SIRA

Motor Accident Guidelines: CTP Care (version 1.0)

State Insurance
Regulatory Authority

NSW GOVERNMENT

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About these guidelines

Parts of the Guidelines

These guidelines are divided into the following parts:

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Part 1	Principles and general obligations
Part 2	Before LCSA is the relevant insurer
Part 3	After LCSA is the relevant insurer
Part 4	Complaints
Part 5	Recovery plans
Part 6	Treatment and care
Part 7	Claims made more than 5 years from the date of accident
Part 8	Internal review and disputes
Part 9	Information and data provision

Publication note

These Guidelines are published by the State Insurance Regulatory Authority (SIRA). SIRA was established on 1 September 2015 under the *State Insurance and Care Governance Act 2015* (SICG Act) as the regulator of compulsory insurance schemes in New South Wales (NSW).

Purpose

The Guidelines support the delivery of the objects of the *Motor Accident Injuries Act 2017* (the Act) and the Motor Accident Injuries Regulation 2017 (the Regulation) by establishing clear processes and procedures, scheme objectives and compliance requirements.

People injured in a motor accident on and from 1 December 2017 who require treatment and care statutory benefits more than five years after the relevant motor accident will, for the purposes of the payment of treatment and care benefits be transferred to the Lifetime Care and Support Authority (LCSA) as the relevant insurer as provided for under sections 3.2 and 3.45 of the Act.

CTP Care is administered by the LCSA and refers to the functions exercised by the LCSA as the relevant insurer under the Act.

The first claimants will transition from the CTP Insurer to CTP Care from December 2022, or earlier in some circumstances.

CTP Care Early by Agreement (EBA) enables an early transfer of an injured person if it is likely that there will be a requirement for ongoing treatment and care more than five years from the date of the accident. The licensed insurer and CTP Care will need to consider all claims information and agree that the injured person is eligible for an early transition in accordance with the Act. Any early transition to CTP Care will not have an impact on entitlements including damages claims, weekly benefits, or treatment and care.

Broadly these Guidelines set out the required procedures for the transition of the payment of statutory benefits for treatment and care from a licenced insurer to the LCSA in accordance with the Act.

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Replacement and Transition

These ***Motor Accident Guidelines: CTP Care*** replace clauses 4.103-4.105 and Part 9 of the Motor Accident Guidelines v 8.2 and commence 25 November 2022. They do not affect, replace, or amend any other Parts of the Motor Accident Guidelines v 8.2.

Unless indicated to the contrary for a particular part or clause, these Guidelines:

- apply to all claims and applications made before or after the commencement of these Guidelines
- do not invalidate a step previously undertaken under Part 9 of the Motor Accident Guidelines v8.2.

Legislative framework

The Act establishes a scheme of CTP insurance and the provision of benefits and support relating to the death of, or injury to, people injured as a consequence of motor accidents in NSW on or after 1 December 2017.

Injury or death to a person as a result of a motor accident occurring before 1 December 2017 is governed by either the *Motor Accidents Act 1988* or the *Motor Accidents Compensation Act 1999* and the relevant Regulation and Guidelines made under the *Motor Accidents Compensation Act 1999*.

The objects of the Act, as described in section 1.3 are to:

- encourage early and appropriate treatment and care to achieve optimum recovery of persons from injuries sustained in motor accidents and to maximise their return to work or other activities
- provide early and ongoing financial support for persons injured in motor accidents
- continue to make third-party bodily insurance compulsory for all owners of motor vehicles registered in NSW
- keep premiums for third-party policies affordable by ensuring that profits achieved by insurers do not exceed the amount that is sufficient to underwrite the relevant risk and by limiting benefits payable for minor injuries
- promote competition and innovation in the setting of premiums for third-party policies, and provide the Authority with a role to ensure the sustainability and affordability of the compulsory third-party insurance scheme and fair market practices
- deter fraud in connection with CTP insurance
- encourage the early resolution of motor accident claims and the quick, cost-effective and just resolution of disputes
- ensure the collection and use of data to facilitate the effective management of the CTP insurance scheme.

