A guide for

Rehabilitation Providers

to providing treatment in the NSW Motor Accidents Scheme
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1. Introduction

This guide was developed by the Motor Accidents Authority (MAA) to facilitate effective communication between rehabilitation providers and insurers to ensure people injured in motor vehicle accidents obtain appropriate, cost effective treatment leading to the best possible outcomes. This guide will also facilitate timely approval of services and payment of accounts.

It was developed in conjunction with Compulsory Third Party (CTP) insurers, the Australian Society of Rehabilitation Counsellors, the Australian Rehabilitation Providers Association, the Australian Physiotherapy Association, The Chiropractors’ Association of Australia NSW, Osteopathy Australia, Australian Psychology Association and Exercise and Sport Science Association.

This guide is designed primarily for rehabilitation providers who provide services to injured people under the NSW Motor Accidents Scheme, but can also be used by insurance staff in their decision making processes.

The guide will:

- outline the principles for rehabilitation provider services
- describe what is considered to be reasonable and necessary treatment
- explain the role of rehabilitation providers in the scheme
- provide guidance for completing the forms for requesting services
- give details about the payment of accounts and release of information
- explain how to solve problems and manage disagreements with insurers.

2. Principles of treatment

All health professionals should apply the nationally endorsed Clinical framework for the delivery of health services when treating people injured in motor vehicle accidents. The five principles of the clinical framework that ensure injured people receive the right care at the right time are:

- measure and demonstrate the effectiveness of treatment
- adopt a biopsychosocial approach
- empower the injured person to manage their injury
- implement goals focused on optimising function, participation and return to work
- base treatment on the best available research evidence.

The clinical framework has been established to:

- optimise participation at home, work and in the community, and to achieve the best possible health outcomes for injured people
- inform healthcare professionals of our expectations for managing injured people
- provide a set of guiding principles for the provision of healthcare services for injured people, healthcare professionals and decision makers
- ensure the provision of healthcare services that are goal oriented, evidence based and clinically justified
- assist in the resolution of disputes.

Evidence of the incorporation of these principles is expected of all rehabilitation provider services. A copy of the Clinical framework for the delivery of health services is available at www.tac.vic.gov.au/files-to-move/media/upload/clinical-framework-single.pdf.

3. The Compulsory Third Party Scheme

Compulsory Third Party (CTP) insurance protects vehicle owners when the driver of their vehicle is at fault in a motor accident that causes injury to others. The CTP insurer is obliged to manage the claims of people injured in a...
crash caused by the driver of a vehicle they have insured. Not all people injured in motor vehicle accidents are covered under the NSW CTP scheme. Therefore it’s necessary to determine the injured person’s compensation status and to identify the relevant insurer.

**How to check claim details**
A person injured in a motor vehicle accident caused, or mainly caused, by the fault of another driver, can seek compensation from the CTP insurer of the vehicle at fault. It is important to check whether the injured person has submitted an Accident Notification Form (ANF) or a Personal Injury Claim Form (PICF). If not, you can advise them to attend their medical practitioner or seek advice from the MAA Claims Advisory Service on 1300 656 919.

**If an Accident Notification Form has been submitted**
From April 2010, anyone injured in a motor vehicle accident in NSW regardless of who was at fault may be able to access the benefits available under the ANF.

The ANF provides for the early payment of ‘reasonable and necessary’ medical expenses and/or lost earnings up to a maximum of $5,000. The insurer will automatically accept provisional liability for the ANF for injured passengers and pedestrians. This does not affect the person’s entitlement to make a full claim for compensation up to six months after the accident; however the injured person may not be eligible to make a claim if they were the driver completely at fault.

To be eligible to access the benefits available, the injured person needs to submit their ANF within 28 days of the accident. It is important the injured person lodges the ANF as soon as possible after their accident. The ANF is available from medical practitioners, the MAA and insurers. A medical certificate that is signed by the medical practitioner must also be included.

If an ANF has been submitted, the insurer will advise the injured person whether it will admit provisional liability within 10 days. An admission of provisional liability means that the insurer is obliged to pay for reasonable and necessary treatment expenses and past lost earnings up to a combined total of $5,000. This includes all medical, x-ray, pharmaceutical and other treatment expenses.

