the TAC and key stakeholders, including the Australian Lawyers Alliance and Law Institute of Victoria, the [Surgery Service Charter](#) was implemented. This was a voluntary commitment by the TAC to adopt a more transparent and accountable approach to surgery decisions.



Since that time, the TAC has made significant progress in reducing the time it takes to make surgery decisions. As at April 2026, 75% of surgery decisions are completed within 21 days, a major improvement compared with the previous four years, when the average timeframe was around 75 days.

The TAC is also working to better understand the drivers of dispute volumes. In 2025, improvements were made to dispute data collection and reporting, to track and respond to trends over time. This aims to inform the quality and communication of decisions in the first instance and reduce the need for dispute lodgements.

Improvements to the TAC Protocols continue to support earlier lump sum decisions and resolution of disputes. The fast-track pathway for urgent disputes is one outcome of this program, reducing median resolution times from 220 days to 43 days for eligible matters.

Together, these reforms represent a comprehensive modernisation of the TAC's claims and dispute processes. They aim to strengthen decision quality, improve timeliness, and ensure clients receive clearer, more responsive and better-coordinated support. By combining technology-enabled efficiency with strong clinical and human expertise, the TAC is building a more consistent, accessible and client-centred experience that supports recovery and maintains the integrity and sustainability of the TAC.



## 2. Circumstances and systems related to fraudulent claims

Maintaining scheme integrity is essential to ensuring that TAC funds are directed to eligible clients and that the TAC remains fair and sustainable for the Victorian community.

In the TAC context, fraud refers to deliberately and dishonestly providing false or misleading information to obtain benefits, services or payments that a person is not entitled to receive.

The TAC strives for effective systems to prevent the type of fraudulent conduct that has impacted interstate and international schemes. TAC's fraud management approach is prevention-focused, risk-based and proportionate, ensuring integrity risks are addressed without creating unnecessary barriers to care.

Fraud controls are designed to operate in the background, so clients and providers acting appropriately experience a straightforward process.

### LEGISLATIVE FRAMEWORK

The [Transport Accident Act 1986 \(Vic\)](#) requires the TAC to administer the scheme in a way that is efficient, effective and economical ([s 11](#)) to ensure that public funds are used responsibly.

The Act also contains specific provisions for dealing with fraud and non-compliance, which underpin the TAC's approach to protecting the integrity of the scheme (Part 8). This includes:

- [Section 116](#) – Fraud
- [Section 117](#) – False or misleading information
- [Section 117B](#) – Obtaining benefits that are not payable
- [Section 117C](#) – Failure to pay full amount of transport accident charge
- [Section 120](#) sets out the procedure for prosecutions, and if a conviction is recorded the TAC may recover compensation under [s 117A](#)
- [Section 127A](#) allows the TAC to enter premises, require a person to provide information and documents, and exercise other powers as necessary to determine whether the Act is being contravened. These powers are subject to strict procedural requirements and independent oversight to ensure they are used appropriately.



### Fraud prevention and controls

It is important to distinguish between eligibility and payment controls, and fraud controls, as they serve fundamentally different purposes.

The TAC administers a high-volume, multi-party payment environment, processing entitlements across tens of thousands of active clients, a large provider network, and a wide range of services and supports. Payment controls are the standard financial governance mechanisms that operate within this environment. They exist to catch errors, duplications, and processing anomalies at scale, and their operation carries no implication of wrongdoing on the part of any client or provider.

Fraud controls, by contrast, are triggered by indicators of deliberate deception. The TAC is structured and resourced appropriately to prevent, detect and respond to fraud through:

- **initial claim procedural controls** at claim lodgement and decision-making to minimise the approval of ineligible claims. Claims lodgement requires mandatory evidence of an eligible transport accident, medical certification of injury, and verification of licence and registration details. Decision-makers apply a structured assessment framework against defined eligibility criteria, supported by training in fraud indicators and clear escalation pathways. Claims that do not meet the required evidentiary standard are not progressed without further investigation.
- **clinical and payment approvals**, ensuring treatments and services are reasonable, necessary for rehabilitation, and approved evidence-based interventions. Requests are assessed using a decision-making framework, and payment controls prevent duplicate or anomalous transactions from being processed without proper verification.
- **data analytics and predictive modelling**, identifying anomalies and emerging risks. Alerts are reviewed by trained staff and referred for investigation where warranted. The analytics capability is regularly updated to reflect new fraud methodologies and evolving scheme and industry risks.
- **post-payment assurance activities**, enabling early detection and intervention where issues arise. Where concerns are identified, TAC has established referral pathways to escalate matters, engage with external agencies where appropriate, and pursue recovery action. Findings inform continuous improvement of upstream controls and staff training.



## Fraud investigation and enforcement

Ensuring compliance with the Act and related legislation is integral to delivering a fair and balanced transport accident scheme.

As a Victorian public authority with investigative and enforcement powers, the TAC looks into suspected misconduct connected to the scheme, including cases where benefits are obtained fraudulently, where a person is not entitled to benefits, or where false or misleading information is provided in any application or document submitted under the Act.

Part 8 of the Act, and the related [TAC compliance and enforcement policy](#), set out the offences that may be committed:

- fraudulently obtaining, or attempting to obtain, any benefits
- providing false or misleading information
- obtaining benefits that are not payable
- failing to pay the full amount of the transport accident charge
- obstructing or hindering the administration of the Act.

