Rehabilitation Standards for CTP Insurers

MOTOR ACCIDENT INSURANCE COMMISSION

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January 2007

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These standards apply to claims made under the *Motor Accident Insurance Act 1994* (MAIA), and are effective from 1 January 2007. These standards should be read in conjunction with the MAIA.

For additional copies of these standards or for enquiries regarding the use of these standards:

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Table of Contents

1. Introduction

One of the aims of the *Motor Accident Insurance Act 1994 (Qld)* (MAIA) is "to promote and encourage, as far as practicable, the rehabilitation of claimants who sustain personal injury because of motor vehicle accidents". The MAIA places obligations on compulsory third party (CTP) insurers to fund reasonable and appropriate rehabilitation as part of claims management.

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 MAIA , particularly the insurers' compliance with their obligations under Part 4 (Claims).

With particular reference to Part 4, Section 51 (Rehabilitation), the 1999 "Review of Queensland Compulsory Third Party Insurance Scheme" recommended the Commission "develop benchmarks and performance standards by which the speed of delivery and effectiveness of rehabilitation can be measured and monitored on an ongoing basis. These benchmarks and performance standards should be related to the scheme overall and to individual insurers." (Recommendation 4.6).

Furthermore, the Commission has the authority as outlined in the *Motor Accident Insurance Regulation 2004 (MAIR)* Schedule 5, Part 2, Section 4, 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; and
(f) monitor the effectiveness of rehabilitation services and the providers of rehabilitation services.

The Commission, in consultation with stakeholders, has developed Rehabilitation Standards A to F in order to review the performance of insurers in terms of compliance with Section 51 of the MAIA, and to ensure insurers' processes are aligned with the provisions of the MAIR.

These standards will:

- provide a framework on which to compare each individual insurer's performance as well as the industry itself;
- promote best practice and further encourage a culture of continuous improvement amongst CTP insurers in meeting their rehabilitation obligations; and
- support a consistent approach to rehabilitation within and between CTP insurers, which will ultimately benefit claimants in this scheme.

2. Principles of rehabilitation in the CTP insurance scheme

1. Rehabilitation is an integral part of CTP insurers' claims management processes.

2. The aim of rehabilitation is to optimise recovery of those injured in motor vehicle accidents.

3. A key principle of best practice rehabilitation is that the intervention is timely and appropriate.

4. The delivery of rehabilitation services within a common law environment can be difficult as the parties in this adversarial environment may define goals differently. It is therefore essential that effective communication and cooperation occur between claimants, treating practitioners, insurers, the legal profession and other parties involved, throughout the continuum from injury to recovery or claims settlement.

5. Rehabilitation within the CTP scheme is based on a medical model where medical information is sought to validate the relationship of the injury to the motor vehicle accident, to define the nature and extent of the injury and to provide rehabilitation recommendations. The medical practitioner, from the outset of completing the medical certificate, is well placed to determine if the treatment proposed is likely to be of benefit and may consider the need for alternative treatment or further investigation if there is limited progress.

6. Balance needs to be maintained between (i) the provision of an appropriate level of rehabilitation to achieve improved quality of life outcomes for injured persons, and (ii) community affordability of the CTP scheme.

7. A distinction needs to be made between (i) the rehabilitation process, which is about optimising the injured person's recovery, and (ii) the medico-legal process, which comes later in the life of a claim when the overall consequences of the person's injuries are assessed by medico-legal experts and used in formulating the damages likely to be recovered.

8. All parties need to strive to resolve disputes on rehabilitation using a transparent and consistently applied process that reinforces the principles of natural justice.

3. Role of stakeholders

Role of the claimant

The claimant's involvement in the rehabilitation process is essential if the claimant is to maximise the opportunities provided by the rehabilitation intervention. There are also legislative obligations placed on the claimant to take all reasonable steps to make a real effort to recover from their injuries and return to normal activities, such as work, as soon as practicable. The claimant must also cooperate with the insurer to determine rehabilitation needs and must notify the insurer when there has been a change of circumstances that may impact on their claim.

Role of the insurer

The insurer is obliged to make rehabilitation services available to a 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 to the claimant. It is not the insurer's role to develop treatment and rehabilitation plans, but to facilitate the rehabilitation process.

Role of the claims officer

The CTP insurer's claims officer manages the claim, including the assessment of whether requests to fund rehabilitation 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.

Role of the rehabilitation adviser/ injury management adviser

CTP insurers may employ permanent or contract health professionals in an advisory capacity to assist the insurer in fulfilling its rehabilitation obligations to claimants. Their role may include 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.

Role of the 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. Quality and appropriateness is reliant on best practice, an evidence-based approach, a thorough assessment that clearly defines barriers and a plan which is developed in conjunction with the claimant to overcome these barriers. Ongoing objective evaluation of the claimant's progress and communication with the insurer are also essential responsibilities.

Role of the legal representative in relation to rehabilitation

A claimant may choose to have legal representation in dealing with the CTP insurer. In respect to rehabilitation, the legal representative should:

- Provide timely information to the CTP insurer that will assist their client's access to rehabilitation. At a minimum, information includes the claim form, medical information, details of treatment already undertaken and any changes in their client's circumstances;
- Ensure there is effective and timely communication between the insurer and their client in relation to rehabilitation; and
- Cooperate with the insurer as the insurer evaluates the extent and need of rehabilitation based on the available information.