Insurers pay accounts in the order they are received, not necessarily in the order that treatments were provided. Therefore, early submission of accounts is recommended to ensure payment. Check with the injured person about other medical expenses they have incurred.

Agreement by the insurer to pay accounts under the ANF is not an admission of liability for the claim or an agreement to pay for any future expenses.

**If a Personal Injury Claim Form has been submitted**
If the injured person is unable to complete and lodge an ANF within 28 days of the accident or their claim is likely to exceed $5,000, they should contact the insurer to obtain a Personal Injury Claim Form. They have six months following their accident to lodge a Personal Injury Claim Form with the CTP insurer but it is important that it is lodged as soon as possible.

Depending on the circumstance of the accident, the injured person may be entitled to compensation that includes:
- ‘reasonable and necessary’ medical, pharmaceutical, rehabilitation, respite care and attendant care expenses
- other expenses and economic losses, for example loss of income and out of pocket expenses
- non-economic loss, such as payment for their pain and suffering if they have a serious, permanent injury.

4. Reasonable and necessary treatment

Under the Motor Accidents Compensation Act 1999, insurers are only obliged to pay for treatment that is ‘reasonable and necessary’. Insurers consider a number of factors when deciding whether requests are ‘reasonable and necessary’ and providers should consider the same factors when requesting services. More information is available in the publication A provider’s guide to decisions on reasonable and necessary treatment, rehabilitation and attendant care. Copies can be downloaded from the MAA website at www.maa.nsw.gov.au or requested by phoning the MAA on 1300 137 131.

The ‘reasonable and necessary’ criteria are:

**Relationship to accident**
- Is there sufficient evidence to demonstrate that services relate to the injuries sustained as a result of the accident?

**Benefit to claimant**
- What information or benefit will be gained by the proposed service?

** Appropriateness of service**
- Is the proposed service appropriate for the injuries? Could other services be considered more appropriate?

** Appropriateness of provider**
- Is the proposed provider qualified and appropriately experienced to deliver this service?

**Cost considerations**
- Is the cost comparable to those charged by similar providers or can other services achieve comparable outcomes?

5. Rehabilitation provider services

The majority of people injured in motor vehicle accidents receiving benefits through the CTP Scheme will recover well with treatment provided by single or a combination of health service providers. However, some injured people may be referred for additional services from a rehabilitation provider to:

- assess or review the injured person’s rehabilitation needs
- recommend or plan for appropriate services for the injured person
- assist the injured person to identify and achieve their goals
- empower the injured person to manage their injury and recovery
- link the injured person to the services they need
- facilitate communication between all parties involved in the injured person’s rehabilitation
- support the injured person to stay at, or return to work while they recover
- assist the injured person to maintain or recommence usual home and community activities
- monitor the appropriateness and progress of services being provided.

Rehabilitation provider services:
- should be provided by someone other than a primary treating therapist. However, in some cases it may be appropriate for a therapist to perform certain rehabilitation provider tasks. For example, in rural and remote regions the rehabilitation provider may also be the treating occupational therapist
- should not be provided by an employee of the CTP insurer, solicitor, attendant care provider, family member or guardian
- do not include advocating for the injured person in relation to the management of their claim, litigation or other compensation processes
- are not for providing or recommending services that are not related to the injuries sustained in the motor vehicle accident.

The expectation for rehabilitation provider services for each person should be discussed with the insurer and the injured person at the time of referral.
6. Providing rehabilitation provider services

Referral for rehabilitation provider services will usually be initiated by the CTP insurer making contact with the provider. In some cases a referral may come from another avenue. If a rehabilitation provider receives a referral from another source and realises that the injured person has a CTP claim, they should contact the insurer as soon as possible to discuss the injury management of the claimant.

Rehabilitation providers must always get approval from the CTP insurer before providing services, including initial assessment, to ensure accounts will be paid.

Communicating with the insurer

Communication can be different between and within insurers, and depending on the circumstances of each case. The rehabilitation provider may speak with claims officers or rehabilitation advisors/injury management advisors, or both, regarding the injured person. It is beneficial to determine the method and frequency of communication with the insurer at the outset.

The Rehabilitation Services report provides the framework for documenting the rehabilitation provider’s observations, findings and recommendations to the insurer. However, rehabilitation providers should contact the insurer by phone to discuss the case whenever there are extenuating circumstances, complex issues or urgent needs. In some cases the insurer may request additional information such as progress or updates between Rehabilitation Services reports or other communication about the injured person. It may be appropriate to determine if payment is applicable for these communications.