Fraud is detected through several channels, including calls to the TAC's Fraud Hotline, internal monitoring and analytics that highlight unusual claim activity, and referrals from TAC employees or providers.

When the TAC has reasonable grounds to consider a person may have breached the Act, it can use its statutory powers to investigate as outlined in [s 127A](#). These powers are used to determine whether a contravention has occurred and to support enforcement of the Act. If a person does not cooperate or obstructs an investigation, the TAC may commence criminal proceedings.

The TAC approaches surveillance as a measure of last resort, used only where less intrusive methods of inquiry have been exhausted and there is a reasonable basis to believe a client may be misrepresenting their injury, claiming reduced work capacity disproportionate to their stated injury, malingering, or engaged in actual or potential fraud. This approach reflects the recommendations of both the [Office of the Australian Privacy Commissioner](#) and the [Office of the Victorian Information Commissioner](#).

The Scheme Integrity Branch leads the TAC's response to suspected fraud committed by clients or service providers. TAC investigators have the delegated authority to lay charges under the Act and the Crimes Act, and to exercise all investigative powers under [s 127A](#).

The TAC may take a range of actions after completing an investigation. These include:

- issuing a letter of caution which may include a demand for repayment
- commencing criminal proceedings
- pursuing civil recovery of overpaid compensation



- referring the matter to Victoria Police, the Coroner, the Office of Public Prosecutions, or relevant professional trade or regulatory bodies such as the Australian Health Practitioner Regulation Agency, the Victorian Legal Services Board and Commissioner, and the Independent Broad-based Anti-corruption Commission
- deciding that no further action is required.

The TAC's fraud investigation approach is targeted, proportionate and directed at identifiable risks. Only matters that warrant investigation are pursued, and the most appropriate action is taken in line with legislated responsibilities. Each case is assessed on its own individual merits, with decisions guided by the public interest principles set out in the [Director of Public Prosecutions' policy](#).

## Built-in oversight of prosecution decisions

If a TAC fraud investigation finds that prosecution may be appropriate, the case must first undergo an internal review before any matter proceeds to court, to safeguard against unprincipled prosecuting. Prosecution is only pursued where:

- there is a reasonable prospect of conviction
- the prosecution is in the public interest.

This mirrors the standard applied by the Director of Public Prosecutions, providing an independent and well-established benchmark for TAC enforcement decisions and interest considerations.

This governance framework ensures prosecution is a measured, last-resort response, applied with appropriate authority and oversight.

## Minimising impact on TAC clients

Fraud controls are designed to protect access to care, not impede it. The TAC achieves this through:

- proportionate, evidence-based decision-making
- continued access to approved treatment during investigations without unnecessary delay
- reliance on post-payment controls rather than front-end barriers
- targeted investigation of higher-risk behaviours

This approach supports clinically appropriate treatment with risk controls applied only when specific behaviours indicate elevated risk, reflecting a trust based and proportionate model of oversight.

