Lawyers for the People

AUSTRALIAN LAWYERS ALLIANCE

QLD CTP INDUSTRY STAKEHOLDERS SUBMISSION

Submission to the Motor Accident Insurance Commission re: rehabilitation standards for CTP insurers

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Contents

Who we are

The Australian Lawyers Alliance (ALA) is a national association of lawyers, academics and other professionals dedicated to protecting and promoting justice, freedom and the rights of the individual.

We estimate that our 1,500 members represent up to 200,000 people each year in Australia. We promote access to justice and equality before the law for all individuals regardless of their wealth, position, gender, age, race or religious belief.

The ALA is represented in every state and territory in Australia. More information about us is available on our website.[1]

The ALA office is located on the land of the Gadigal of the Eora Nation.

[1] www.lawyersalliance.com.au.

Introduction

1. The ALA welcomes the opportunity to provide this submission to the Queensland Motor Accident Insurance Commission's ("MAIC") ongoing series of consultations with stakeholders on various factors relating to the efficiency of the scheme.

2. We believe the scheme generally continues to operate in line with its stated principles of affordability, efficiency, fairness and flexibility.

3. Rehabilitation is a critical part of the scheme and the ALA welcomes a review of insurer standards to ensure that injured motorists are being given the best opportunity to recover from their injuries.

4. The ALA provides the following submission in relation to the draft Rehabilitation Standards for CTP insurer ("the Standards").

Are there major problems with the existing regulation of CTP rehabilitation in Queensland?

5. The current legislative framework for rehabilitation provision in Queensland's CTP scheme is, on its face, simple. Section 51 of the *Motor Accident Insurance Act 1994* ("the *MAIA*"), imposes a positive obligation on CTP insurers to provide reasonable rehabilitation. Rehabilitation is defined in the definitions section (s.4) of the *MAIA*. There is great attraction in the simplicity of the language of s.51 of the *MAIA*, as each individual claimant has unique rehabilitation needs; no two claims are identical.

6. Reasonableness as the touchstone for rehabilitation allows all key participants in the process – claimant, claimant's family, legal practitioner, insurer and treatment providers – to form a holistic view about the best mix of rehabilitation for the claimant. Moreover, it allows, in cases of unresolved disputes, courts to determine such disputes without being constrained by prescriptive criteria.

7. This simplicity extends to the absence of any prescriptive material on rehabilitation in the regulations promulgated pursuant to the *MAIA*.

8. MAIC has since 2007, published and relied on a set of rehabilitation standards. Those standards have the character of guidelines: they are not legislatively binding. They are supplemented by some guidelines published in 2012, entitled "Guidelines for Rehabilitation Providers". In our view, the standards and guidelines are commendable for what they do not say; that is, they are not prescriptive. Each provides some guiding principles for provision of rehabilitation services, but do not descend into detail. This is commendable because, as mentioned above, each individual claimant's needs are unique.

9. The simplicity of the current framework should not be misunderstood as one lacking in efficacy. In the experience of our members, disputes about rehabilitation in Queensland's CTP scheme are uncommon. The process is typically for more complex claims involving multidisciplinary needs:

a. Legal practitioner arranges, usually in consultation with the claimant, family and treating practitioners, an evaluation of the claimant's rehabilitation needs;

b. Those needs are contained in a report, usually from an Occupational Therapist;

c. That report is presented to the CTP insurer;

d. Only rarely do CTP insurers dispute the rehabilitation recommendations. Almost invariably, the rehabilitation recommendations are accepted in their entirety or minor adjustments are agreed to;

e. In rare cases of significant disputation about rehabilitation recommendations, those disputes are usually resolved by further discussions between the insurer, the legal practitioner and the author of the rehabilitation report. Again, it is only a small proportion of those matters that need to be the subject of an application to the court pursuant to s.51 of the MAIA. In our members' experience, it is exceptionally rare for those matters to be adjudicated by a Court; most resolving before a hearing; and

f. To the best of our knowledge there have only been a few decided cases in the Queensland Supreme Court dealing with such issues.

10. Accordingly, ALA comes to this submission with the view that the low disputation rates under the present system is cogent evidence that existing legislative and regulatory frameworks (including MAIC's existing guidelines) provide all stakeholders with a good level of clarity about their respective rights and obligations.

11. It is the experience of our members, who have practiced in jurisdictions outside of Queensland, that prescriptive and inflexible regulatory frameworks for rehabilitation:

a. Are frustrating for claimants and their families;

b. Are regarded as paternalistic; and

c. Tend to generate much higher disputation rates than presently evidenced in the Queensland system; thereby adding to scheme costs.