Receiving a referral

The insurer may make a referral for:
- an assessment only, specifying the issues to be addressed (for example, treatment needs review, workplace assessment or care needs assessment) and a summary of recommendations
- an assessment and rehabilitation plan when it is apparent services will be required.

Once a referral has been received, the rehabilitation provider may want to contact the insurer with any questions about the referral. The insurer may also have additional information available that is relevant to the referral.

Initial rehabilitation provider contact

After conducting the initial assessment with the injured person, the rehabilitation provider should contact the insurer to discuss the findings. It may be appropriate to explain the expected goals, timeframes and recommended services. This initial contact is important to enable collaboration and alignment for any proposed rehabilitation plan requests.

Rehabilitation providers should then submit a Rehabilitation Service report to the CTP insurer. The assessment section of the report should include the findings of the assessment according to the referral. If a rehabilitation plan is not required then the rehabilitation provider can simply submit the report to the CTP insurer as an assessment report only.

Rehabilitation planning, goal setting and requesting services

If a rehabilitation plan is required for ongoing services, then the planning/goal setting/service request section of the Rehabilitation Services report should also completed.

The plan period should be no more than 12 weeks unless previously agreed by the insurer. Plans may be for a shorter period if appropriate to the goal/s and if agreed by the insurer.

A rehabilitation plan must:
• include SMART goals that focus on function at the activity or participation level\(^1\), and that are consistent with pre-injury roles (where participation has changed due to injury/ies from the motor vehicle accident). Where possible, the goals and steps should be generated by the injured person

• include the steps the injured person is expected to achieve toward each goal (during the plan period). A step is an activity or behaviour that the injured person needs to do to achieve the goal; for example, to achieve the overall return to work goal (which may carry over several plan periods) the injured person may need to achieve two steps: be able to walk 200 metres unassisted, and manage their anxiety at home in a particular plan

• describe the service provider’s action plan. This will include the rehabilitation provider’s proposed actions (where they are specific to a particular goal/step), as well as the plans of other health service providers, such as physiotherapists or psychologists. When the action plan refers to services being delivered by others, it is sufficient to reference that the request is to be provided directly for example, ‘physiotherapist request (notice of commencement (NOC) or review form)’

• describe the injured person’s action plan for each goal/step; for example, participate in home exercise program and keep a record of attendance at therapy

• include the rehabilitation provider services that are required to facilitate the rehabilitation plan, but not directly related to a specific goal/step; for example report writing, provider travel or case conferencing.

The rehabilitation provider should ensure that the injured person and all other health service providers involved are aware of, and striving for, the same goals. To confirm this, the rehabilitation provider can complete the standard Agreed Rehabilitation Goals form letter and send it out to all parties once the plan has been approved by the insurer.

• At times it may be appropriate to include a goal that appears to be unrealistic or is addressing therapy/impairment level goal\(^2\) in order to engage the injured person in the rehabilitation plan. Alternatively an injured person may be unable or unwilling to identify or prioritise a goal for all domains. If so, the rehabilitation provider is expected to provide additional information to explain their clinical reasoning and management strategy.
  o For example, the rehabilitation provider should explain they are aware the injured person has set an unrealistic timeframe for goal achievement but plans to work with them during this plan period to adjust to injury and set a more realistic timeframe.
  o If the rehabilitation provider has included a therapy/impairment level goal, the clinical justification could be that it is appropriate to the stage of recovery but that the rehabilitation provider will work with the injured person to develop a more functional (activity or participation level) goal during the plan period.
  o If the injured person has not yet identified a goal, the rehabilitation provider may report that the recovery toward goal/s that have been included will have transferable skill application and that the rehabilitation provider is working with the injured person to develop a goal for this domain. Alternatively if the injured person is unable or unwilling to develop a goal, the rehabilitation provider will need to contact the insurer to discuss the best approach.

**Insurer’s review of rehabilitation plans**

The insurer will use the information provided in the Rehabilitation Services report and plan to decide whether proposed services are ‘reasonable and necessary’. They may contact the rehabilitation provider to discuss the plan or request additional information or clarification.