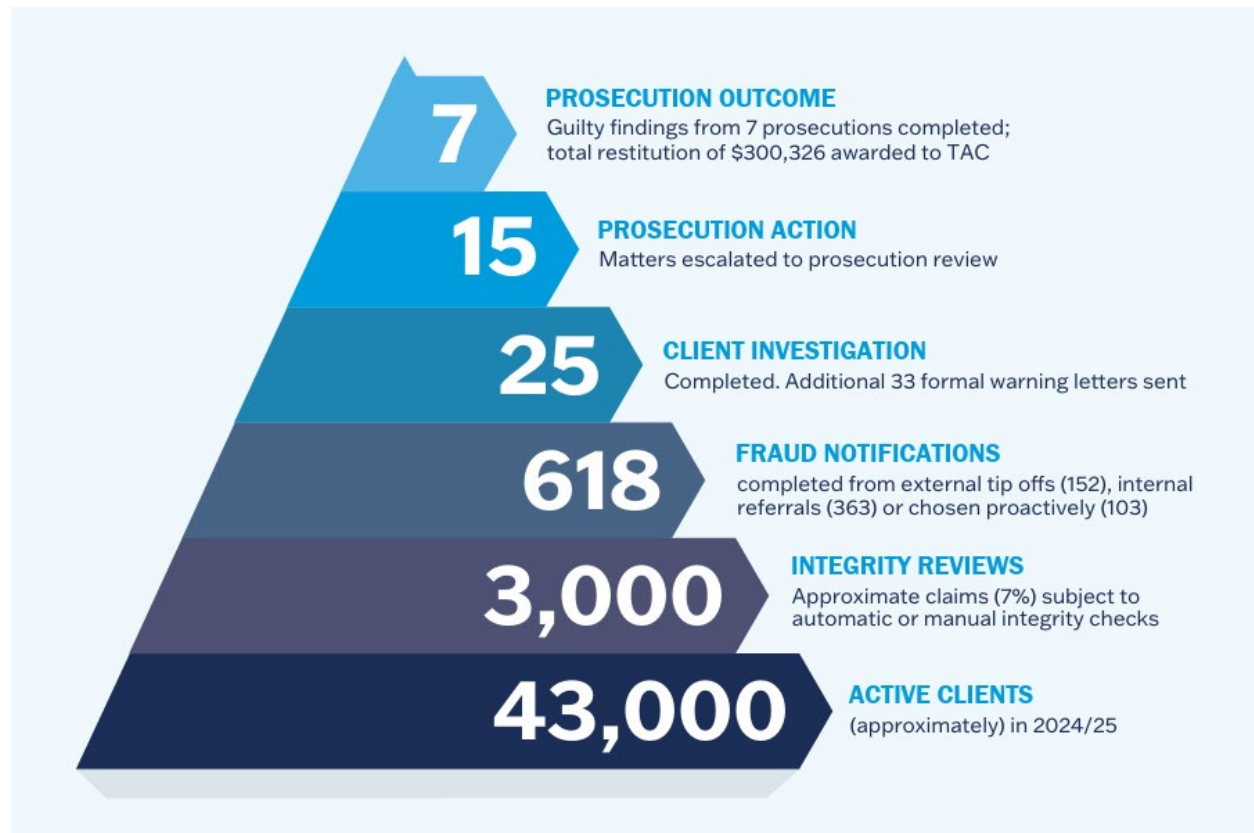


## Fraud prosecution action – Clients

Calibrated on decades of evidence, the TAC’s control environment recognises that while the incidence of deliberate client fraud is very low, it does exist and must therefore be appropriately managed. Controls are designed to identify and address material risks without disrupting the management or experience of clients.

In 2024-25, there were 43,255 active clients who received \$1.87 billion to support their recovery. The information below from that period outlines the TAC’s fraud prevention activities, including the reviews and actions undertaken and the finalisation of seven client prosecutions for fraudulently obtaining benefits.

**Figure 3: TAC Client enforcement action – 2024-25**





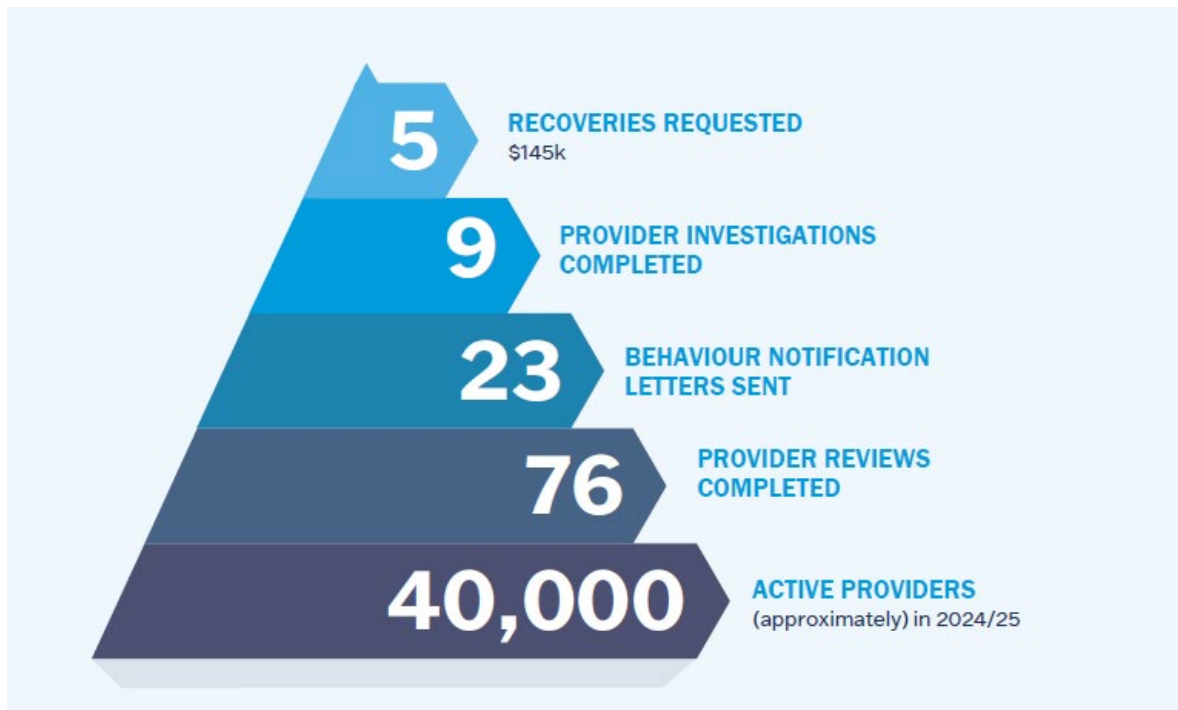
## Fraud prosecution action – Providers

Potential provider fraud is identified through multiple channels, including public referrals, internal detection by employees, and automated systems within the TAC’s processes that analyse information received from healthcare providers and, in some cases, other agencies.

The TAC also uses analytics and modelling to detect suspicious trends, behaviours or anomalies within the claims environment that may indicate potential fraudulent conduct.

The information below from 2024–25 highlights the risk-based compliance model that focuses investigative resources on a very small subset of providers, with most issues addressed through early intervention before escalating to formal enforcement or recovery.

**Figure 4: Provider enforcement action – 2024–25**





## CASE STUDY

### Integrated fraud detection – income benefits

A self-employed worker was receiving maximum TAC statutory Loss of Earnings benefits while certifying zero work capacity and actively denying any return to work. TAC claims staff identified concerns after noticing evasive behaviour, limited treatment engagement, and vocational reports that did not align with the client's stated incapacity. The file was referred for investigation.

Initial intelligence gathering confirmed the client was the sole director of several businesses and was actively promoting their services online. Based on this, targeted surveillance was approved and captured the client attending worksites dressed for active work and overseeing day-to-day operations. With this evidence, TAC formed a reasonable suspicion of a statutory breach and escalated the matter to a formal investigation under pt 8 of the Act.