12. In short, it is our view that the present rehabilitation system in Queensland is not broken. It may benefit from refinement, but the risks alluded to above, should be avoided.

Comment upon overarching principles

13. The ALA agrees with all of the overarching principles particularised on page 5. We would add to principle number 5 such that the first sentence references expertise from both allied health professionals and medical practitioners. Allied health professionals are less likely to view rehabilitation needs through the narrower prism of medical specialist disciplines.

Updated language to reflect contemporary rehabilitation practice

14. The ALA supports the updated language in the draft.

15. The ALA notes the acknowledgment that rehabilitation often requires a multi-disciplinary approach; that each claimant will require a bespoke rehabilitation plan, reflective of their individual circumstances.

16. The ALA considers that "evidence based" should be further defined. It is unclear whether it is reference to evidence supported from appropriately qualified experts, including

treating practitioners, or whether it is a reference to extraneous material, such as research material differentiating between mainstream treatment and treatment that may be regarded as alternative or experimental.

Reference to the Clinical Framework for the Delivery of Health Services

17. The ALA supports reference to this framework, and the five guiding principles.

18. When stakeholders commence to work within the framework, evaluations will need to occur about the practical application of the framework. We sound a cautionary note about the application of this framework in Queensland. In Victoria, the home jurisdiction of the TAC, medical practitioners are signed up to contractual terms making it clear that the practitioner is working for the TAC. Independence is removed or at least placed in significant doubt. Any arrangements which bind, contractually or otherwise, practitioners to the regulator or insurer ought to be avoided. The primary duty of the expert must always be to the Court.

Comment upon the 'Roles of Stakeholders' and 'Defined Terms'

19. The ALA agrees with the broad statement of principle that the claimant should be involved in the rehabilitation process. Of course, the ability to of a claimant to be actively involved in the rehabilitation process depends greatly on the nature and extent of their injuries. For example, claimants with significant acquired brain injuries will be wholly or heavily reliant on others to participate. Such claimants more commonly than not, have as a consequence of the acquired brain injury, major psychological difficulties. Those psychological difficulties can also raise complex challenges for participation in rehabilitation activities. It should be clearly understood that the cooperation of claimants in a rehabilitation process is not enhanced by punitive, dictatorial and prescriptive approaches adopted by insurers.

20. The following statement is factually wrong:

> "There are legislative obligations placed on all claimants to take all reasonable steps to make an effort to recover from their injuries and return to normal activities, such as work, as soon as practicable"

Claimants in the common law process are subject to the common law duty to mitigate their losses. In our members' experience the vast majority do. Most claimants are very keen to return to work and other meaningful activity as soon as their injuries allow.

21. The ALA is troubled by the proposition that the claimant must cooperate with an insurer to determine reasonable and necessary rehabilitation needs. The legislative obligation is placed upon the insurer to provide reasonable rehabilitation. The determination of what are reasonable rehabilitation needs for the claimant ought to involve a broad cooperative matrix; more than merely the claimant cooperating with the insurer.

22. As noted above, in our members' experience, optimised rehabilitation outcomes involve cooperation between the claimant, their family, legal practitioner and treating medical and allied health professionals. Typically this operates with great efficacy through a hub and spoke case management model, whereby a case manager works with the claimant, insurer and other stakeholders to formulate holistically a bespoke rehabilitation plan, which is then approved by the insurer, monitored and adjusted as needs change.

23. We concur with the need for any change in circumstances, which impact on rehabilitation, to be communicated to all stakeholders, including the insurer. Any change in circumstances which impacts the common law damages claim, is a change in circumstances about which rehabilitation protocols have no concern and which existing common law process are well understood with respect to obligations imposed upon claimants and their lawyers.

24. The role of the *CTP Insurer* is described in terms reflective of the existing processes that flow from the *MAIA*. Further clarification should be provided in relation to what is meant by the following:

a. What are the key factors for an efficient and cost effective procedure? For example, what information is required prior to a decision being made and

timeframes? The Rehabilitation Standards ought to provide guidance on this requirement.

b. Quality assurance process. MAIC should develop a consistent standard across the industry for quality assurance checks by insurers of their consistent compliance with the Rehabilitation Standards.

25. The role of the *Claims officer* states that a claims officer should have sufficient training in injury recovery and rehabilitation. The ALA submits that MAIC consider what standard ought to constitute "sufficient training".