The insurer should provide feedback about the acceptability of the plan within 10 working days. If the rehabilitation provider has not received a response within this timeframe they should contact the insurer. They should always ensure they have approval before proceeding, and should discuss options for payment with the injured person in cases where treatment proceeds without approval from the insurer.

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\(^1\) Refer to “Completing the Rehabilitation Services form”, section 7 for more information on what an activity/participation level goal is.

\(^2\) Refer to “Completing the Rehabilitation Services form”, section 7 for more information on what an impairment level goal is.
If the insurer considers the plan or components of the plan not ‘reasonable and necessary’, they are to provide written feedback clearly explaining why they have not approved or only partially approved services within 20 working days of receipt of the rehabilitation plan.

Case closure
The insurer may require a case closure report when:
- the injured person’s goals have been achieved
- the injured person has made significant progress and is now able to independently manage their recovery
- the injury has stabilised and further treatment is not indicated
- the claim is approaching settlement
- services are not of benefit
- the injured person has not complied with the rehabilitation plan they have agreed to.

If requested by the insurer, sections 1-6 of the Rehabilitation Services report may be used as a case closure report. The rehabilitation provider will need to check with the insurer to confirm the requirement and payment for a case closure report.

7. Completing the Rehabilitation Services form

The Rehabilitation Services report has been designed for use by rehabilitation providers. The form can be used for:

Assessment/progress report/case closure
Sections 1 to 6 of the Rehabilitation Service form should be used to report on the assessment of the injured person, according to the reason for the referral, and should include a summary of recommendations. It is also used to report on progress from an earlier rehabilitation plan, and can act as a case closure report.

Planning, goal setting and requesting for services
Sections 7 to 8 of the Rehabilitation Services form detail the injured person’s goals, the steps to achieve the goals, the services required to facilitate goal achievement, and the injured person’s actions towards their goals.

If the referral from the insurer is for assessment only, only sections 1 to 6 should be completed. The provider can delete sections 7, 8 and 10 of the form and complete section 9 which includes signature and contact details. If an assessment and rehabilitation plan, or progress report and new rehabilitation plan is required, the entire form should be completed.

The form can be downloaded and saved for individual use as an editable form from the MAA website at [www.maa.nsw.gov.au](http://www.maa.nsw.gov.au). Call the MAA for assistance on 1300 137 101.

The following outlines the information to be included in each section of the form (see the samples in Appendix A).

Header
- Page 1 header: include date of this report and rehabilitation plan number (if relevant) – this information will auto populate to subsequent headers
- Tick the type of rehabilitation service report; select from the following options:
  - assessment report only
  - assessment report and rehabilitation plan
  - progress report only (where the provider has reviewed the outcome of the rehabilitation plan and no further rehabilitation services are required)
  - progress report and new rehabilitation plan
- Provider name and name of the practice (if relevant)
Section one – injured person’s details
- Make sure the person’s details are correct.
- Ensure the insurer, claim number and date of injury are correct.

Section two – reason for this referral
- Briefly describe the purpose of the referral as discussed with the insurer.

Section three – background information
- Provide an overview of the injured person’s history, only including information that is additional to that provided in the referral.
- This section will be more detailed for initial assessment reports.
- Subsequent progress reports need only include updates or new information.
- Describe any pre-existing factors relevant to the compensable injury.

Section four – assessment
- Include the date or dates the assessment took place.
- Describe the location or situation where the assessment took place; for example, at home with spouse, at work with employer present.
- List the other people involved in the assessment; for example, family members or work colleagues.
- Provide the diagnosis or injury and its source. For example, medical report, insurer referral, etc. Note if there are different or conflicting diagnoses or injuries described in reports about the injured person.
- List all medications the person has prescribed including dosage, frequency and reported benefit. Note if there are different or conflicting medications or compliance issues. Only include this information if it is relevant to the injured person’s capacity and/or rehabilitation plan.
- Current status – provide a general description of the injured person’s presentation at the assessment.
- Impairment level information – report on the relevant impairment level physical or personal factors. Only report on factors that are relevant to the injured person’s restriction from their injury/ies. For the factors that are appropriate, name the factor, for example pain, range of motion or depression and include information about their pre-injury status. In ‘current status’ advise on reported and observed ability and include appropriate objective measures. For example:
  - physical – may include reporting on how their sitting tolerance has changed subsequent to the injury or if their pre-injury coping strategy may impact on the rehabilitation plan.
- Environment information – report on the relevant work or home environment factors. Only report on factors that are relevant to the injured person’s restriction from their injury/ies. For appropriate factors, name the factor (for example, work role and environment or description of the home environment) and include information about pre-injury status. In ‘current status’ advise on reported and observed ability and include appropriate objective measures. For example:
  - work – may include reporting pre-injury role and current work role
  - environmental – may include brief information about the injured person’s home (size) and household makeup (number and age of residents).
- Provide an overview of the treatment or therapy received to date. Provide a total number of sessions to date for each service. Include any surgical or medical interventions, as well as allied health or non-traditional therapies. Give an opinion on current treatment (if there is a treatment program in place) and its benefit.
- When the treatment overview is completed in a progress report, report on the services that were listed as part of the ‘service provider actions’ for the goals/steps in the previous plan. Note if the approved services were provided as planned and the treatment outcomes (referring to objective measures if used by the therapist). Do not include capacity change in this table as it is captured in section five, ‘capacity’.

