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Current issues in rehabilitation funding in CTP claims

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Introduction

Jack (not his real name), was trapped in his mind. He suffered an amputation of his leg and a significant psychological injury. Jack had a lovely wife and young son. Their lives were irrevocably changed as a result of his accident; nothing would be the same ever again. Living in a two-story house meant that on discharge from hospital he lived on the ground floor and his wife and son upstairs, the family dynamic was destroyed. Months of prosthetics fittings had caused serious issues with his stump, his pain levels, his mental health and his relationships. An alternative treatment modality was suggested – osseointegration, which costs hundreds of thousands of dollars and could only be undertaken in Sydney. He was at the end of his teether, but the insurer refused to fund. After a bit of work gathering evidence, a bit of a blue and under the threat of an application, we finally got Jack to Sydney. His life changed, he could after intense rehab and some home modifications get back upstairs and engaged with family life. When I settled his claim, he was also looking at return to work opportunities, something he said he never thought would happen; he was no longer trapped in his mind.

Rehabilitation is so critically important for injured people and their families. Never lose sight of the broader impact – mental, familial and on the injured person's broader community around them. And this applies to any injury, don't just think this is a 'simple whiplash case', imagine living with severe headaches and neck pain day-in, day-out. This is why rehabilitation should never be something that is just there on the side when lawyers are running claims. Rehabilitation is, and should be, very much central to everything we do for our clients. Insurers will quickly learn those lawyers willing to fight for their client's rehabilitation and bring insurers to account for their obligations.

Back to basics

1. Meaning of rehabilitation

Rehabilitation under s.4 of the *Motor Accident Insurance Act 1994* ("*MAIA*") means –

> "the use of medical, psychological physical, social educational and vocational measures (individually or in combination)-
>
> (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."

This must be the foundation of any argument that is had with an insurer about rehabilitation funding. It must guide the evidence that is obtained from treatment providers and experts; that is, evidence needs to answer how and why the proposed rehabilitation will achieve *rehabilitation* as defined.

2. Section 51 of the *MAIA* outlines the rehabilitation obligation of insurers, as well as avenues by which they may seek to recover rehabilitation costs. Section 51 is commendably simple, with reasonableness and appropriateness being the foundations and always in the context of each individual's circumstances. Other schemes and jurisdictions impose more prescriptive and restrictive rules, which fail to achieve quality rehabilitation and ultimately recovery for injured people.

3. Industry Deed

Pursuant to s.65 of the *MAIA*, an Industry Deed may be developed by the Motor Accident Insurance Commission (MAIC) and I may regulate the management of claims and "provide direction and guidance" for insurers about "initiating, managing, monitoring and measuring" the effectiveness of rehabilitation service provision.
The Industry Deed is located at Schedule 4 of the *Motor Accident Insurance Regulation 2018*. It is therefore legally enforceable, and in fact impacts the licensing ability of each of the insurers. Section 4 of the Industry Deed deals with rehabilitation, but merely states that MAIC may issue *rehabilitation standards and guidelines* for insurers.

4. Rehabilitation Standards

The current (and former) version of the Rehabilitation Standards and the Guideline for CTP insurers about reasonable and appropriate rehabilitation can be found on the MAIC website (https://maic.qld.gov.au/for-service-providers/for-licensed-ctp-insurers/rehabilitation-standards/).

I have seen many times insurers referring to the Standards and the Guideline when either rejecting or partially approving rehabilitation requests under s.51 of the *MAIA*, and in the overwhelming majority of such decisions the insurer (in my view) misapplies or misunderstands these documents in its reasoning; thus, the reasoning is often flawed.

Common themes from rejected or partially approved rehabilitation requests are:

i. The insurer requires further information.

ii. Suggesting that the Rehabilitation Standards or Guides somehow provide a limit to the number of treatment sessions that ought to be approved at any one time (this is especially the case with physiotherapy and psychology).

iii. Medicinal cannabis – that MAIC don't approve or support it. Alternatively, that it isn't effective treatment. I had one insurance claims officer tell me that they did not ever fund medicinal cannabis, yet on a matter for a lawyer I supervised that insurer's injury management advisor had approved funding same.

iv. The claimant ought to be aiming at self-directed exercises.

v. The claimant is stable and stationary, especially if there is medico-legal evidence.

vi. An expert for the insurer doesn't recommend a particular treatment modality.