Section 3.2(3)(a) of the Act provides that in the case of statutory benefits for treatment and care provided more than five years after the motor accident concerned the relevant insurer is the LCSA.

Special provisions relating to the payment of statutory benefits for treatment and care by the LCSA are outlined in section 3.45(2), including:

- the LSCA is not an insurer for the purposes of the Act, rather provisions of the Act relating to insurers extend to the LSCA in the exercise of its functions under the Act
- the LSCA may enter into an agreement with an insurer to assume responsibility and become the relevant insurer for treatment and care provided during the period of five years.

CTP Care EBA enables an early transfer of an injured person if it is likely that there will be a requirement for ongoing treatment and care more than five years from the date of the accident.

The Regulation contains provisions that supplement the implementation and operation of the Act in a number of key areas.

Guideline-making powers

These Guidelines are made under sections 6.1 and 10.2 of the Act.

- Section 10.2 of the Act enables SIRA to issue Motor Accident Guidelines with respect to any matter that is authorised or required by the Act.
- Section 6.1 of the Act provides that the Motor Accident Guidelines may make provision with respect to the manner in which insurers and those acting on their behalf are to deal with claims.

Section 3.45(1) of the Act provides that the description of the LCSA as the relevant insurer for the purposes of the Act does not make that Authority an insurer when it exercises functions under the Act, but provisions of the Act relating to insurers extend (subject to the regulations) to the LCSA in connection with the exercise of those functions.

Interpretation

These Guidelines should be read in conjunction with relevant provisions of the Act, the Regulation, and the Motor Accident Guidelines and in a manner that supports the objects of the Act as described in section 1.3 of the Act.

A reference in these Guidelines to a number of days is a reference to a number of calendar days, unless otherwise specified.

Words defined in the Act or Regulation have the same meaning in these guidelines.

Note: information provided in these boxes is provided for context and clarification.

Commencement

These Guidelines will come into effect on **25 November 2022** and apply to motor accidents occurring on or after 1 December 2017.

They apply until the Authority amends, revokes, or replaces them in whole or in part.

Application

These Guidelines describe and clarify expectations that apply to respective stakeholders in the scheme. The Authority expects stakeholders to comply with relevant parts of the Guidelines that apply to them.

These Guidelines apply to licenced insurers. It is a condition of an insurer's licence under section 10.7 of the Act that it complies with relevant provisions of the guidelines.

These Guidelines also apply to the LCSA in the exercise of its functions as the relevant insurer:

- for the payment of statutory benefits for treatment and care provided more than five years after a motor accident under section 3.2 of the Act, or
- when it enters into an agreement with a licenced insurer to assume responsibility for the payment of statutory benefits for treatment and care provided within five years after a motor accident under section 3.45 of the Act.

These Guidelines also apply to key scheme stakeholders and service providers including injured persons and claimants, health practitioners, lawyers and other representatives, decision-makers, courts and other dispute resolution bodies.

Compliance

SIRA will monitor and review compliance with the guidelines in line with its statutory functions.

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Part 1: Principles and general obligations

Principles

1.1 The following principles apply to an insurer and the LCSA when the payment of treatment and care expenses for an injured person is transitioned from an insurer to LCSA:

a) to act in good faith

b) to work collaboratively to ensure proactive and timely support for the injured person to optimise their recovery and return to work or other activities

c) apply SIRA's Customer Service Conduct Principles

d) open and transparent sharing of relevant information to support a smooth transition.

1.2 The principles at clause 1.1 are to be read together with those principles outlined in Part 4 of the Motor Accident Guidelines, which continue to apply across all claims management aspects for the life of the claim.

General obligations

1.3 The licensed insurer and LCSA are required to:

a) facilitate a seamless transition to ensure that injured people can access treatment and care in accordance with the Act

b) ensure the injured person is not adversely affected by the transition process and is kept informed about all relevant matters

c) proactively support the injured person to optimise their recovery and return to work or other activities

d) ensure the transition does not adversely affect quality decision-making on whether statutory benefits are payable for the cost of treatment and care

e) work together to advance the objective of section 1.3(2)(g) of the Act in resolving claims and disputes

f) respond to requests for information about the claim as relevant to the payment of treatment and care expenses

g) provide relevant material and/or information to each other to enable each to fulfill its obligations

h) promptly respond to requests from each other

i) ensure the injured person is informed of any ongoing responsibilities of the licenced insurer, including any ongoing payment of weekly statutory benefits and / or management of any damages claim.