Section five – capacity
In the capacity summary table, tick the areas/domains where the injury/ies is impacting upon the injured person’s capacity at the time of this report. Use the blank spaces to include areas not listed in the boxes. An injured person may have several areas/domains that the injury is impacting and need describing in the report.

This section is for reporting on capacity at the activity and participation level; for example, an activity level could be, ‘ability to lift and carry heavy objects,’ and participation level, ‘to be able to perform role at work as a store person.’

Complete the table for each identified domain or area of capacity impacted by the injury. For each, report on:

- domain or the actual task that has reduced capacity due to the injury
- pre-injury capacity for the area along with any relevant contextual information (for example, the injured person may have managed the household cleaning of a small, three-bedroom house (the details of which are provided in section four, ‘environment information,’ of the report)
- progress in capacity during the last plan (note: only to be completed in a progress report). Specify how the injured person’s capacity has changed during the plan period and also if the steps or goals were achieved/partially achieved/not achieved as a result of the services in the plan. If services were not provided as planned, information on this is provided in section four, ‘treatment overview’ of the report
- current capacity, describing function at time of progress review and areas of strength
- barriers or restrictions; include biopsychosocial flags identified or environmental restrictions
- comments or any additional observations
- recommendations for what is needed to return to pre-injury capacity (if possible).

Repeat the table for each domain.

**Section six – recommendations**

Summarise all recommendations into key areas of need. For example, if physiotherapy is required to enable improvement in all areas note physiotherapy required for A, B and C.

**For assessment report or progress report only: delete sections 7, 8 and 10 of the form and complete section 9, which includes signature and contact details. Otherwise, continue with remaining sections.**

**Section seven – work and/or functional goals for this plan period**

- The plan period should be no more than 12 weeks unless previously agreed by the insurer. They may be for a shorter period if appropriate to the goal/s and agreed by the insurer.

- Goals may be longer than the plan period. Steps and actions included for each goal should be for the plan period only. At times it may be appropriate to include a goal that appears to be unrealistic or is addressing a therapy goal/impairment level goal in order to engage the injured person in the rehabilitation. Provide additional information to explain the clinical reasoning in the section entitled ‘additional information to explain the plan’; for example, the rehabilitation provider should explain they are aware that the injured person has set an unrealistic timeframe for goal achievement and that they plan to work with them during this plan period to adjust to injury and set a more realistic timeframe

- Focus on goals that target function (activity or participation) in areas consistent with the injured person’s pre-injury roles and participation which have changed due to injury/ies from the motor vehicle accident. Participation goals are broader and relate to the person’s roles and lifestyle.

- The injured person will not always be able to identify or prioritise a goal for recovery in all domains (for example, return to work or domestic duties). This will be influenced by many factors, and the rehabilitation provider will need to explain how this will be addressed. For example, the rehabilitation provider may report that the recovery towards goal/s that is included in the plan will have transferable skill application and that they are working with the injured person to develop a goal for this domain. Alternatively if the injured person is unable or unwilling to develop a goal, then the rehabilitation provider should contact the insurer to discuss the best approach to injury and claims management. This information is included in section ‘additional information to explain the plan’.