After reviewing some of the key cases, I will provide some takeaways addressing these common themes. However, I do want to address a couple of matters at the outset so that some of the misconceptions or misunderstandings of insurers do not infect lawyers.

Neither the Rehabilitation Standards, nor the Guideline on reasonable and appropriate rehabilitation, place any limitation on the number of sessions of treatment that should be approved. In other words, if a provider treatment plan recommends 8 sessions over 8 weeks and it is justified because it is evidence-based and outcomes focused (i.e. it restores or optimises per the definition of *rehabilitation*), it ought to be approved fully. Partial approval on grounds that there is some limit in the Standards or Guideline is simply wrong.

MAIC has overseen, and continues to oversee, one of the best CTP schemes in the country. MAIC does not make decisions about rehabilitation, MAIC does not determine what treatment modality or delivery method or duration ought to be either scheme wide or for individual claimants. Even if any staff of MAIC were to express personal or individual views about particular treatment modalities (such as medicinal cannabis), that has no legal force and cannot form part of an insurers determination on the reasonableness or appropriateness of rehabilitation. In the countless discussions I've had with MAIC on behalf of the ALA, I have not once heard an expression of approval, support, disapproval or otherwise about particular treatment modalities.

In respect of medicinal cannabis, Queensland has legislated its use and that comes with a stringent regulatory framework. The Therapeutic Goods Administration controls authorisations and prescription management. There may well still be ongoing clinic trials and research, but the fact remains it is now utilised in practice by a not insignificant number of medical practitioners.

Review of key cases

Delaney v AAMI Insurance Ltd [2007] QSC 174

The applicant sustained a serious brain injury. The application concerned the appointment of specific treatment providers, where the parties were agreed that particular services were needed just not who should provide those services. Services were required by a Neurologist, Dietician, Occupational Therapist, Physiotherapist, Case Manager and Speech Pathologist.

The court reviewed the Industry Deed and the Rehabilitation Standards. It was critical of the insurer, noting:

> "the respondent's intransigent attitude that it will meet the costs only if the rehabilitation services are provided by persons it selects. This dictatorial attitude is inconsistent with the Legislature's expressed intention to promote and encourage rehabilitation of injured persons and with the express provision in the Rehabilitation Standards which are binding on it that claimants be informed of their ability to exercise choice and control in the selection of an appropriately qualified and experienced service provider whose intervention is supported by the medical evidence."[1]

[1] At paragraph [16].

Interestingly, despite this commentary, the court then made its own decision as to which of the applicant's or respondent's recommended treatment provider ought to be appointed, rather than accepting the applicant's choice.

In respect of a Neurologist, the court ordered one of the Neurologist proposed by the insurer be appointed on the basis that the insurer obtain these names from the Director of the Brain Injury Rehabilitation Unit at the Princess Alexandra Hospital.

In respect of the Speech Pathologist, the court again appointed the insurer's recommended provider because no details of the experience of the applicant's proposed provider were available and the insurer had provided details of the comprehensive experience of its preferred provider.

In respect of a Case Manager, the court's decision was quite unexpected. The court refused to appoint either the applicant's or respondent's preferred provider on the basis that it was not in the applicant's interests to appoint a case manager "…to whom her representatives or the respondent is antipathetic."[2] Instead the court ordered the parties seek a recommendation from CRS Australia.

Aldridge v Allianz Australia Insurance Ltd [2009] QSC 257

This is the seminal case on rehabilitation obligations of insurers and the interpretation of the *MAIA*. The applicant suffered paraplegia, liability was admitted. The question was: what was the reasonable and appropriate accommodation option to be funded by the insurer.

Background

The applicant was a mother of three teenage daughters whom she supported. They lived in their own two-story home. Modifications had already been made to the home, and it still remained unsuitable for her accommodation and rehabilitation needs. The following options were considered:

1. Further extensive modifications to the existing home;
2. Construction a new 'project home';
3. Renting and modifying such rental property; or
4. Purchase and modification of an alternative existing residence.

