Rehabilitation Standards for CTP Insurers

Updated 1 February 2020

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This document comprises explanatory notes and Rehabilitation Standards A to E. The Rehabilitation Standards were revised on 1 February 2020 and the revisions are effective from this date. The Rehabilitation Standards apply to claims made under the *Motor Accident Insurance Act 1994 (Qld)* and should be read in conjunction with this Act.

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Explanatory Notes

1. Introduction

One of the aims of the *Motor Accident Insurance Act 1994 (Qld)* (MAI Act) is *"to promote and encourage, as far as practicable, the rehabilitation of claimants who sustain personal injury because of motor vehicle accidents"*. The MAI Act places obligations on compulsory third party (CTP) insurers to fund reasonable and appropriate rehabilitation as part of claims management once liability has been admitted or the insurer has agreed to fund rehabilitation services without making an admission of liability.

The Motor Accident Insurance Commission (MAIC), in its role as scheme regulator, has the legislative responsibility to monitor the scheme in terms of CTP insurers' compliance with the MAI Act. The *Motor Accident Insurance Regulation 2018 (MAI Regulation)* Schedule 4, Part 2, section 4 provides authority for MAIC to issue rehabilitation standards and guidelines for insurers to:

A. Provide for the assessment of the nature and extent of an injured claimant's need for rehabilitation.

B. Ensure that injured claimants are properly informed about their obligations to undertake appropriate medical treatment and rehabilitation programs.

C. Facilitate access to appropriate rehabilitation services for injured claimants.

D. Provide guidance to help insurers decide what rehabilitation services and costs of the services are reasonable and appropriate.

E. Ensure the rehabilitation process for an injured claimant is appropriately managed.

F. Monitor the effectiveness of rehabilitation services and the providers of rehabilitation services.

MAIC, in consultation with stakeholders, developed Rehabilitation Standards A to E in order to:

- promote best practice rehabilitation of people injured in motor vehicle accidents;
- encourage a culture of continuous improvement amongst CTP insurers in meeting their rehabilitation obligations;
- provide a framework for comparison of insurer performance and insurer legislative compliance; and

- support a consistent approach to rehabilitation across the scheme.

2. Overarching principles

The Rehabilitation Standards are guided by the following overarching principles:

Rehabilitation Standards Overarching Principles	
Principle 1	Rehabilitation is an integral part of CTP insurers' claims management processes.
Principle 2	The aim of rehabilitation is to optimise recovery of people injured in motor vehicle accidents.
Principle 3	Intervention is evidence-based, timely and appropriate for the injury.
Principle 4	Effective communication and cooperation between claimants, treating practitioners, insurers, rehabilitation advisors, lawyers and other parties involved, occurs throughout the continuum of the claim from injury to recovery or claims settlement.
Principle 5	The rehabilitation process is supported by expertise from treating medical practitioners to validate the relationship of the injury to the motor vehicle accident, and to provide diagnosis and rehabilitation recommendations. MAIC recognises that best practice rehabilitation is underpinned by a biopsychosocial model of health. An evidenced-based, biopsychosocial rehabilitation approach often requires a number of specialised medical and/or allied health treatment providers working in coordination with the claimant to maximise health outcomes.
Principle 6	Balance is maintained between: (i) the provision of an appropriate level of rehabilitation to achieve improved quality of life outcomes for claimants, and (ii) community affordability of the CTP insurance scheme.

Rehabilitation Standards Overarching Principles	
Principle 7	A distinction is made between: (i) the rehabilitation process, which is focussed on optimising the claimant's recovery, and (ii) the medico-legal process, where medico-legal experts assess the overall consequences of a person's injuries for the purpose of formulating the damages likely to be recovered in a claim.
Principle 8	All parties strive to resolve rehabilitation disputes using a fair and transparent process.

Alignment with the Clinical Framework for the Delivery of Health Services

Rehabilitation in the Queensland CTP insurance scheme is in line with guiding principles set out in the *Clinical Framework for the Delivery of Health Services*, as developed by the Transport Accident Commission and WorkSafe Victoria.