- Impairment level goals are very specific, with scores on measures and reporting on discrete impairments; for example, to improve range of motion or to improve the score on a depression scale. Impairment level goals
are generally more relevant to single disciplines and are not appropriate in an inter disciplinary rehabilitation plan. If an impairment level goal is to be included, the rehabilitation provider should include additional information to explain the clinical reasoning in the relevant section; for example, that an impairment level goal is included because: it is appropriate to the stage of recovery and the injured person’s priority; and that during the plan the rehabilitation provider will work with the injured person to understand the impact of the injury at an activity or participation level and provide functional goals for subsequent rehabilitation plans. This information is included in section ‘additional information to explain the plan’.

• Goals should be SMART, that is:
  o Specific: name the particular variable of interest, for example distance able to walk, hours at work on modified duties, social outings with friends
  o Measurable: has a measurement unit (metres, hours, 1 to 10 scale)
  o Achievable: likely to be achieved given the diagnosis and prognosis for the injured person’s injury and environmental constraints
  o Relevant: relevant or important to the injured person and other stakeholders
  o Timed: timeframe within which the goal is expected to be achieved.

• Where possible, the goals and steps should be generated by the injured person and reflect their preference.

• Goals generated by injured people reflect their priorities and clearly outline the anticipated level of change desired by them. They are also more meaningful to the injured person which increases motivation and participation in rehabilitation, and encourages behaviour change.

• For each goal complete the steps and action plans required for this plan period as follows:
  o The injured person’s steps for how they will progress towards the goal. Steps are also known as objectives or sub goals. There may be several steps required to achieve a goal.
  o The service provider’s action plan is the intervention or services required to achieve the steps and goal. Each step may comprise a number of actions.
  o The injured person’s action plan includes the self-management plan or actions required by the injured person to achieve the step/goal.

• **Injured person’s steps to achieve in the plan period**
  o Describe the activity or behaviour that the injured person needs to do in order to achieve the goal.
  o When the goal will require more than one plan period, the steps are to be achievable in the plan period. This helps the injured person to see progress. It also helps to specify the services to be requested in the plan.
  o For example, for someone who has sustained a back injury and the goal is returning to full time work (5 x 8-hour shifts/week) as a nurse in six months’ time, the steps for the 12-week rehabilitation plan number one may include: walk without assistance and sit without pain.
  o Some goals are appropriate for the injured person to achieve in the plan period, and may be straightforward and not require the injured person to progress through steps to achieve the goal.
  o Refer to Appendix A for sample reports.

• **Service provider’s action plan**
  o In this table outline what needs to be done and by which service providers.
  o Include the rehabilitation provider services specific to a particular goal/step. Other rehabilitation services that are required to facilitate the rehabilitation plan, but not directly related to a specific goal/step, are included in a separate table, ‘additional rehabilitation services’; for example, report writing, provider travel or case conferencing.
  o Include treatment being provided by other health service providers; for example, ‘Manual therapy and supervised exercise program to lumbar sacral spine by physiotherapist T Jones; prescription and training of ergonomic chair by occupational therapist S Smith as per Therapy Review form.’
  o When the same service is intended to meet several goals/actions, state the service name, for example physiotherapist as per Therapy Review.
  o Refer to Appendix A for sample reports.

• **Injured person’s action plan**
  o List the injured person’s action during the plan period.
This could include, for example, completion of the home based exercise program prescribed by the physiotherapist, or contacting their employer or visiting the workplace.

This section should outline the injured person’s progress to self-management and engagement in their recovery.

**Additional rehabilitation services**
- A separate table has been included to outline the rehabilitation provider, case management, report writing, case conferencing and provider travel.
- It is important to provide the rationale for the services that are being requested; for example, why a case conference might be required in this plan period or why a number of home visit reviews are being requested.

**Additional information to explain the plan**
- Include the information that will explain the clinical reason for inclusions in the plan if further information is required. Examples of these are included for unrealistic goals, impairment level goals and an inability or unwillingness to identify goals however you are not limited to this type of additional information.
- Include the date when the injured person agrees to the plan.
- Include the anticipated date of discharge or completion. This provides a clear message to the injured person that they are expected to recover and to self manage and enables the CTP insurer to understand how complex or long term the recovery may be.

**Section eight – service requested**
- List all services required to support the injured person to achieve the goals described in the plan.
- Provide the details of the rehabilitation provider services being requested including number of sessions, frequency, costs, type (for example, workplace visits, travel, report writing, case management).
- Note the other services being provided that are described in therapist plans or requests by noting the provider type and name, and details provided via the therapy review or psychological/counselling plan.