Comments on rehabilitation requirements

Section 51 is to be construed beneficially and widely for the claimant. The terms reasonable and appropriate connote their ordinary meanings – founded on reason and suitable or fit for the purpose of rehabilitation. In this case the question was one of reasonable and appropriate rehabilitation needs now, not in the long-term or how the applicant may choose to use some future damages amount on housing. However, what is reasonable and appropriate rehabilitation may satisfy both short-term and long-term needs.

Whilst the assessment of damages in a claim is distinct from the question of reasonable and appropriate rehabilitation, the damages claim and expected outcome is a relevant consideration.

[2] At paragraph [17].

The central question always remains: whether the rehabilitation will 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.

The general proposition is that the claimant is entitled to the additional costs associated with obtaining and modifying a suitable premises as a result of the injury, and not the ordinary expenditure on housing which would have been incurred anyway. There may be exceptions where the capital cost of a house may be claimable. Further, whether the damages ought to be modified to account for the possible increase in capital value of the home is dependent on the circumstances of each case and the defendant bears the evidentiary onus. For example, a home with an additional bedroom to accommodate carers or wide, open plan spaces or a newer home which is more adaptable to modification may well increase its value, but this is a cost incurred in order to acquire a suitable home which meets the plaintiff's accident-related needs. The court compared this to a situation where there is an upgrade beyond that required to meet a claimant's injury-related needs, in which case an accounting for capital gain may be appropriate.

Modification of the applicant's home

The insurer contended for this option as a suitable and functional short-term solution.

The costs was high, some $279,000 and it would still not be suitable for the applicant's needs or to permit her to care for her daughters. The modifications would be extensive and thus would likely require them to move out during the process. The court found this option costly, inconvenient and not suited to the application's rehabilitation needs.

Project home

This would require purchase of land and construction of a purpose-built home. The applicant would sell her present home and the net proceeds of that sale would be received by the insurer as an offset. The cost of this option was somewhere between $600,000 - $1 million. This option was one that was both a short-term and long-term solution. However, it would take some 12 – 16 months to complete, which fails to address the applicant's immediate need. Whilst the applicant was willing to bear the burden of remaining in her present residence during this time, the court considered that to be an unattractive option.

The applicant submitted an interim measure could involve the insurer funding rental accommodation (which was separately option 3 as well).

Rental and modification

The concerns with this option were lack of tenure in rental accommodation, notice period to vacate from the premises, the need to find a suitable premises, the costs to modify same and then to remediate the house on vacating it. This option would have required the applicant to move at least twice and there was medical evidence that this could impact her rehabilitation goals, such as return to recreational activities and return to work. The evidence of available and possibly suitable premises was limited – one premises the insurer identified, the court accepted, was actually unsafe for the applicant and could not accommodated her mobility around the house. There was no evidence of other potentially suitable properties becoming available in the near future.

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Purchase and modification of an alternative existing home

This option would have a shorter timeframe than a project home, would avoid the uncertainties of a rental and was estimated to have lower modification costs for an appropriate home, compared to other options. The applicant was able to provide evidence of appropriate existing homes.

Conclusion

In this case, the project home or purchase and modify options did not involve the insurer having an unqualified obligation to buy the applicant another home. Rather, the obligation was to financially assist the applicant's transition to a home that is necessary for her rehabilitation and to meet needs caused by the accident. In this case, the insurer would receive the net proceeds of the sale of the applicant's existing home, because that home was no longer suitable to accommodate her injury-related needs.

The court found that ss.51(4), (9) and (9A) operated such that, if the insurer gives the appropriate notice, then it can seek to recover all or part of the rehabilitation costs incurred through a reduction in the damages. It was suggested this provision could be used in cases of a proven capital gain or where rental costs were paid by the insurer to the extent that such costs would ordinarily have been incurred anyway.

The applicant also gave an undertaking to agree to a proposal on reasonable terms to protect the insurer's interests over any new home in the event that she were to pass away prior to the resolution of the damages claim. Accordingly, the court considered the reasonable and appropriate option was to purchase and modify an existing premises, provided the purchase price was kept within reasonable limits

Rogers v Suncorp Metway Insurance Limited [2013] QSC 230

The applicant suffered a severe brain injury. The application predominantly concerned the seeking orders for the construction of a purpose build residence with associated attendant care and services.

In making it's decision the court considered:

1. The applicant was at the time in a residential group care facility. He had been in the shared facility area. However, by the hearing date, he was housed in a one-on-one facility with the provider.