Only after reasonable grounds were established did investigators use compulsory powers under [s 127A](#) to obtain banking, accounting, and taxation records. Forensic accounting analysis revealed expenditure and trading patterns consistent with active business operations. Transaction data led to witness statements confirming completed jobs, including drone footage from a witness capturing the client physically performing work. Throughout this period, their treating GP continued to certify zero capacity based on the client's false presentations.

The client was offered a formal interview as part of procedural fairness but declined. Income benefits were ceased immediately upon conclusion of the investigation. Given the alleged fraud exceeded \$100,000 and fell outside the limitation period for Transport Accident Act offences, the TAC confirmed a viable criminal pathway. A full brief of evidence was referred to Victoria Police for prosecution under the *Crimes Act 1958 (Vic)*, alongside pursuit of financial restitution.

Importantly, throughout the intelligence, surveillance, and forensic phases, the client continued to receive their full entitlements and access treatment. Benefits were only suspended once the evidence met the threshold for a strong likelihood of conviction.

Once charged, TAC will typically offer a person the opportunity to repay the funds obtained, and where that does not occur, seeks restitution through the sentencing process. This reflects the TAC's design principle: investigations must remain client-focused and preserve legitimate entitlements until the evidence justifies intervention, while still protecting the scheme through active recovery of fraudulently obtained funds.



## CONTINUOUS IMPROVEMENT

As part of its current strategy, the TAC continues to strengthen its approach to fraud prevention and scheme integrity, ensuring it remains well-positioned to respond to increasingly sophisticated and complex fraud risks across the wider service system.

This includes investment in improved technology, expanded data and analytics capability, enhanced provider monitoring, and closer alignment between claims management and integrity functions.

These initiatives not only strengthen the TAC's ability to identify risks even earlier and respond effectively but also deliver value for clients. Enhanced technology enables more real-time, largely invisible controls and checks, reducing delays and minimising any disruption to client experience.

At the same time, expanded data and analytics capabilities support even earlier identification of emerging trends or risks, allowing timely review and refinement of processes, as well as proactive engagement with clients and providers – often before issues escalate into fraud.

The TAC also recognises that effective fraud management relies not only on systems and controls, but on the capability and integrity of its people. Ongoing investment in workforce education and uplift ensures TAC employees understand their obligations, are equipped to identify potential fraud risks, and are supported to appropriately escalate concerns.

Collectively, these changes support a modern, transparent and efficient approach that strengthens scheme integrity while maintaining a strong focus on timely, client-centred outcomes and the long-term sustainability of the TAC.



### 3. Private provider discretion to set fees exceeding the Medicare Benefits Schedule rate

Access to timely, appropriate care is central to the TAC's approach to setting fees. Published fee schedules are designed to support clients to access the healthcare and services they need, while reflecting the realities of the private healthcare market and ensuring the sustainable use of public funds.

Clear pricing benchmarks promote consistency and equity across the scheme, helping to reduce variation in provider fees and protect the TAC's long-term viability. Through ongoing transparency and targeted improvements, the TAC continues to manage cost pressures while maintaining reliable access to services for clients.

The TAC does not have the authority to require private providers to cap their fees, nor can it direct clients to choose providers who do not charge a gap fee. However, the TAC can establish fees in a consistent and reasonable manner, and provide clients with clear information when selecting providers, including whether a provider chooses to align their fees with TAC rates.

This framework helps ensure clients can access necessary services at fair and competitive prices, comparable with other major healthcare funders such as the Medicare Benefits Schedule (MBS), WorkSafe, National Disability Insurance Scheme (NDIS) and private health insurers.



## LEGISLATIVE FRAMEWORK

The TAC must pay for the reasonable cost of medical and like services described within [s 60](#) of the [Transport Accident Act 1986 \(Vic\)](#). The Act also requires the TAC to manage the scheme in an efficient, effective and economical manner, as set out in [s 11](#), ensuring public funds are used responsibly.

[Section 3\(1\)](#) defines "reasonable" in respect of costs as having regard to:

- the costs that TAC has determined as a reasonable amount in relation to that service
- the maximum amount of costs for that service (if any) specified in an [Order of the Governor in Council](#) made on the recommendation of TAC
- and the service actually rendered and whether it was necessary in the circumstances.

The maximum amount of costs specified in an Order of the Governor in Council must not be lower than the relevant Medicare Benefits Schedule (MBS) rate for that type of service in Victoria, which aligns fee caps with Commonwealth benchmarks.

[Section 23](#) enables the TAC to authorise specified services and persons to deliver a range of treatment, rehabilitation, and disability services to clients.



## Current practice

The TAC operates within Victoria's broader public and private healthcare system, funding treatment provided by clinicians who also have patients across other schemes including WorkSafe, the Department of Veterans' Affairs, the NDIS, Comcare, and private insurers.

TAC clients access services in a market where providers set their own prices. This creates both opportunity and complexity – clients have access to a broad and established provider network, but the TAC must actively manage the risk that its funding doesn't drive up prices in the broader market. In response, the TAC sets clear and reasonable funding benchmarks that support informed client choice, consistent expectations, and sustainable access to care.