26. The role of *Rehabilitation advisor* references contact directly with an injured motorist. It is the ALA's position that the Rehabilitation Advisor should not contact an injured motorist directly, if they are legally represented; unless there is clear permission to do so provided by the injured motorist's legal team. Further, the definition should provide that if permission is provided, discussions must only involve what rehabilitation services should be provided. Our members' experience of direct contact from insurance companies is confusing, upsetting and particularly for those claimants who may have cognitive difficulties engenders a sense of feeling threatened. Some have reported claims officers pursuing a fishing expedition for information which has no relevance to rehabilitation, information presumably sought to forensically advantage the insurer in the common law process. These claimant beliefs and responses are counterproductive to effective rehabilitation. Under the existing MAIC protocols, insurers are usually respectful of those who are legally represented and do not make direct contact without the express permission of the legal practitioner. That situation must not be modified.

27. The role of *Rehabilitation provider* is well described in the document. We particularly commend the explicit reference to the need for personalised plans and ongoing evaluation to reflect evolving circumstances. As to fees, ALA also agrees that fees should reflect normal commercial rates. In some jurisdictions interstate rehabilitation frameworks have included tables of costs whereby the insurer and/or regulator have sought to prescribe and limit the rates charged by the providers involved in the rehabilitation process. This prescriptiveness has generated dissatisfaction and disputes; and some providers, particularly in thin markets, may decline to provide services at the prescribed (non-market) rates. This has been and remains a serious problem in the NDIS context, a problem even more acute in rural, regional and remote areas, where rehabilitation provider availability is limited.

28. The role of *Legal representative* is generally well described. In practice, the present common law process mandates a reciprocal exchange of information between the insurer and the claimant's legal representative. That material commonly includes, but is not limited to, material related to rehabilitation. Moreover, legal representatives will explain to claimants their common law obligations to mitigate their loss an element of which is cooperation to the best of their physical and psychological abilities with the rehabilitation process.

Comment upon "defined terms"

29.

a. Rehabilitation – we agree with this definition. It is important to note that this definition is both appropriately broad, and consistent with contemporary best practice which concentrates upon improving function and quality of life. The breadth of the definition allows a wide variety of interventions including assistive devices; all framed within the s.51 touchstone of reasonableness. Specifically in the context of a world in which technology is evolving at an exponential pace, it will remain vital to ensure that a full suite of options is available for consideration. Interventions which may have earlier been regarded as experimental and unproven, may quickly become proven and thus part of a best-practice rehabilitation plan.

b. *Treatment Plans* – we agree with this definition. The terminology in Queensland for tertiary rehabilitation plans includes rehabilitation case management plans – covering those with complex needs requiring multi-disciplinary supports.

c. Rehabilitation requests – we agree with this definition.

d. Service provider, rehabilitation provider or provider – we agree with this definition.

e. Claimant – we agree with this definition.

f. Days – we agree with this definition.

g. Date of receipt – we agree with this definition.

h. Change of circumstances – we agree with this definition.

Revision to the standards and timeframes

30. In relation to Standard A, the timeframe for rehabilitation screening being up to 14 days presents a potential problem for early intervention. Often several weeks may elapse between the date of the accident and the lodging of the NOAC. ALA recommends a change in the wording such that the screening is as soon as practicable, and no later than 14 days and that each insurer have an internal protocol to escalate matters for which there is demonstrated urgency. Any documentation utilised by the insurer in the screening process should be exchanged with the claimant's legal practitioner.

31. In relation to Standard B:

- **a.** All information for represented claimants should be sent to the legal representative. The insurer is entitled to ask that that information be given to the claimant or their litigation guardian.
- **b.** Proposed Standard B criteria B2, reflects existing requirements in practice with regard to the reciprocal exchange of documents between the insurer and legal representatives.

32. In relation to Standard C:

- **a.** The Standard should explicitly acknowledge that there will be a cohort of claimants in respect of whom the claimant and/or their legal representative have arranged a rehabilitation case management report (a tertiary rehabilitation plan). Standard C should acknowledge that, where such a plan has been received, it is capable of being approved by the insurer either with or without some suggested amendment.
- **b.** Again, the time frame should reference "as soon as practicable, and no later than".

33. In relation to Standard D1(c), it should be made clear that the insurer is required to provide the claimant or their legal representative the material relied upon in making the decision and the reasons for the decision. That Standard should reflect both allied health and medical evidence.