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Part 2: Before LCSA is the relevant insurer

Data and information

2.1 The licensed insurer must provide LCSA with accurate and current data including:

a) all active claims in which the injured person is likely to require treatment and care more than 5 years after the motor accident, and

b) all active claims in which an injured person is requiring treatment and care post 5 years of the motor accident and was not initially transferred.

2.2 The licensed insurer must provide LCSA with copies of all supporting documents and information agreed between them to be relevant to the transitioning claim as soon as reasonably practicable, and no later than 5 business days (prior to the claim being transferred to LCSA as the relevant insurer). For active claims (including inactive claims which have recently become active), where there are ongoing treatment and care needs, this is to include clearly labelled data and information about:

a) the injured person's current contact details

b) a copy of the signed 'Personal Injury Benefits claim form' and/or 'Liability Notice claim for damages' handover form

c) liability notice(s)

d) medical/ allied health reports relevant to ongoing treatment and care

e) most recent recovery plan

f) most recent or current certificate of fitness (where applicable)

g) any current complaints relevant to the licensed insurer's ongoing management of the claim for treatment and care

h) any current internal review requests and/or decisions relevant to treatment and care

i) details of approved current or future treatment and care approved up to 5 years after the motor accident concerned

j) other information as agreed between LCSA and the licenced insurer.

2.3 If LCSA enters into an agreement with a licensed insurer to assume responsibility for the payment of statutory benefits for treatment and care during the period of five years after the motor accident concerned, LCSA and the licensed insurer must retain a copy of the executed agreement and provide it to the Authority on request.

2.4 After 5 years from the motor accident, when an inactive claim becomes active and there is likely treatment and care needs, the licensed insurer must notify LCSA within two business days once the claim becomes active.

CTP Care Early by Agreement (EBA) under section 3.45 of the Act

The licenced insurer and LCSA may agree to an early transition to CTP Care as outlined in section 3.45 of the Act.

2.5 Where it is agreed that the injured person will transfer early to LCSA as the relevant insurer for the purposes of the payment of statutory benefits for treatment and care, the licenced insurer is to confirm in writing with the injured person and LCSA the agreement and the expected date for transition as soon as reasonably practicable (but not later than 2 weeks before the agreed date of transition).

Under section 2.36 of the Act, the Nominal Defendant allocates claims made against it to licenced insurers. A licenced insurer to whom a claim is allocated is authorised, on behalf of and in the name of the Nominal Defendant, to deal with the claim in such manner as it thinks fit.

If the injured person will transfer early to LCSA as the relevant insurer, and the licenced insurer is managing the claim on behalf of another insurer or the Nominal Defendant, then the licenced

insurer should contact the relevant insurer to inform them of the early agreement under section 3.45 of the Act.

Active and Inactive claims

2.6 Before classifying a claim as administratively 'inactive' in the system, the insurer must:

a) make contact with the injured person by their preferred communication method to:

i. understand any current and future treatment and care needs

ii. ensure that statutory benefits for treatment and care provided has been paid in accordance with the Act

iii. ensure that the injured person is informed of all ongoing entitlement to statutory benefits under the Act, and the relevant contact details for making a claim for any further statutory benefits.

iv. ensure that the injured person is aware that the classification of a claim as inactive as per cl 2.7 does not affect their ongoing entitlement to claim future statutory benefits such as for treatment and care, where reasonable and necessary, and that their right to legal representation in respect of such future claims is also preserved.

b) The insurer must provide written notice to the injured person confirming the information in cl 2.6(a)(iii) to (iv) above:

i. after making contact, or

ii. after at least two unsuccessful attempts to make contact.

2.7 The insurer may 'close' the claim for claims administration purposes in their system on the basis the claim is inactive only after completing the requirements as per cl 2.6 (b).

2.8 If further statutory benefits are claimed, the insurer must promptly, and within 2 business days, 'reopen' the claim file in their system and the claim will become 'active'.