2. The applicant's injury was such that he engaged in temperamental and inappropriate behaviours. This led to strained relationships with hospital staff (during his admission) and his carers and other residents. Such behaviour included aggression and conduct of a sexual nature.

3. His litigation guardian would be used to de-escalate his behaviour when possible.

4. Due to his behaviours, the care facility recommended one-on-one care.

5. Medical evidence noted serious concerns as to the safety of others. It was preferrable to ensure the applicant had a familiar and stable physical environment to assist his rehabilitation.

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6. Whilst ongoing recovery was possible, the applicant would be left with significant cognitive, behavioural and physical impairments.

7. The applicant sought to argue that moving away from institutional care would best assist with his independence, and on his own medical evidence that a group environment with others suffering brain injury was chaotic and damaging to his need for stability.

8. The insurer argued, on medical evidence, that a shared facility had the advantage of trained staff in sufficient numbers to cope with difficult behaviours and limit the exposure of carers and other to aggressive and inappropriate behaviour. It was also noted that the care facility had already implemented a successful behavioural management program.

9. For the determination under s.51 here, it was relevant to consider whether the current accommodation being funded was reasonable and appropriate.

10. A purpose built residence may itself not be conducive to long-term rehabilitation. This is because the court considered he could be vulnerable to exploitation, as he lacked capacity and decisions could be made on his behalf as to others residing at such residence. This opened up risks of access to illicit substances (there seems to have been some history of use) and also placed carers and other potential residents at significant risk, moreso than in a shared facility where there were more staff and concerted management plans in place.

Weighing this up, the court found that a purpose-built residence was not reasonable or appropriate. The current arrangements of one-on-one care in a care facility remained appropriate and reasonable.

Lee v RACQ Insurance Limited **[2015] QSC 120**

This matter concerned a claim where the insurer, without an admission of liability, agreed to fund rehabilitation under s.51. As the matter proceeded substantial evidence came to light that the applicant perhaps was the at-fault driver of the vehicle in which he and his family stated he was a passenger. On receiving this evidence, the insurer sought to stop rehabilitation funding and the applicant sought an order preventing this.

The court considered that, once rehabilitation services are agreed to be funded under s.51, such services are required to be continued; i.e. cannot be withdrawn. The court further considered s.51(10) and determined that was a provision entitling a recovery of rehabilitation costs in cases of fraud, but didn't apply to the present case as determination of liability (and whether or not the claim was fraudulent) could only occur at trial.

The question for the court was whether the applicant had proven a prima facie case; that is, a sufficient likelihood of success to justify the circumstances of the status quo pending trial. Here, the court found a prima facie case, but also noted concern about the strength of that case, strong circumstantial evidence of fraud, that the applicant had no assets and was unable to offer any security to the insurer should it transpire that the payment of rehabilitation was induced by fraud. The applicant had suffered severe injuries though and medical evidence suggested it was important to receive rehabilitation for 2 years, that is to 25 September 2015, as improvement was still possible.

At the time of the judgement there was only another 4 months till that 2-year period. The court balanced the above factors and ordered the insurer to continue to fund rehabilitation, under s.51(3), until 25 September 2015 (another 4 months).

McIntyre and anor v AAI Limited [2021] QSC 251

This is probably the most important and comprehensive decision on rehabilitation obligations since *Aldridge*. Mr McIntyre and Ms Ho each suffered multiple serious physical injuries and Ms Ho also suffered substantial psychological injuries.

The court considered in detail the statutory scheme and how rehabilitation fits into context. In particular:

1. The object of the *MAIA* includes to promote and encourage, as far as practicable, the rehabilitation of claimants.
2. The meaning of rehabilitation, as already detailed above.
3. Insurers are bound by the Industry Deed, which specifically states that it is not the insurer's role to develop treatment and rehabilitation plans, but rather to facilitate the rehabilitation process.
4. An insurer's rehabilitation obligation should not be read narrowly. Section 51 is to be construed and applied beneficially to a claimant, especially considering the ability of insurers to recover expenditure on rehabilitation under ss.51(9) and (9A) as an offset against the damages.
5. The legal considerations outlined in *Aldridge* were cited with approval. It was especially highlighted that rehabilitation need not equate to a particular head of damage, nor is it purely to fulfill a short-term need.
6. Considerations that may be relevant include:
    a. An admission of liability;
    b. The severity or injuries and thus the contingent liability of the insurer, which in this case was "…unarguably, large"[3]
    c. Protection of the insurer's interests. In this case, the applicants agreed that, should the insurer fund rehabilitation which was later determined as inappropriate, then those costs together with interest at 10% p.a. from date of payment would be offset against the damages claim.