Endorsed by MAIC and widely supported by compensable bodies and Australian allied health professional associations, this clinical framework outlines five principles to guide the delivery of health services:

Clinial Framework for the Delivery of Health Services Guiding Principles	
Principle 1	Measure and demonstrate the effectiveness of treatment.
Principle 2	Adopt a biopsychosocial approach.
Principle 3	Empower the injured person to manage their injury.
Principle 4	Implement goals focused on optimising function, participation and return to work.
Principle 5	Base treatment on the best available research evidence.

The framework's guiding principles seek to facilitate treatment strategies which result in the best possible health and functional outcomes for claimants.

3. Role of stakeholders

Claimant

The claimant's involvement in the rehabilitation process is essential if they are to maximise the opportunities provided by rehabilitation intervention. A claimant has a duty to mitigate their loss, which includes taking all reasonable steps to make an effort to recover from their injuries and return to normal activities, such as work, as soon as practicable. The claimant may also cooperate with the insurer to help determine their rehabilitation needs and must notify the insurer when there has been a change of circumstances that may impact on their claim or injury recovery.

CTP insurer

The CTP insurer may make rehabilitation services available to the claimant on the insurer's own initiative or at the claimant's request. Once liability has been admitted on a claim, or the insurer has agreed to fund rehabilitation services without an admission of liability, the insurer must, at the claimant's request, ensure that reasonable and appropriate rehabilitation services are made available.

It is not the insurer's role to develop treatment and rehabilitation plans, but to facilitate the rehabilitation process. The insurer must ensure that its procedures for dealing with rehabilitation services and requests are efficient and cost effective.

There is an expectation that insurers will undertake their own quality assurance activities to ensure compliance with the Rehabilitation Standards.

Claims officer

The CTP insurer's claims officer manages the claim from receipt to finalisation within a common law environment, and this role may include the assessment of whether rehabilitation requests are reasonable and appropriate. It is therefore essential that the claims officer has sufficient training in injury recovery and rehabilitation, applies decision-making in a consistent manner and has access to a health professional as a resource when required.

Rehabilitation advisor (or injury management advisor)

CTP insurers employ permanent or contract health professionals in an advisory capacity to assist the insurer in fulfilling its rehabilitation obligations to claimants. Their role includes providing a point of contact for the claimant and treatment providers, facilitating assessment and access to appropriate services, and assisting in determining whether requests to fund rehabilitation are reasonable and appropriate. The injury management advisor may make direct contact with a claimant to investigate the need to provide rehabilitation, to assist with the establishment of

reasonable and appropriate rehabilitation treatment, and to measure the effectiveness of ongoing rehabilitation treatment and progress.

The injury management advisor's expertise in injury management allows them to review and assess rehabilitation requests in line with evidenced-based practice and liaise and coordinate with the claimant or their legal representative, rehabilitation service providers and medical practitioners to facilitate an optimal rehabilitation outcome.

Rehabilitation provider

While it is the insurer's role to facilitate rehabilitation, the provider is responsible for the quality and appropriateness of the service provided, which is reliant on a biopsychosocial approach, best available research evidence and a focus on empowering the claimant to manage their injuries.

It is expected that treatment and rehabilitation will also be consistent with the overarching principles in the *Clinical Framework for the Delivery of Health Services*. A thorough assessment that clearly defines any barriers, a personalised plan which is developed in conjunction with the claimant, ongoing objective evaluation of the claimant's progress and communication with the insurer are also essential responsibilities.

In instances where objective evaluation demonstrates limited progress, rehabilitation providers are encouraged to communicate with the insurer and consider alternatives and/ or referral back to the treating medical practitioner. The provider should negotiate and agree fees with the insurer prior to the rehabilitation service being provided, noting that fees should reflect normal market rates for the service provided.

Legal representative

A claimant may choose to have legal representation to assist them with their CTP claim. In respect to rehabilitation, the legal representative should:

- provide timely information to the CTP insurer that will assist their client's access to rehabilitation including rehabilitation and medical reports, as well as any change in their client's circumstances such as return to work status;
- ensure that all rehabilitation information provided by the insurer is passed on to the claimant;
- encourage effective and timely communication between the CTP insurer and their client in relation to rehabilitation;
- assist their clients to access evidenced-based rehabilitation to maximise health outcomes; and

- cooperate and assist the CTP insurer as the insurer evaluates the extent and need of rehabilitation based on the available information.