Notification requirements claims active at 4.5 years after the motor accident concerned

2.9 A licensed insurer must give an injured person notice in accordance with the timeframes specified in the table under cl 2.10 that LCSA will become the relevant insurer for the purposes of the payment of statutory benefits for treatment and care after 5 years. The notice must be in accordance with the provisions set out at 2.11-2.14 below.

This clause applies unless:

a) the claim is inactive (where the claim is inactive, notice must have been provided to the claimant in accordance with cl 2.6(b))

b) the claim is active for reasons other than treatment and care needs (for example, the claim is open only for processing outstanding invoices, recovery or a claim for damages).

2.10 The notice must be in writing and given at the following times:

Written Notice	Timeframe
In the case of CTP Care early transition by agreement under section 3.45	At least **2 weeks before** the agreed date that LCSA becomes the relevant insurer
When LCSA becomes the relevant insurer more than 5 years after the motor accident in accordance with section 3.2(3) of the Act	• No later than at **4 years and 6 months** after the date of the motor accident concerned (6-month notice), and • No later than **2 weeks before** the 5-year anniversary of the motor accident concerned (2-week notice)

2.11 The licensed insurer must provide LCSA with a copy of the notice at the same time the licensed insurer gives a copy of the notice to the injured person.

2.12 Where a 6 month notice is required prior to the date of transfer, the notice must contain:

a) the date of transition to LCSA as the relevant insurer for the payment of statutory benefits for treatment and care

b) the relevant legislative provisions

c) the ongoing responsibilities of the licensed insurer (where relevant to the claim), including payment of weekly statutory benefits, management of any claim for damages and the payment of statutory benefits for treatment and care provided before the LCSA becomes the relevant insurer

d) that the insurer will notify the injured person's current treatment and care service providers that LCSA will soon be the relevant insurer

e) the general contact details for SIRA's CTP Assist and the LCSA

f) A copy of the SIRA 'CTP Care – fact sheet'

2.13 The 2-week notice must contain:

a) the transfer process and the likely effect on the management of the claim

b) the ongoing responsibilities of the licensed insurer (where relevant to the claim), including management of any claim for damages and the payment of statutory benefits for treatment and care provided before the LCSA becomes the relevant insurer

c) that LCSA will notify the injured person in writing to confirm the transfer has taken place

d) the general contact details for SIRA's CTP Assist and the LCSA

e) A copy of the SIRA 'CTP Care – early transition factsheet'

2.14 The licensed insurer must also notify the injured person's current treatment and care service providers that LCSA will soon be the relevant insurer and to whom accounts should be directed and from when (depending on when the treatment and care was provided). This notice must be given at least 2 weeks before LCSA becomes the relevant insurer.

Note: this clause does not apply for a licensed insurer if the injured person is an interim participant of the Lifetime Care and Support Scheme and there is an early transition to LCSA as the relevant insurer (LCSA is responsible for notifying treatment and care service providers in this case).

Part 3: After LCSA is the relevant insurer

Data and information

3.1 After LCSA is the relevant insurer, the licensed insurer must continue to provide LCSA with copies of any new data and information (listed under cl 2.2 (a) to (j)) relevant to the payment of statutory benefits for treatment and care.

3.2 The licensed insurer must provide the following to LCSA as early as practicable after the licenced insurer receives it, and no later than 5 business days from receipt:

a) any new relevant data and information

b) any relevant communication between the licensed insurer and the injured person.

Initial notification requirements

3.3 No later than 5 business days after LCSA becomes the relevant insurer for the payment of statutory benefits for treatment and care, LCSA must notify the injured person in writing of the following:

a) confirmation that LCSA is the relevant insurer for the payment of statutory benefits for treatment and care
b) the date LCSA became the relevant insurer for the payment of statutory benefits for treatment and care
c) details of what LCSA will be responsible for
d) contact details of the LCSA contact officer
e) details of how to make a complaint
f) contact details for SIRA's CTP Assist

3.4 No later than 2 weeks after LCSA becomes the relevant insurer for the payment of statutory benefits for treatment and care, LCSA must notify the injured person's current treatment and care service providers that LCSA is the relevant insurer and provide contact details for the LCSA contact officer.