The following passage provides a particularly powerful insight into the court's approach:

> "…Mr McIntyre and Ms Ho had the obligation to determine what rehabilitation and treatment services are undertaken, not AAI and not their experts. Except to the extent that AAI's experts' evidence reflects upon the reasonableness or appropriateness of the rehabilitation treatment services requested, it is beside the point that those experts may have different views as to the proper ways in which Mr McIntyre and Ms Ho might undertake rehabilitation."[4]

Decision on rehabilitation services

There were some 46 odd items of rehabilitation for consideration. Here I will touch on only a select few to understand how the above legal principles were applied by the court.

[3] See paragraph [28].
[4] See paragraph [23].

1. Tilt and lift chair – Mr McIntyre and Ms Ho had a restricted sitting tolerance and shared an old/worn recliner which failed to provide proper postural support. The insurer argued that they could lie down in bed if they wanted to change into a recumbent position. The court suggested being in a recumbent position in a recliner does have rehabilitative value and given the OT's view it was reasonable to fund for each of them.

2. Kalbarri dining chair – the court considered would allow Mr McIntyre to comfortably participate in mealtimes and other family activity. The insurer's suggestion he could eat and then sit somewhere else was diplomatically considered "less than satisfactory".[5] Further, it was considered that having dining chairs that matched the furnishing of the house, so as not to promote the perception of disability, was reasonable and appropriate.

3. Manual wheelchair and mobility scooter – the insurer argued at the current time it was not appropriate as further surgery was anticipated to improve mobility. Consistent with the principles in *Aldridge*, the court held that it is the rehabilitation need presently that is to be considered, thus in the meantime such wheelchair was reasonable and appropriate to increase Mr McIntyre's mobility. For the same reason, and to permit him to engage socially and travel independently longer distances, an assessment by an OT to determine an appropriate mobility scooter was allowed.

4. E-bicycle – this item was also allowed to permit Mr McIntyre to participate in family activities as he did pre-accident. An interesting comment from the court was that "riding a mobility scooter next to children on bicycles is, with respect, hardly a satisfactory engagement in the children's activity."[6]

5. Stairlift – they lived in a two-story house and Mr McIntyre resided downstairs whilst the rest of the family were upstairs. The insurer argued he could slowly, and with a walking stick and handrail, traverse the stairs, and he did not require regular access to the top floor. This latter comment was put in proper context by the Judge noting that, as a matter of necessity he could survive downstairs, however this has isolated him from the family. The court considered it was reasonable and appropriate that he have access to his whole house.

6. Shower stool – the insurer seemed to suggest one could be shared between Mr McIntyre and Ms Ho, however the court considered that inappropriate given the living arrangement. At least until the stairlift was installed, it was necessary to properly equip the house upstairs and downstairs.

7. Neuropsychology for Ms Ho – Dr Chalk assessed an adjustment disorder, but not PTSD, and did not consider she exhibited signs of cognitive impairment. Ms Ho's OT relied on her subjective reporting, and the court noted that she did not form any opinion on cognitive function as such diagnosis was not within her expertise. It was within Dr Chalk's. Thus, this was not allowed.

8. Pain management for Ms Ho – the court allowed a pain physician and OT for pain management education, however refused to allow for a pain management clinic. This decision seems to be based also on reference to commentary by Dr Bruce McPhee that non-operative treatment was likely counter-productive as it would reinforce

[5] See paragraph [45].
[6] See paragraph [66].

invalidity and not result in any substantial or sustained improvement. There was no contradictory evidence presented.

9. Physiotherapy for Ms Ho – the court relied on Dr McPhee's view that non-operative treatment was not of utility, which was not challenged by any competing medical evidence, despite the OT evidence recommending this to improve independence and function at home and in the community. It is interesting that the courts continue to heavily rely on particular fields of expertise – in this case an Orthopaedic Surgeon – despite the often more comprehensive and holistic assessment performed by physiotherapists and OT's.