NIISQ Agency

The National Injury Insurance Scheme Queensland (NIISQ) is a no-fault scheme that provides necessary and reasonable treatment, care and support to those who sustain eligible serious personal injuries in a motor vehicle accident in Queensland, on or after 1 July 2016. The National Injury Insurance Agency, Queensland (NIISQ Agency) administers and pays for the necessary and reasonable treatment care and support for participants in the NIISQ. A person may apply directly to NIISQ or, if they have already made a CTP claim against an insurer, the insurer may make an application on the person's behalf if they believe the person has suffered an eligible injury. CTP claimants who are also participants of NIISQ receive their necessary and reasonable treatment, care and support from NIISQ. Information may be exchanged between the participant, their legal representative (if applicable) NIISQ and the CTP insurer.

4. Defined terms

Rehabilitation is defined in the context of the CTP scheme in its broadest sense. Under the MAI Act, rehabilitation means the use of medical, psychological, physical, social, educational and vocational measures (individually or in combination) to:

- restore, as far as reasonably possible, physical or mental functions lost or impaired through personal injury; and
- optimise, as far as reasonably possible, the quality of life of a person who suffers the loss or impairment of physical or mental functions through personal injury.

Rehabilitation in the Rehabilitation Standards reflects the broad scope of the definition of rehabilitation in the MAI Act, and includes both treatment (medical and allied health) and tertiary rehabilitation services.

Treatment plans are defined as plans completed by single service providers, such as physiotherapists, which outline findings on assessment, treatment provided and future measurable goals. Where a claimant has complex needs that require a coordinated rehabilitation program, tertiary rehabilitation plans are used. A rehabilitation plan outlines a comprehensive assessment and provides an action plan to manage the complex needs of the claimant including care needs, home modifications and equipment requests.

Rehabilitation requests are defined as a request for an insurer to fund reasonable and appropriate rehabilitation costs. Examples include, but are not limited to:

- A request to pre-approve a treatment plan.
- A request to pre-approve a rehabilitation plan.
- A request to reimburse a claimant for pre-approved or non-pre-approved rehabilitation costs.
- A request to pay pre-approved or non-pre-approved rehabilitation costs directly with a provider.

Service provider, rehabilitation provider or ***provider*** in the Rehabilitation Standards means all health professionals who provide a service to claimants whether the service is rehabilitation, treatment or medical intervention.

Claimant means a person who has suffered personal injury because of a motor vehicle accident and by whom or on whose behalf a claim is made and therefore includes the legal representative for those claimants who choose to have a lawyer acting on their behalf.

NIISQ participant means a person who has been accepted by the NIISQ Agency as either an interim or lifetime participant in the scheme.

Days means calendar days.

Date of receipt means day that the request or information is received, irrespective of whether this falls on a work day, weekend or public holiday.

Change of circumstances means where there is an event, activity or decision that impacts on the claim and consequent review of rehabilitation needs. This may include a change in the claimant's health, change in employment status or a change in the liability status.

Rehabilitation Standards

Rehabilitation Standard A

Insurers provide for the assessment of the nature and extent of a claimant's need for rehabilitation.

CTP insurers have in place:

(i) an effective system for screening new claims to assist with the early and accurate identification of claimants who may require rehabilitation; and

(ii) a system in place for re-assessing rehabilitation needs of existing claimants when additional relevant information is received or when there has been a change in the claimant's circumstances.

Rehabilitation Standard A Criteria	
A1	A system is in place which aims to identify claimants who may require rehabilitation.
A2	The screening of new claims is undertaken no later than 10 days following the receipt of a Notice of Accident Claim form. When the medical certificate is not received with the initial Notice of Accident Claim form, it is acceptable to complete the screen within 10 days of receipt of the medical certificate.
A3	The screening process is clearly documented on each file.
A4	There is an effective system in place for the re-assessment of a claimant's rehabilitation needs when additional relevant information is received or there has been a change of circumstance. The re-assessment must occur no later than 10 days of the insurer either: (i) receiving the relevant information, or (ii) becoming aware of the change of circumstance.
A5	A system is in place to identify claimants who may be potential NIISQ participants.