Ongoing notification requirements

3.5 The licensed insurer must notify LCSA within 5 business days after a damages claim has finalised that is related to a claim for which LCSA is the relevant insurer for the payment of statutory benefits for treatment and care.

3.6 LCSA must notify SIRA in writing within 5 business days of the following:

a) disputes under section 3.45(5) of the Act that are likely to be referred to the Personal Injury Commission
b) applications for judicial review, from decisions of the Commission in matters which the LCSA, as relevant insurer under the Act, is named as a party
c) any likely or actual dissolution of an agreement between a licensed insurer and LCSA under section 3.45(2) of the Act
d) notifiable Data Breaches in accordance with the relevant privacy legislation
e) any funding issues identified relating to an early assumption of responsibilities by LCSA under section 3.45 of the Act
f) all significant breaches of any legislation relevant to the functions of LCSA as relevant insurer under the Act.

Communication with the injured person

3.7 When communicating with an injured person, LCSA must:

a) communicate directly with the injured person to deal with the claim (regardless of whether the injured person is legally represented)
b) where a friend assists the injured person with the claim – communicate directly with that friend in addition to the injured person (or, instead of the injured person if appropriate in all the circumstances), regardless of whether the injured person is legally represented
c) if requested in writing to do so by the injured person, friend or injured person's legal representative, copy the injured person's legal representative into all written correspondence
d) in this clause *friend* means a person, including a family member, who is assisting the injured person with the claim and has written authority from the injured person to give and receive information (including as relevant, personal and health information) about the claimant and their claim. It does not include a legal representative acting on instructions. The injured person can revoke the authority at any time by notifying LCSA or can limit the friend's authority to a specified timeframe.

3.8 If a dispute arises between LCSA and a legally represented injured person and proceedings are commenced at the Personal Injury Commission, LCSA is not to communicate with the

injured person directly about the dispute and must communicate only with the injured person's legal representative.

Making a claim 'inactive'

3.9 Where a claim has transferred initially to the LCSA as the relevant insurer and the LCSA has determined that there is no ongoing treatment and care need, in order to classify the file as 'inactive', the LCSA must:

a) ensure that the injured person is informed of all ongoing entitlement to statutory benefits under the Act, and the relevant contact details for making a claim for any further statutory benefits
b) ensure that the injured person is aware that the classification of a claim as inactive as per cl 3.12 does not affect their ongoing entitlement to claim future statutory benefits such as for treatment and care, where reasonable and necessary, and that their right to legal representation in respect of such future claims is also preserved
c) provide to the injured person the general contact details for LCSA.

3.10 Where the LCSA has been managing the claim as the relevant insurer after the transfer and the LCSA has determined that there is no ongoing treatment and care need, in order to classify the file as 'inactive', the LCSA must make contact with the injured person by their preferred communication method to:

a) understand any current and future treatment and care needs
b) ensure that statutory benefits for treatment and care provided has been paid in accordance with the Act
c) ensure that the injured person is informed of all ongoing entitlement to statutory benefits under the Act, and the relevant contact details for making a claim for any further statutory benefits.
d) ensure that the injured person is aware that the classification of a claim as inactive as per cl 3.12 does not affect their ongoing entitlement to claim future statutory benefits such as for treatment and care, where reasonable and necessary, and that their right to legal representation in respect of such future claims is also preserved.

3.11 The LCSA must provide written notice to the injured person confirming the information in cl 3.9 a) to c), or cl 3.10 a) to d) as relevant, above:

a) after making contact, or
b) after at least two unsuccessful attempts to make contact.

3.12 The LCSA may 'close' the claim for claims administration purposes in their system on the basis the claim is inactive only after completing the requirements as per cl 3.9 a) to c) or cl 3.10 a) to d) as relevant.

3.13 If after making the claim 'inactive' in the system, the injured person later identifies a treatment and care need and makes a claim for statutory benefits, the LCSA must promptly, and within 2 business days, 'reopen' the claim file in their system and the claim will become 'active'.