Key takeaways

1. Broadly, the jurisprudence in this area is helpful to claimants and their treating practitioners. Over the last 15 odd years, the cases broadly demonstrate that the Courts consider rehabilitation as a central element to our CTP regime, and will construe the provisions broadly and beneficially.

2. Lawyer who set up effective rehabilitation early, also are setting up their client's evidence when it comes to medico-legal assessments.

3. Proactive support of a client early has been critical in the success of applications. Ensuring the treatment providers and experts are addressing the rehabilitation requirement in proper assessments and reports, is what ensures best prospects of success in cases.

4. For serious injury or multi-trauma cases, it is prudent to engage an expert OT (in particular) early who can assist a client with case manage, with this also intimately tied with ensuring a proper evidence base is gathered for rehabilitation requests. I handled a case involving a catastrophic brain injury where I got the litigation guardians consent early to introduce an OT whilst the client was still in hospital. This step allowed forward planning for discharge, and time to have a fight with the NIISQ Agency about appropriate supports and equipment. Even then, there was a period of limbo where the client really stayed in a hospital setting longer than he really ought to have.

5. The cases demonstrate that often there are numerous specialties involved in giving sufficient evidence for a success application; often, the experts and providers are not communicating or see each other's reports. The lawyer's role is to ensure holistic consideration, ensure proper briefs are compiled, that each specialty has considered the relevant consider for *rehabilitation*, and if there are any gaps in evidence they are filled.

6. Medicinal Cannabis:

- **a.** Whatever one's personal view may be, it is important to remove personal bias on any treatment modality.

- **b.** Whether or not a Regulator thinks a particular treatment modality is appropriate, is not the question.

c. If there is evidence of a need for medicinal cannabis within a claimant's treatment regime, then funding ought to be sought and there is no reason why a court would or could not determine it to be reasonable and appropriate rehabilitation. There is no Queensland precedent yet, to my knowledge, however the New South Wales Workers' Compensation Commission has allowed the funding of medicinal cannabis: see Longworth and Secretary, Department of Transport [2020] NSWWCC 52 (https://www.pi.nsw.gov.au/__data/assets/pdf_file/0018/603072/6164-19-Longworth-COD-SOR.pdf).

d. If an application is to be run on this point, it is prudent to ensure the claimant has undergone mainstream treatment options (surgery, manual therapies, pain management etc…), that there is evidence to demonstrate no unintended negative consequences (i.e. claimant doesn't have a history of drug abuse) and the recommendation for medicinal cannabis is support by a Pain Physician.

7. Ensure provider treatment plans or additional supporting evidence from treatment providers addresses the purpose of the recommended *rehabilitation* as defined by the *MAIA*.

8. Before filing an application:

a. Consider what security or undertaking may be offered to the insurer to assuage concerns;
b. Ensure alternative options have been considered and sufficient evidence obtained addressing why it may or may not be appropriate;

9. If there is a question of use of a residential care facility, it is prudent to:

a. Obtain some evidence as to the nature of the facilities around the claimant, their costs, their experience in housing individuals with similar injuries and their capacity to do so;
b. Understand the nature and extent of any behaviours exhibited by the claimant, and how this does/may impact others;
c. Consider, in advance of any dispute on housing issues for someone with behavioural problems, seeking funding for an appropriate provider to develop and implement a behaviour management plan with the care team and family. This ought to be reasonable and appropriate rehabilitation for those with brain injuries and could address the concerns expressed in *Rogers v Suncorp Metway Insurance Limited*; and
d. Identify why a private residence is a better option through expert evidence, particularly addressing how any behavioural risks can be managed in a private setting (such as a rehabilitation physician, Occupational Therapist especially who has particular expertise with seriously injured people, treating specialists, Psychiatrist). Also lay evidence from family (or litigation guardian) to demonstrate why greater independence away from a shared facility would improve rehabilitation outcomes.

10. An insurer cannot withdraw rehabilitation funding, even if liability becomes an issue at a later stage. However, practically they can deny funding requests and a court may consider it appropriate to limit the insurer's obligation in certain cases, such as strong evidence of fraud.