### Medical services and the Medicare Benefits Schedule

The Medicare Benefits Schedule (MBS) provides a nationally consistent framework for defining medical services and supporting clinical validation. The TAC adopts the MBS as a benchmark for service definitions, rules and fee relativities, while maintaining its own [Medical Reimbursement Schedule](#) for payable fees.

TAC fees are derived from MBS fees, with calibrated loadings applied to reflect the TAC context. Fees are indexed annually using a methodology incorporating variations in the Consumer Price Index (CPI) and Average Weekly Earnings (AWE).

The TAC also updates fee schedules to reflect MBS changes and applies clinical oversight to ensure services remain appropriate for transport accident injuries. The TAC's impartial Clinical Panel reviews any updates to ensure alignment with contemporary practice and client needs.

This approach maintains alignment with a nationally recognised standard while enabling scheme-specific controls that promote consistency, transparency and appropriate use of public funds.

### Approach to setting fees

Clear pricing benchmarks and targeted reforms are improving transparency, limiting unnecessary cost pressures, and protecting the TAC scheme – while ensuring clients can access timely and appropriate care.

Within this context, fee setting is a key lever for both scheme sustainability and equitable access to care for injured Victorians. The TAC's approach balances provider autonomy within a private healthcare market with the need to ensure public funds are used appropriately, consistently, and in line with clinical need through sustainable and transparent fee-setting practices.

The TAC anchors its assessment of reasonableness to the MBS for medical services and maintains Scheduled Fee Rates for other treatments. This provides a consistent benchmark that supports equitable access and long-term scheme sustainability.



The TAC utilises a base fee calculation method informed by private market analysis and periodic business cost review combined with an annual indexation approach. More comprehensive re-baselining of fee schedules is also undertaken by discipline as required, evidenced by new schedules for physiotherapy and occupational therapy released in 2026.

Private providers may set fees above these benchmarks, which is common in the private healthcare market. This can lead to differences in pricing, higher costs overall, and uneven client experiences, including clients having to pay gap fees.

## Determining the reasonableness of provider fees

The TAC's approach to assessing whether a fee is reasonable seeks to strike a balance between provider autonomy within a private healthcare market with the need to ensure public funds are used appropriately, consistently and in line with clinical need.

The TAC determines that a reasonable amount to pay or reimburse for a service is the price at which that service is reasonably accessible to the client. In this context, reasonable accessibility means that the client can obtain treatment without needing to travel too far to access a practitioner who is suitably qualified and experienced to provide the required service.

## Rehabilitation and disability services and Above Rate Service Agreements

The TAC publishes [fee schedules](#) that set maximum payable amounts for authorised rehabilitation and disability services, often referred to as allied health or support services.

In recent years, increases have largely tracked with the CPI, creating pressure where private market rates have risen more rapidly influenced by wage growth, NDIS pricing, and the expansion of larger provider groups. Consequently, some providers have been reluctant to accept TAC rates, prompting calls for discipline-specific increases or full alignment with private market pricing.

To respond to this, and to support client access to quality services, the TAC introduced the [Above Rate Service Agreement](#) process, enabling providers to seek approval for fees above the scheduled rate. Whilst this has provided flexibility, reliance on above-rate agreements increases administrative burden, reduces pricing transparency, and limits visibility of overall cost growth, highlighting the unsustainability of case-by-case pricing in the long term.

The TAC respects and supports client choice of provider. Where a client chooses a provider who charges above the TAC fee schedule and there is no approved Above Rate Service Agreement in place, the TAC reimburses up to the scheduled fee. This may result in a part-payment and a gap that the client may need to cover themselves. The TAC recognises that these gap payments can create financial pressure and may influence their ability to continue treatment with their preferred provider.

Clients may contact the TAC to discuss gap payments and whether the higher fees may be considered reasonable in their particular circumstances. The TAC Protocols also enable lawyers to submit a fee query on behalf of the client ([No Fault Dispute Resolution Protocol, clause 2.8](#)) to improve consistency and reduce disputes relating to reasonable costs. Where a dispute arises around the cost of urgent dental or surgical treatment, clients may access a 'fast-track' pathway to reduce the impact of the outcome on the timeframe to receiving treatment.



## Independent and Joint Medical Examination fees

The challenge of managing specialist fees within a funded scheme is not unique to the TAC. Across Australia, there is growing recognition that unregulated specialist pricing creates access and affordability pressures, and that some form of transparent benchmarking is necessary to protect both patients and the systems that fund their care.

In the TAC context, independent and joint medical examinations (IMEs and JMEs) are a necessary feature of fair and evidence-based decision making, and they are critical to resolving complex claims and legal matters.

In July 2025, the TAC transitioned from individual examiner contracts for IMEs, to two Intermediary Panels. [IME fee schedules](#) were agreed as part of the contract negotiations.

JMEs are referred to as 'Joint' because they are mutually engaged by the TAC and the client's lawyer to answer complex questions. JMEs have historically operated without effective fee regulation, allowing providers to set their own prices and resulting in sustained cost escalation out of pace with inflation. For example, in 2024–25 the TAC received 65 invoices in excess of \$7,000 each for a single medical assessment, with some exceeding \$10,000.

JMEs are arranged by the client's lawyer, with the invoice rendered to the TAC after the examination is complete and the report delivered. Under an unregulated model, fee disputes have arisen at that point, creating friction between the TAC, the legal community, and the examiner community, and consuming time and resources that serve no one well.