34. In relation to Standard D2(b), in addition to notification of the claimant's right to a referral for mediation or to make an application to the court, unrepresented claimants should be advised of their right to seek independent legal advice.

35. Further, in relation to Standard D, the experience of ALA members is that disputes most often occur when there are differences between treating practitioners, service providers or independent experts. Where such divergence of opinion exists, any MAIC guideline could provide the option of the involvement of reputable, independent Occupational Therapists to resolve any issues and to refine and optimise the rehabilitation plan, in a non-binding report. The Court should always have ultimate power to determine the question of reasonableness.

36. Standard D2(b) should include a mechanism by which urgent matters are elevated for earlier consideration. Delays in some interventions can have permanent negative consequences for claimants. Further in relation to standard D, there should be confirmation of minimum standards of training in injury recovery and rehabilitation that insurers are to provide their claims staff.

37. Generally, in relation to Standard EF, the ALA submits that the timeframes should be shortened in order that the guiding principles and the framework are met. The following timeframes are suggested:

a. EF3 – both 10 day periods should be 5 business days;

b. EF6 – there should be an acknowledgement of home modification requests within 5 business days and the in-principle approval or rejection of the request should be advised within 1 month of the request. As this is an "in-principle" decision, there is no valid reason why it should take longer.

c. EF8 – accounts should be paid by insurers within 10 business days. Reasonable business terms generally have a 14 day payment period. Unreasonable delays can cause some treatment providers to stop service provision to the detriment of the claimant.

d. EF9 – as noted above, there should be no reason why an insurer cannot process, approve and reimburse a claimant for their out of pocket expenses relating to rehabilitation within 10 business days. Injured motorists are often not working, or working reduced hours, therefore financially in a difficult situation.

38. Further, in relation to Standard EF, there should be a new standard added, being EF10, which should provide as follows:

a. If a rehabilitation request or home modification request is partially approved or not approved, the insurer must:

i. provide the claimant or their legal representative the material relied upon in making the decision and reasons for the decision; and

ii. advise the claimant of their right to a referral for mediation or to make an application to the court, and the right to seek independent legal advice.

b. If an insurer decides to discontinue funding for pre-approved services, for reasons other than claim settlement, the insurer must:

i. provide the claimant or their legal representative the material relied upon in making the decision and reasons for the decision;

ii. give reasonable notice of the intended cessation; and

iii. advise the claimant of their right to a referral for mediation or to make an application to the Court, and the right to seek independent legal advice.

c. If an insurer refuses or does not approve reimbursement of expenses, pursuant to EF9, the insurer must:

i. provide the claimant or their legal representative the material relied upon in making the decision and reasons for the decision; and

ii. advise the claimant of their right to a referral for mediation or to make an application to the court, and the right to seek independent legal advice

39. In relation to EF7:

a. There is no definition of a serious injury or serious multi-trauma. This must be defined to provide clarity, as these concepts otherwise can be subjective.

b. The reference to "reaching certain milestones" is unexplained and is unclear. In its place, the ALA proposes that the Standards state "…fresh medical, occupational therapy or allied health evidence."

40. The ALA also notes that there is no guidance offered in the standards in relation to the access to, and cooperation with, the National Injury Insurance Agency ("NIISQ"). The ALA recommends the provision of standards and guidelines to support cohesive, regular and consistent communication and information exchange between insurers and NIISQ. Communications between NIISQ and insurers must be disclosed to the claimant's legal representative by the insurer. At present, CTP insurers and NIISQ share information with each other, and the claimant's legal representatives; with respect to rehabilitation. It is vital that protocols to ensure the sharing of information are embedded and adhered to. There will be claimants who exit NIISQ after 2 years as interim participants, for whom ongoing rehabilitation under s.51 *MAIA* is required. A seamless transition out of NIISQ is essential to optimise rehabilitation outcomes.

41. There can be issues in relation to the provision of rehabilitation when there is a dispute regarding liability when clearly there is a primary breach of duty but the issue surrounds contributory negligence. In these circumstances it should be clear that rehabilitation should be provided. Our members have experience of cases where primary liability is absolutely clear, yet the CTP insurer may, presumably for strategic reasons, deny liability. Such a denial then operates to preclude rehabilitation. MAIC should be empowered and encouraged to investigate, and act upon such unjustifiable denials of liability.

Should you have any questions about any of the issues identified above, please do not hesitate to make contact.

Yours sincerely,

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