11. The rehabilitation obligation doesn't stop just because medico-legal reports have been obtained or a compulsory conference scheduled or proceedings commenced. If there is a need for reasonable and appropriate rehabilitation, the obligation remains to provide same if liability is admitted or the insurer, of its own decision, has offered rehabilitation.

12. 'Standard' medico-legal evidence isn't necessarily the right approach. As expert evidence can reflect upon the reasonableness or appropriateness of the rehabilitation treatment services requested, it may be necessary to seek input from various experts in respect of particular areas of dispute concerning rehabilitation services. It is necessary to ensure the expert in fact has the expertise to comment on that particular rehabilitation service (e.g. per *McIntyre* an OT is unlikely to be in a position to undertake a cognitive function assessment, at least not without evidence of some particular training or expertise in this field). The strength of such expert evidence is that this expert can holistically consider the claimant's injuries, their impact and the rehabilitation sought in line with the definition of rehabilitation under the *MAIA*. Thus, briefing of the expert becomes really important, ensuring appropriate questions are asked about each particular rehabilitation recommendation.

13. Despite several decisions noting the formulation of rehabilitation is a matter for a claimant and their treatment providers, there continues to be a heavy reliance by courts on medical expert evidence (i.e. Orthopaedic Surgeon or Neurosurgeon). If an Application is to be run and the insurer has such medical evidence, it is necessary to obtain specific commentary from a doctor as to the insurer's evidence. Without this, it seems the courts will not accept an OT's or other allied health professional's recommendations.

Workers' compensation scheme rehabilitation

Whilst the focus of this paper is the CTP scheme, it is important to point out that the *Workers' Compensation and Rehabilitation Act 2003* defines *rehabilitation* differently to the CTP scheme. Here, the intent is a return to work or to maximise independent functioning.[7] Whilst some of the general principles from CTP cases may provide some guidance, it is important to ensure rehabilitation recommendations from a claimant's provider match the outcomes sought to be achieved in the workers' compensation scheme.

Some claims will involve a mix of obligations under multiple schemes (e.g. CTP claim with a WCRA journey component). Some of these may be such that rehabilitation obligations, when they end under one scheme, may continue under another scheme.

National Injury Insurance Scheme (Queensland)

It was not my intention to cover this is a complex and evolving area. The dynamic of treatment, care and support funding and the decision-making processes of the NIISQ Agency are fundamentally different to both the CTP and WCRA schemes. The governing Act and Regulations are for more prescriptive then either the CTP or WCRA schemes.

[7] s.40 *Workers' Compensation and Rehabilitation Act 2003.*

The professional risks in NIISQ matters is great, not just in respect of rehabilitation, but in the damages claim and process. The ALA has run many sessions so far, and will no doubt run more, in respect of the unique challenges of NIISQ claims.

I have little doubt some of the broad principles from the existing rehabilitation related cases are likely to be considered by the courts in respect of NIISQ matter, but the legislative framework is vastly different and complex, therefore lawyers must familiarize themselves with the limited jurisprudence to date.

Everything I've expressed about early, high quality rehabilitation being set up in the CTP scheme applies equally (if not more importantly) in the NIISQ context.

National Disability Insurance Scheme (NDIS)

As with NIISQ, the NDIS is a complex behemoth. A client may well be eligible to access a number of schemes, including the NDIS, and it is important to set this up strategically at the right time.

Lawyers need to be familiar NIISQ provisions relating to the exiting of participants from that scheme. Most NIISQ participants are admitted to the scheme as interim participants. The NIISQ Act mandates that at a time no later than 2 years from entry, interim participants be re-assessed for ongoing eligibility. This process is most likely to affect those with ABIs, who make up over two-thirds of the scheme participants. Decisions to exit a person are reviewable, and that's something upon which expert evidence will usually be needed in the form of a FIM assessment. Likewise, decisions to keep a person in the scheme are reviewable.

If a person exits NIISQ, and has ongoing rehabilitation needs, it would be prudent to ensure that the CTP insurer is given an updated OT's needs assessment so that the claimant's rehabilitation needs are then addressed under s.51 of the *MAIA*. That may come as an annoying surprise to some CTP insurers. And, of course, many people under the age of 65 who may no longer meet NIISQ eligibility criteria may also be eligible for supports under the NDIS. Thinking ahead, and laterally about those matters should minimise the risk of time gaps in rehabilitation.