The TAC's [JME fee schedule](#) resolves this by establishing rates upfront that are agreed between the TAC, ALA and LIV. Examiners know what the TAC will fund, and lawyers know to engage examiners who will work within that framework. The result is no disputes after the assessment has been completed, and a process that is transparent and predictable for all parties from the outset.

Transparent, consistent pricing protects clients, supports scheme integrity, and ensures public funds are directed to the assessment rather than absorbed by an unregulated pricing environment. This approach reflects both the TAC's broader fee-setting philosophy and the direction of reform across the health system more broadly.



## CASE STUDY

### Public health service model reform

The TAC is leading a reform, in partnership with the Victorian Government Department of Health, to strengthen the approach for how services delivered by Victorian public health services for TAC clients are funded.

From 1 July 2026, the TAC will transition to direct funding of health services, with payments structured as a single episode-of-care payment, replacing multiple individual billing arrangements from providers.

Under this model, the Department of Health will receive a single national-aligned bundled payment directly from the TAC, so that:

- individual medical practitioners and diagnostic providers will no longer invoice the TAC separately
- health services will manage the full cost of care, including medical and diagnostic services.

This reform aims to modernise and simplify funding arrangements. Importantly, the change is to how services are funded, not to what clients can access or the standard of care they receive. It will improve transparency for each TAC patient episode, streamline billing and payment processes, and strengthen sustainability of the TAC scheme through clearer oversight, reduced risk of fraud and billing errors, improved cost efficiency, and reduced administrative burden.



## CONTINUOUS IMPROVEMENT

Under the TAC Strategy, the TAC is focused on enhancing the experience of both providers and clients, ensuring injured people can access high-quality care, and delivering services in a cost-effective and sustainable way.

In 2025, the TAC introduced the Provider Health and Outcomes Framework (PHOF) as its main approach for working with and engaging providers. As part of this, the TAC is updating how fees are set across medical and allied health services. This includes setting clearer rules for when fees are reviewed and updating item codes and service descriptions, so they better reflect current clinical practice.

The TAC is also undertaking a comprehensive review of MBS-aligned reimbursement rates. The work will continue throughout 2026–27 and is designed to ensure fees stay up to date, reflect current evidence and market conditions, and reduce reliance on above-rate charging over time.

Fee adjustments in allied health are already underway. From 1 February 2026, the TAC's **physiotherapy fees increased** significantly, including a 46% increase for initial assessments and a 43% increase for standard consultations.

From 13 April 2026, following consultation with providers and peak bodies, the TAC launched a **new occupational therapy service model and related fee updates**.

These changes reinforce the TAC's commitment to reasonable fees, remove the need for Above Rate Service Agreements, and support improved client access to timely, high-quality care.

Further fee reviews across allied health disciplines – including psychology, hand therapy, osteopathy, chiropractic, exercise physiology and speech pathology – are scheduled progressively throughout 2026.



## **4. Interactions with other services, including the National Disability Insurance Scheme (NDIS), and restrictions on health privacy and information sharing between state and federal agencies.**

Effective coordination between the TAC and other schemes and services is essential to delivering safe, consistent and client-centred outcomes.

Recent federal reforms to the NDIS are reshaping how NDIS supports are coordinated and how information can be shared across jurisdictions. These changes have direct implications for TAC clients who interact with multiple systems, particularly those with complex or long-term needs.

Within this evolving environment, the TAC continues to work closely with state partners such as WorkSafe, and with the NDIS at the federal level, to maintain clarity of roles, support coordinated client pathways and manage emerging risks.



## LEGISLATIVE FRAMEWORK

The TAC's responsibilities under the [Transport Accident Act 1986 \(Vic\)](#) (the Act) extend to supporting Victorians injured in transport accidents, even where a client may also be eligible for support under other schemes. The TAC engages with these schemes to ensure clarity of responsibility and to avoid duplication, while maintaining its statutory role as Victoria's transport accident compensation authority.

The NDIS was established in 2013 under the [National Disability Insurance Scheme Act 2013 \(Cth\)](#) ('NDIS Act') to provide funding to people with a permanent and significant disability. Its creation did not alter the long-standing arrangements for people injured in transport accidents. Compensation for transport accident injuries remains the responsibility of the TAC.

The NDIS interaction between other compensable schemes is outlined in [ch 5](#) of the NDIS Act along with the [National Disability Insurance Scheme \(Supports for Participants - Accounting for Compensation\) Rules 2013 \(Cth\)](#) ('Compensation Rules').

In October 2024, the [National Disability Insurance Scheme Amendment \(Getting the NDIS Back on Track No. 1\) Act 2024 \(Cth\)](#) came into effect, introducing a new statutory definition of 'NDIS supports' and requiring NDIS supports to be declared in the National Disability Insurance Scheme Rules.

The TAC also regularly interacts with interstate and federal workers compensation schemes and their relevant legislation, particularly [WorkSafe Victoria](#) and [Comcare](#).

Information sharing and privacy obligations are regulated across multiple Victorian and Commonwealth statutes, including:

- [s 131](#) of the Act
- [Health Records Act 2001 \(Vic\)](#)
- [Privacy and Data Protection Act 2014 \(Vic\)](#)
- [Privacy Act 1988 \(Cth\)](#).
- ss [58](#) and [67](#) of the NDIS Act
- [Disability and Social Services Regulation Amendment Act 2023 \(Vic\)](#).



# Current practice

## Coordination across support systems

The TAC recognises the critical importance of effective interaction between state-based compensation schemes and federal service systems in delivering coordinated, client-centred outcomes.