Rehabilitation Standard B

Insurers ensure claimants are properly informed about their obligations to undertake appropriate medical treatment and rehabilitation programs.

Where the CTP insurer has indicated preparedness to meet the reasonable and appropriate cost of rehabilitation, the insurer has a system in place to ensure claimants who have been identified as requiring rehabilitation are informed about their obligations to undertake appropriate medical, treatment and rehabilitation programs.

Rehabilitation Standard B Criteria	
B1	Information is sent to all claimants, for whom the insurer has admitted liability or indicated preparedness to meet the reasonable and appropriate cost of rehabilitation, advising them of their obligation to undertake appropriate medical treatment and rehabilitation, including return to work programs where appropriate. For legally represented claimants, the insurer is to request that the information provided is given directly to the claimant. Information is not required to be sent to a claimant when: (a) the claimant indicates on their Notice of Accident Claim form that they are in a position to settle their claim, and settlement negotiations are commenced; or (b) the claim is made by a party other than the claimant or their representative to recover costs e.g. a workers' compensation insurer or statutory authority recovering costs; or (c) the claim is a dependency claim; or (d) the claim is for reimbursement of funeral expenses; or (e) the claim is only for loss of consortium or loss of servitium; or (f) the claimant has already been accepted as a NIISQ participant.
B2	In order for claimants to be properly informed of their obligations to participate in rehabilitation, claimants are provided with copies of reports and other documentary material on the claimant's medical condition or prospects of rehabilitation within 1 month of receipt by the insurer.

Rehabilitation Standard C

Insurers facilitate access to appropriate rehabilitation services for claimants.

Following the screening and identification of possible rehabilitation needs, and where the CTP insurer has indicated its preparedness to meet the reasonable and appropriate cost of rehabilitation, the insurer undertakes appropriate action to facilitate access to services for injured people. This may include the assignment of staff by the insurer to facilitate the provision and coordination of treatment and rehabilitation.

Claimants identified as requiring services are provided details of who to contact at the insurer and how to contact them.

Rehabilitation Standard C Criteria	
C1	Within 10 days of identifying rehabilitation needs, the insurer undertakes appropriate action to facilitate access to services for claimants. Appropriate action for non-complex injuries may include reviewing and responding to the treatment recommendations outlined in the medical certificate. Appropriate action for complex injuries may include the insurer: (a) gathering further information from treatment providers to clarify rehabilitation needs; (b) referring the file to an internal or contracted health professional for review; (c) making a reasonable attempt to facilitate the claimant's referral to a provider in cases where unmet needs are identified and referral would be potentially beneficial; and (d) considering whether an insurer application to NIISQ would be appropriate, in instances where a potential NIISQ partipant is identified.

Rehabilitation Standard C Criteria	
C2	The insurer ensures: (a) Staff is assigned to take responsibility for meeting the insurer's rehabilitation obligations including acting as a point of contact for all rehabilitation requests and monitoring the rehabilitation process. (b) Claimants who have been identified as requiring rehabilitation services are given useful information about the process for making rehabilitation requests to the insurer including: (i) the role of the assigned staff in relation to rehabilitation; and (ii) the direct contact details of assigned rehabilitation staff. (c) Staff have access to a health professional who has current knowledge of best practice rehabilitation processes whenever necessary.
C3	Claimants are informed of their ability to exercise choice in the selection of an appropriately qualified and experienced service provider whose intervention is supported by the medical evidence.
C4	Potential conflicts of interest, such as a formal relationship between the service provider and the insurer or insurer's contracted staff, are identified and disclosed to the claimant.

Rehabilitation Standard D

Insurers provide guidance to help staff decide what rehabilitation services, and costs of the services, are reasonable and appropriate.

To assist in the determination of rehabilitation requests, the CTP insurer has in place guidelines which are based on objective criteria and which are consistently applied.