Part 4 Complaints

An injured person may complain to the **Independent Review Officer (IRO)** about any act or omission of an insurer that affects their entitlements, rights or obligations under the *Motor Accident Injuries Act* 2017 (see clause 8, Part 4 of Schedule 5 to the *Personal Injury Commission Act 2020*).

Any complaints about the LCSA in respect of its functions related to the payment of treatment and care expenses under the *Motor Accident Injuries Act 2017* may also be directed to the **IRO**.

Complaints handling

4.1 The LCSA must handle all complaints in a fair, transparent and timely manner.

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4.2 The LCSA must have a documented internal complaint and review procedure and make the procedure and information on how to make a complaint readily available and accessible to all stakeholders. This must include who the injured person can contact.

4.3 The LCSA must acknowledge all complaints in writing within 5 business days of their receipt. The acknowledgment must include:

a) if LCSA can resolve the complaint to the satisfaction of the complainant within 5 business days from the receipt of the complaint – the LCSA's written decision resolving the complaint

b) if LCSA cannot resolve a complaint to the satisfaction of the complainant within 5 business days from the receipt of the complaint – a copy of the LCSA's complaints procedure and the contact details of the representative(s) of LCSA handling the complaint.

4.4 The LCSA must resolve all complaints within 20 business days from the date of receipt and notify the complainant in writing of:

a) the outcome and reasoning of the complaint

b) the opportunity to have the complaint considered by a more senior representative of LCSA who is independent of the original decision-maker

c) information on the availability of external complaint or dispute resolution handling bodies if the complainant is dissatisfied with the LCSA's decision or procedures.

4.5 The LCSA must keep a record of all complaints it receives in a complaint register and provide a summary report to the Authority every six months. This report is due within 30 calendar days of the end of the 30 June and 31 December reporting periods. It should be formatted as set out by the Authority and include a complaints trend analysis of the risks and potential issues.

4.6 If LCSA receives a complaint regarding the conduct of a licensed insurer, then LCSA must:

a) forward the complaint to the licensed insurer within 5 business days

b) confirm with the complainant that the complaint has been forwarded.

4.7 Where the complaint concerns the conduct of both LCSA and a licensed insurer, then the party who received the complaint must:

a) respond to the complaint in respect of its own conduct

b) consult with the other party as required to investigate the complaint

c) forward the complaint to the other party for its separate response within 5 business days

d) advise the complainant of any action taken.

Part 5: Recovery plans

Requirement for recovery plans

5.1 All injured persons must have a tailored recovery plan with the following exceptions:

a) where the injured person meets one of the exceptions listed under 'Recovery Plan' in Part 4 of the Motor Accident Guidelines, or

b) where the injured person no longer has treatment and care needs but has not returned to pre-accident function.

Review of recovery plans

5.2 Where the transition to LCSA as the relevant insurer for the payment of statutory benefits for treatment and care happens more than 5 years after the motor accident, LCSA must:

a) issue the recovery plan within 3 months after the date LCSA becomes the relevant insurer

b) review the recovery plan if significant changes occur.

5.3 Where the transition to LCSA as the relevant insurer for the payment of statutory benefits for treatment and care happens early by agreement, the original recovery plan remains in place, but LCSA must:

a) review the recovery plan within 3 months or earlier where significant changes occur.

5.4 When reviewing the injured person's recovery plan, LCSA must consider:

a) the nature of the injury and the likely process of recovery
b) treatment and rehabilitation needs, including the likelihood that treatment or rehabilitation will improve earning capacity and any temporary incapacity that may result from treatment
c) any employment engaged in by the injured person after the accident
d) any certificate of fitness provided by the injured person
e) the injured person's training, skills and experience
f) the age of the injured person
g) accessibility of services within the injured person's residential area.

5.5 If, following a review, LCSA revises the injured person's recovery plan, LCSA must send the revised recovery plan to both the injured person and their nominated treating doctor (where relevant) with the following details:

a) name of injured person
b) claim number
c) date of injury
d) current treatment being undertaken
e) future treatment expected to be undertaken
f) current fitness for work and/or pre-accident activities
g) expected fitness for work and/or pre-accident activities with milestones
h) obligations of the injured person
i) consequences for the injured person if they do not adhere to the recovery plan
j) contact details of all current insurers
k) what action the injured person can take if they disagree with the recovery plan.