At a state level, arrangements are in place governing interaction between the TAC and WorkSafe. The TAC's liability to WorkSafe is described on the [WorkSafe website](#). The TAC and WorkSafe also have arrangements that guide the processes for dispute resolution, ensuring that eligible clients are not, or are only minimally, affected by inter-jurisdictional disputes over liability and determining liability for transport accidents arising in the course of employment. These arrangements align with the Victorian [Model Litigant Guidelines](#), and are also dealt with in the TAC Protocols ([Common Law – cl 5.5](#)). Senior leaders from both agencies meet on a quarterly basis to discuss and plan responses to any identified themes and risks.

In addition, for almost 20 years the TAC has administered the medical and like benefits of around 280 seriously injured workers as an agent of WorkSafe Victoria. This program, known as the [Community Integration Program](#), was recently renewed in 2025.

At a federal level, the TAC and NDIS serve different purposes and operate independently but some TAC clients, particularly those with significant injuries, may be eligible under both schemes. In these cases, the schemes work alongside each other: the TAC funds transport accident injury-related rehabilitation and medical supports, while NDIS funds disability supports unrelated to the transport accident injuries.

## TAC and NDIS mutual clients

In principle, the delineation of responsibilities is clear: the TAC funds supports directly related to transport accident injuries in accordance with its obligations under the Act, while the NDIS provides supports related to broader or non-compensable disability needs.

There are two main scenarios where someone may be a mutual client of TAC and NDIS:

- **A person with an existing disability who is already receiving NDIS supports, and who then sustains new injuries in a transport accident.** In these situations, the TAC is responsible for funding supports directly related to the new accident injuries in line with eligibility set out in the Act, while the NDIS continues to fund supports associated with the person's pre-existing disability.
- **A person who sustains significant permanent injuries in a transport accident.** In this situation, the TAC is responsible for funding supports directly related to the accident injuries, and the client may also be eligible for NDIS supports that are not payable under the Act, such as Specialist Disability Accommodation (SDA).

As of October 2024, based on data matching with the NDIA, around 676 TAC clients and 30 WorkSafe Victoria injured workers managed by the TAC had an approved NDIS plan.



For an individual supported by both schemes, there are differences that may create some complexity, for example:

- In the first 90 days after a transport accident, TAC clients can access a range of TAC funded treatments and services without needing individual approval if aligned with the TAC Clinical Framework. After 90 days, providers must submit a written request or treatment plan. The TAC then considers whether it can fund the treatment or service under [s 60](#) of the Act.
- NDIS participants are approved for supports by demonstrating that their disability is permanent and significant, which requires reasonable and necessary services to achieve their goals. Approval involves submitting evidence of disability, meeting with the NDIA for planning, and ensuring requested supports promote independence and provide value for money.

In practice, this distinction can be difficult to apply particularly in cases where TAC clients can go to the NDIS or vice versa when there are service gaps, or when the Act or NDIS Act do not cover a particular type of support.

The TAC has operated for decades prior to the establishment of the NDIS and has consistently supported clients who interact with one or both schemes as NDIS policies have developed. The TAC recognises that some seriously injured clients have experienced changing NDIS decisions regarding eligibility, access and entitlements. These shifts have, at times, created confusion about whether the TAC's coverage or responsibilities have changed. They have not.

The TAC supports clients who use both schemes and continues to reaffirm their entitlements to treatment, rehabilitation and compensation, especially as further NDIS policy changes take effect.

Mutual clients with pre-existing conditions, multiple injuries, or evolving care needs may interact with both schemes over time. Without clear coordination, this can result in:

- delays in accessing essential supports
- duplication of assessments and administrative processes
- uncertainty regarding eligibility and funding responsibility
- increased reliance on the client to coordinate their own care across systems.

In addition, the TAC and NDIS operate separate provider registration systems, which can affect service continuity for shared clients.

Providers delivering certain disability services to a TAC client with a disability must be registered with the Social Services Regulator (SSR), as required under [SSR legislation](#).

If a client wants to use their existing NDIS disability services provider for TAC-funded supports, that provider must first register with the SSR which typically takes 60-90 days. The dual registration requirement may also discourage providers from working across both schemes, reducing the options available to TAC clients.

## Impacts of NDIS reforms

Amendments to the NDIS Act do not alter the TAC's statutory obligations, nor affect the entitlements of a person who is eligible for TAC support.



However, the TAC acknowledges that the operationalisation of NDIS reforms has made existing challenges more pronounced for TAC clients. Reforms to the NDIS and the National Disability Insurance Agency (NDIA), while aimed at improving financial sustainability of the NDIS, have changed the practical environment in which some TAC clients interact with both schemes.

- **Changes to access criteria** have resulted in some individuals no longer qualifying for NDIS and changes to the definition of NDIS support may have resulted in participants receiving reduced packages.
- **Changes to more clearly define the scope of “reasonable and necessary supports”** have emphasised the overlaps in TAC and NDIS support types, making it harder to determine which scheme is responsible for what support.
- **NDIS’ evidentiary and administrative requirements** differ from the TAC’s, creating complexity and ambiguity at the interface between the two schemes.

These changes have, in some cases, created pressure where support needs remain and responsibility between schemes is still being worked through. Clients can find this process confusing and disruptive, especially when supports they previously received are no longer available to them.