Rehabilitation Standard D Criteria	
D1	(a) A system is in place to assist insurer's staff in assessing reasonable and appropriate aspects of rehabilitation requests in a timely manner. The system is consistent with guidance issued by MAIC and includes consideration of: (i) the relationship of the injury to the accident; (ii) best available research evidence in rehabilitation; (iii) expected functional outcomes; and (iv) appropriateness of service provider and reasonableness of service costs. (b) Reasonable steps are taken by the insurer to ensure ongoing training is provided to claims staff regarding: (i) their role in relation to meeting the insurer's rehabilitation obligations; and (ii) reasonable and appropriate decision making including application of current, best available research evidence in rehabilitation. (c) The decision-making process is based on objective information and medical evidence and is adequately documented on file. (d) There is demonstrated consistency in decision-making across all the insurer's CTP claims.
D2	(a) Insurers have in place an effective system for handling rehabilitation related complaints and disputes. (b) Where a dispute is unable to be resolved by the insurer in the first instance, claimants are informed of alternative courses of action such as: (i) referral to MAIC for the appointment of a mediator; or (ii) an application to the court.

Rehabilitation Standard E

Insurers ensure the rehabilitation process for claimants is appropriately managed.

Insurers monitor the effectiveness of rehabilitation services and the providers of rehabilitation services.

The insurer has a system in place whereby the rehabilitation process is managed appropriately and effectively by the insurer to deliver outcomes for claimants.

Rehabilitation Standard E Criteria	
E1	A system is established whereby service providers are required to outline specific goals to be achieved during the rehabilitation program within specified timeframes and within reasonable costs. The system should also include regular updates of progress towards the specified goals using objective measures as well as documenting barriers to progress.
E2	The insurer reviews all rehabilitation requests and evaluates them with reference to guidance issued by MAIC in relation to reasonable and appropriate rehabilitation.
E3	The insurer responds in writing to the claimant and provider regarding rehabilitation requests (refer Criteria E6 for home modification requests) within 10 days of receipt, stating whether a rehabilitation request is approved, partially approved or not approved. If further information is required, this is communicated within 10 days of receipt of the original rehabilitation request. Upon receipt of the further information, the insurer must respond in writing to the claimant and provider within 10 days of receipt, stating whether the request is approved, partially approved or not approved.
E4	If the insurer declines a rehabilitation request in full or in part, a clear written explanation is provided to the provider and claimant explaining why the request was not considered reasonable and appropriate, and the details of the decision are documented on file.

Rehabilitation Standard E Criteria	
E5	If an insurer decides to discontinue funding for pre-approved services for reasons other than claim settlement, the insurer must provide prior notice in writing to the provider and claimant including a clear explanation as to why the insurer has discontinued funding for pre-approved services. The insurer must also liaise with the provider in situations where cessation of funding for services could place the claimant at significant risk, to ensure that sufficient time is allowed for alternate arrangements to be made (for example, when ceasing funding for attendant care or psychological treatment).
E6	Home modification requests are acknowledged in writing within 10 days of receipt to the claimant and provider. The insurer must advise the claimant and provider in writing within 3 months of the request whether the request is approved in principle or not approved.
E7	There is a system in place to review at appropriate and regular intervals, the rehabilitation needs of: (a) claimants who have sustained serious injury or serious multi-trauma, during the life of the claim, such as when there has been a change in circumstance or in association with reaching certain milestones; and (b) claimants with other injuries who have been identified as having complex needs or who are at risk of a poor outcome (for example, return to work issues, psychosocial issues or multiple service providers).
E8	Accounts for approved rehabilitation services are processed within 10 days of receipt of a valid invoice.
E9	Claimant requests for reimbursement of rehabilitation expenses following admission of liability, or where the insurer has indicated preparedness to meet the reasonable and appropriate cost of rehabilitation, must be processed within 10 days of the insurer determining they were reasonably and appropriately incurred (refer Criteria E3) provided: (a) the total amount or total accumulated amount is $200 or greater; or (b) if the total amount or total accumulated amount is less than $200, the claimant does not expect to make further requests for reimbursement.