4. Explanatory notes

Rehabilitation is defined in the context of the CTP scheme in its broadest sense. Under the MAIA, "rehabilitation" means the individual or combined use of medical, psychological, physical, social, educational and vocational measures:

a) to restore, as far as reasonably possible, physical or mental functions lost or impaired through personal injury; and

b) to 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 these Standards reflects the broad scope of the definition of rehabilitation in the MAIA, and includes both treatment (medical and allied health) and tertiary rehabilitation services.

Plans

(a) **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.

(b) 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.

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

Claimant means a person 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.

Days means calendar days.

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.

5. Standards

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

STANDARD A

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 there has been a change in the claimant's circumstances.

Standard A Criteria	
Criteria 1	A system is in place which aims to identify claimants who may require rehabilitation.
Criteria 2	The screening of new claims is undertaken no later than 14 days following the receipt of a Notice of Accident Claim form. When the medical certificate is not received with the initial Notice, it is acceptable to complete the screen within 14 days of receipt of the medical certificate.
Criteria 3	The screening process is clearly documented on each file.
Criteria 4	There is a system in place where a claimant's rehabilitation needs can be re-assessed: **o** when additional relevant information is received, or **o** when there has been a change of circumstance.

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

STANDARD B

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.

Standard B Criteria

Criteria 1	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. Information is not required to be sent to a claimant when: • 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; • the claim is made by a party other than the injured person or their representative to recover costs e.g. a workers compensation insurer or statutory authority recovering costs; • the claim is a dependency claim; • the claim is for reimbursement of funeral expenses; or • the claim is only for loss of consortium or loss of servitium.
Criteria 2	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.

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

STANDARD

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 claimants. 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 advised who to contact at the insurer and how to contact them.

Standard C Criteria	
Criteria 1	Within 14 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: • gathering further information from treatment providers to clarify rehabilitation needs; • referring the file to an internal or contracted health professional for review; or • 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.
Criteria 2	(2.1) The insurer assigns staff with the responsibility for meeting the insurer's rehabilitation obligations including acting as a point of contact for all rehabilitation requests and monitoring the rehabilitation process. (2.2) Information is sent to claimants who have been identified as requiring rehabilitation services on the role of the assigned staff in relation to rehabilitation and how to contact them. (2.3) The insurer takes reasonable steps to ensure their staff have access to a health professional who has current knowledge of best practice rehabilitation processes whenever necessary.
Criteria 3	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.
Criteria 4	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.

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

STANDARD D

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.

Standard D Criteria	
Criteria 1	(1.1) A system is in place to assist insurer's staff in assessing reasonable and appropriate aspects of rehabilitation requests. (1.2) Reasonable steps are taken by the insurer to ensure training is provided to claims staff regarding their role in relation to meeting the insurer's rehabilitation obligations as well as the application of guidelines. (1.3) The decision-making process is based on objective information and medical evidence and is adequately documented on file. (1.4) There is demonstrated consistency in decision-making across all the insurer's CTP claims.
Criteria 2	(2.1) Where disputes or complaints about rehabilitation arise, insurers will endeavour to resolve these issues internally. (2.2) Where the dispute is unable to be resolved, claimants are informed of alternative courses of action such as the appointment by MAIC of a mediator to help resolve the dispute or an application to the court.

Section E: Ensure the rehabilitation process for an injured claimant is appropriately managed; and

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

STANDARD

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

Standard E & F Criteria	
Criteria 1	A system is established whereby service providers are required to outline specific goals to be achieved during the rehabilitation program within specified timeframes and costs. The system should also include regular updates on progress towards the specified goals using objective measures as well as documenting barriers to progress.
Criteria 2	The insurer reviews treatment and rehabilitation plans, progress reports, accounts which have not been pre-approved, and other requests for rehabilitation, and evaluates them considering the reasonable and appropriate guidelines in making funding decisions.
Criteria 3	The insurer responds in writing to the claimant and provider regarding rehabilitation requests* within 10 days of receipt, stating whether they are approved, not approved, partially approved or further information is required to consider the requests. *for home modification requests see criteria #6
Criteria 4	If the insurer declines the plan in full or part, an explanation is provided to the provider and claimant in writing and the reasons are documented on file.
Criteria 5	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 an explanation as to why the insurer has terminated payment. 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).
Criteria 6	Home modification requests are acknowledged in writing within 10 days 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 rejected.
Criteria 7	There is a system in place to review at appropriate intervals, the rehabilitation needs of: (7.1) Claimants who have sustained serious injury such as spinal cord injury, acquired brain 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 (7.2) 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).

Standard E & F Criteria Continued

Criteria 8	Accounts for pre-approved rehabilitation services are processed within 21 days of receipt of valid invoices.
Criteria 9	Following admission of liability, reimbursement of the claimant's rehabilitation costs must be processed within 21 days: • of the insurer determining they were reasonably and appropriately incurred, and • if the total amount is $200 or greater, or • if the total amount is less than $200 and the claimant does not expect to make further requests for reimbursement.