**Section nine – service provider details**
- Ensure details are completed and correct to ensure communication and payment of accounts occur promptly.

**Section ten – insurer decision**
- This will be completed by the insurer and returned within 10 days of the request being received.
- If the request is partially or completely declined the insurer will advise the injured person and provider with the reasons for declining within 20 days of receiving the Rehabilitation Plan.

- **Agreed goals of rehabilitation**
  - When the insurer decision is received, send a copy of the Agreed Goals of Rehabilitation to the treating doctor and all service providers listed in the actions under each goal.

**8. Payment of accounts**
To facilitate prompt payment, rehabilitation providers can do the following:
- Send accounts directly to the insurer. It is difficult to ensure timely submission of accounts by other parties (for example, injured person, their solicitor).
- The account should be in the form of a tax invoice and include: the injured person’s name, date of accident, the insurer’s reference/claim number, the provider’s ABN, address and GST (if applicable).
- Rehabilitation Providers should direct all enquiries about payment to the claims officer they have been dealing with.
Once an insurer has admitted liability they are only obliged to pay for services that are reasonable and necessary. If the insurer denies liability, the injured person is personally responsible for payment of accounts. They may be able to claim part or all of their expenses from Medicare, private health insurance, or from a personal accident insurance policy.

**Without prejudice payments**

The insurer may agree but is not obliged to pay for treatment on a ‘without prejudice’ basis before a decision is made on liability. ‘Without prejudice’ means that although the insurer has agreed to pay for treatment, it does not mean they are accepting liability for the accident or will pay for ongoing treatment once they have determined liability. Agreement to pay on a ‘without prejudice’ basis should be obtained in writing from the insurer before services are provided.

**9. Release of information**

When a CTP claim is submitted to the insurer, the injured person or their guardian signs a statutory declaration authorising the insurer to obtain information pertinent to the motor vehicle accident from treating medical practitioners and health providers.

An excerpt from the statutory declaration follows:

“I authorise the Nominal Defendant or the insurer, against whom this claim is made to:

i. contact and obtain information and documents relevant to the claim from persons specified in the authorisation;

ii. provide information and documents so obtained to persons specified in the authorisation.

Persons specified in the authorisation are:

- any doctor, ambulance service, hospital or other service provider
- any employer or accountant of the injured person
- any police department
- any personal injury claim or workers compensation insurer
- any property damage insurer
- Lifetime Care and Support Authority (LTCSA)
- Centrelink
- Medicare Australia

I understand that information obtained under this declaration from doctors, an ambulance service or as part of clinical notes from hospitals may include general medical information relevant to my claim.”

The statutory declaration should give rehabilitation providers confidence that the insurer is only requesting access to information to which they are entitled, to make decisions about the injured person’s claim.

**10. Problem solving and disagreements**

There are two main problems that can arise from time to time in the provision of services.

1. **The injured person does not progress as expected.**

   Unfortunately, not all cases progress as initially expected. If functional improvement is slow or absent, the cause/s should be identified and where appropriate, expectations in relation to recovery may need to be adjusted. In some circumstances, it may be appropriate to recommend referral to another health care practitioner. Discussing this option with the insurer, the injured person and their GP will help to re-direct the intervention and get things moving in the right direction.
2. **The insurer declines the proposed services.**

Sometimes the insurer may not agree with the proposed direction for treatment. This can happen for a variety of reasons. If this occurs, there are several ways to move forward:

- All insurers are required to provide reasons for declining services. Review the insurer response and if discussions with the claims officer do not resolve matters, rehabilitation providers should speak with a senior claims officer or rehabilitation advisor. These issues can often be resolved through discussion and/or by both parties providing further information.
- The injured person may ask for the decision to be reviewed at the Medical Assessment Service (MAS), which is the dispute resolution service at the MAA. This is an independent process, but it may take some time to resolve. For further information about MAS or any other aspect of their claim, the injured person should contact the Claims Advisory Service at the MAA on 1300 656 919.
APPENDIX A

CTP insurer contacts

AAMI       CTP Claims Department, PO Box 112 Sydney 2001, phone 132 244, fax 1300 104 041.
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