5.6 Clauses 5.2 to 5.5 are to be read together with relevant provisions in Part 4 of the Motor Accident Guidelines which deal with recovery plans.

Part 6: Treatment and care

Facilitating referrals

6.1 If LCSA has identified an injured person requiring treatment and care, it must facilitate referral to an appropriate treatment provider (including vocational provider, if appropriate) within 10 days of the identification, with the injured person's agreement.

6.2 LCSA must refer the injured person to an appropriate service provider reasonably accessible to the injured person.

6.3 If the injured person expresses a preference for a particular provider, then LCSA must refer the injured person to that provider subject to LCSA being satisfied as to the suitability of that provider.

6.4 If the LCSA determines that the injured person's preferred service provider is not suitable, it must notify the injured person of the reasons for its decision and refer the injured person to another service provider reasonably accessible to the injured person.

Determining requests

6.5 Where LCSA is required to determine the injured person's request for treatment and care, it will advise the injured person and service provider in writing as soon as possible but within 10 days of receipt of a request, and

(a) if approved:

i. state the costs for treatment and care the LCSA has agreed to meet

ii. when an invoice is issued directly from a treatment or care provider, verify the expenses in accordance with 'Verification of expenses' in Part 4 of the Motor Accident Guidelines

iii. pay the account as soon as possible but within 20 days of receipt of an invoice or expense.

(b) if declined, in whole or in part, provide:

i. the reasons for the decision with reference to the information relied upon in making the decision

ii. a list of all information relevant to the decision, regardless of whether the information supports the decision, including copies of all listed information

iii. an explanation of the LCSA's internal review process, including the timeframe in which an application for internal review must be made and/or right to make an application to the Personal Injury Commission

iv. information on how a claimant may make a complaint with the Independent Review Office (IRO), including the IRO's contact details.

6.6 Where the LCSA is required to determine a request for treatment and care statutory benefits, and the licensed insurer holds relevant information, the licenced insurer must provide relevant claim information to the LCSA as soon as reasonably practicable, and:

a) within 2 business days if the claim is active

b) within 5 business days if the claim is inactive

6.7 Where the insurer's claim has been inactive and the LCSA requires access to file information held by the licenced insurer to determine a request for treatment and care statutory benefits, the LCSA is to determine the request as soon as reasonably practicable, and within 10 business days of receipt of information from the licenced insurer.

6.8 If LCSA is determining an injured person's request for treatment that will potentially alter the injured person's minor injury decision, LCSA must contact the licensed insurer related to the claim before the decision is made and within 5 business days of receiving the request.

Determining requests around the transfer date

6.9 Where there are requests for treatment and care needs at around the transfer date, the following applies:

a) requests for payment of expenses in connection with providing treatment and care to an injured person at a time up to 5 years after the date of accident concerned (before the LCSA becomes the relevant insurer for the payment of statutory benefits for treatment and care) are to be made to the licensed insurer managing the claim

b) requests for payment of expenses in connection with providing treatment and care to an injured person more than 5 years after the date of accident concerned, or where the injured person has transferred EBA to CTP Care, are to be made to the LCSA who becomes the relevant insurer in accordance with sections 3.2(3) and 3.45 of the Act

c) subject to section 3.45(5) of the Act, if an invoice relates to expenses related to treatment and care provided both before and after 5 years after the date of accident concerned, the licensed insurer and the LCSA must provide each other with a copy of the invoice and only deal with payment of expenses invoiced that relate to the provision of treatment and care in the period of time when each is the relevant insurer for the purposes of payment of treatment and care in accordance with sections 3.2(3) and 3.45 of the Act

d) if the licensed insurer receives a request for the payment of expenses related to providing treatment and care to the injured person more than 5 years after the date of the accident concerned the licensed insurer must:
    i. forward a copy of the request to the LCSA, and
    ii. inform the claimant and the relevant service provider that the request has been forwarded to the LCSA including explaining why it has been referred to the LCSA and provide the relevant contact details of the LCSA to both the injured person and the relevant service provider.

e) in the event that a request for treatment and care is made in relation to treatment and care that is to be provided in the period both up to and after 5 years from the date of accident (e.g. surgery schedule to be performed while the insurer is responsible and the nursing and rehabilitation to be provided after the LCSA assumes responsibility for the payment of treatment and care after 5 years) the LCSA and the licensed insurer must consult with each other before determining the request. Responsibility for this decision will be made in accordance with Part 7 of these Guidelines.