Importantly, these are operational and interface challenges. They do not reflect a change in what the TAC is obligated to provide, nor do they represent a new category of risk to scheme integrity. The TAC’s obligations to injured people remain defined by the Act, and the TAC continues to administer those obligations in line with its requirements.

Several activities are underway to improve and strengthen the engagement and collaboration between the TAC and NDIA, outlined in the ‘Continuous improvement’ section.

## Collecting and sharing information

The TAC collects personal and health information so it can assess and manage transport accident claims, as required under the Act. All information is managed in accordance with the information privacy principles under the [Privacy and Data Protection Act 2014](#) and health privacy principles under the [Health Records Act 2001](#).

When a person lodges a TAC claim, they sign an [Authority to Release Information form](#). This gives the TAC permission to collect and share relevant personal and health information from medical and other service providers, employers, Medicare, the NDIA, and other organisations involved in their care. This helps reduce the burden on clients and ensures decisions are based on accurate, up-to-date information, although delays can occur if providers are slow to respond or clients decline consent.

The TAC also shares relevant information with WorkSafe when lawful and required, using information-sharing powers available under legislation, to ensure people are not compensated twice for the same injury.

To support people who use both TAC and NDIS services, the TAC has an information-sharing Memorandum of Understanding (‘MOU’) with the NDIA. This sets out when information can be exchanged lawfully and safely.



Under this arrangement, the NDIA submits formal requests for information, and the TAC responds within 30 days. The MOU, established in 2018, is currently being reviewed to make the process clearer, more efficient, and better aligned with each scheme's legislation and privacy obligations. The aim is to ensure that only necessary information is shared and that clients experience a smoother, more coordinated process.

When the TAC needs information from the NDIA, it provides a signed General Authority to Release information form. NDIS participants can decline to provide consent, and this is common. In these cases, TAC may seek new clinical information from service providers before it can determine liability for conditions. This can contribute to delays in decision making.

The TAC also has an Information Sharing Protocol with the NDIS Quality and Safeguards Commission, created in 2020. This supports lawful information exchange to regulate shared service providers and protect vulnerable clients.

The TAC and the NDIS Quality and Safeguards Commission are working together to develop an MOU to ensure coordinated oversight and safety across services funded by both schemes.

The TAC sees no unreasonable legal barriers in sharing information with the NDIA in relation to claims decision-making or timeliness. However, coordination between the TAC and the NDIS can always be improved. While the TAC strongly supports robust privacy protections, current settings can:

- impede timely decision-making
- require duplicative assessments and documentation
- limit the ability of agencies to take a coordinated, whole-of-person approach.

This can result in inefficiencies across the system and a poorer experience for clients, who are often required to repeatedly provide the same information to different agencies.



## CASE STUDY

### TAC and NDIS mutual clients

While the situations of TAC and NDIS clients vary depending on their individual circumstances, the following example illustrates how both schemes can work well together when responsibilities are clear.

An individual lodged a new TAC claim after sustaining a left femur injury in a transport accident. Before the accident, the client was already an NDIS participant with diagnoses of nonverbal autism and epileptic seizures. Their existing NDIS plan funded assistance with daily activities, transport, occupational therapy, speech therapy, and domestic support.

Following the transport accident, the client experienced reduced mobility which increased their day-to-day care needs beyond what their NDIS plan covered. Because the additional support needs were directly related to the transport accident injury, the TAC assessed the situation and approved dual funding on a short-term basis.

The TAC agreed to temporarily fund the increased level of services required while the client recovers from the femur injury. Once the accident-related mobility issues are resolved, the expectation is that the client will return to solely accessing their NDIS supports.



## CONTINUOUS IMPROVEMENT

A number of forums have been established to further strengthen TAC and NDIA collaboration and engagement:

- NDIA and TAC Senior Executive meeting – drives strategic engagement and governance between TAC and NDIA senior leaders on policy and practice interface. Meets quarterly.
- Senior Leadership Group (SLG) meeting – identifies, considers and agrees on resolutions where systemic legislative, policy, regulatory and practice issues arise. Meets every second month.
- Operational Working Group meeting – responsible for co-designing processes to clarify liability and funding for mutual clients, for endorsement by SLG. Meets monthly.

These forums strengthen the working relationship between the TAC and NDIA and provide a regular mechanism to raise and resolve issues. Participants from both organisations have built strong connections that enable timely resolution of operational matters and help progress strategic initiatives.

The maturity of the TAC's engagement with the NDIA reflects a foundation built over more than a decade. In the early years of the NDIA, geographical co-location between TAC and NDIA employees in Geelong helped create the conditions for genuine collaboration, and that relational foundation has endured.

Looking ahead, the TAC considers further opportunities to continue improving alignment between the NDIA and state-based compensation schemes, and is committed to pursuing the following objectives:

- Clearer and more consistently applied boundaries of responsibility, supported by updated national guidance.
- Stronger inter-agency coordination mechanisms, including formally agreed mutual client pathways for resolving complex or disputed cases in a timely manner. This includes the ability to determine which scheme is liable for what conditions. Work on this is underway.
- Improved information sharing arrangements, enabled by streamlined consent processes and clearer legislative frameworks. This is being addressed through the current review of the existing TAC and NDIA Information Sharing MOU.
- Greater alignment of evidentiary requirements to reduce duplication and ability to share relevant information to reduce duplication and administrative burden.
- Ongoing, structured engagement between jurisdictions, to ensure reforms to one system do not have unintended consequences for another.



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