6.10 Clause 6.9 a) to e) are to be read together with the relevant provisions under clause 6.5 in these Guidelines (if LCSA is the relevant insurer for payment of expenses) and Part 4 of the Motor Accident Guidelines (if the licensed insurer is the relevant insurer for payment of expenses) in relation to payment of invoices and timeframes.

SIRA Funded Programs under section 3.41 of the Act

An injured person whose treatment and care benefits are paid by the LCSA may participate in a SIRA funded program (vocational and return to work support schemes under section 3.41 of the Act) if they meet the eligibility criteria as determined by SIRA (see *SIRA Guidance for CTP vocational support programs – April 2020*).

6.11 If an injured person has been transferred to LCSA they may participate in a SIRA funded program if:

a) the injured person meets the eligibility criteria for the program (including certified as having a current fitness for work, and currently receiving or entitled to receive weekly payments under the Act, and

b) they are subject to an agreement under section 3.45(3) of the Act between the relevant insurer and LCSA (early by agreement).

6.12 Only the licensed insurer can approve and administer a SIRA funded program.

6.13 If the licenced insurer approves a SIRA funded program and the injured person has transferred to LCSA early by agreement, then the licenced insurer should inform the LCSA of its decision within 5 business days.

Part 7: Claims made more than 5 years from the date of accident

Responsibility for claims decisions

7.1 For claims made more than 5 years after a motor accident, LCSA and the licensed insurer are responsible for making decisions about the claim as follows:

a) LCSA in the case of the payment of statutory benefits for treatment and care.

b) licensed insurer for all other claim-related decisions.

7.2 The licensed insurer must make all decisions relating to the claim, except concerning the payment of statutory benefits for treatment and care. These include:

a) whether a late claim may be made

b) whether the injury to a person resulted from a motor accident in NSW

c) whether the motor accident was caused wholly or mostly by the fault of the person

d) whether the person's only injuries resulting from the motor accident were minor injuries

e) assessing the degree of contributory negligence.

7.3 Where the licensed insurer accepts liability for the payment of statutory benefits, LCSA must make all decisions relating to the payment of statutory benefits for treatment and care provided 5 years after the motor accident concerned. These include:

a) whether expenses were incurred in connection with providing treatment and care

b) whether the cost of specific treatment and care was reasonable and necessary in the circumstances

c) whether the requested treatment and care relates to the injury resulting from the motor accident concerned.

Part 8: Internal review and disputes

Dispute resolution is set out in Part 7 of the Act and Part 7 of the Motor Accident Guidelines. The process begins with an internal review by the insurer. If the internal review does not resolve the matter, proceedings may be commenced in the Personal Injury Commission.

General

8.1 The licenced insurer and LCSA must endeavour to resolve disputes as justly and expeditiously as possible.

8.2 Clauses 8.3 to 8.5 are to be read together with relevant provisions in Parts 4 and 7 of the Motor Accident Guidelines.

Internal review

There may be matters where an insurer internal review is requested either just before or after the LCSA becomes the relevant insurer for treatment and care 5 years after the motor accident, or early by agreement.

8.3 Responsibility for making internal review decisions are as follows:

a) if the application for internal review relates to treatment and care expenses incurred before the LCSA becomes the relevant insurer, the licensed insurer is to complete the internal review in the usual way (in compliance with the Act and the Motor Accident Guidelines)

b) if the application for internal review is in respect to any other claims-related decision not related to the payment of statutory benefits for treatment and care, the licensed insurer is to complete the internal review in accordance with cl 7.1 and 7.2 of these Guidelines

c) where a decision has been made in the first instance (by the licensed insurer), any application for internal review of decisions relating to treatment and care provided or proposed 5 years after the motor accident, or when the claim has transferred early by agreement, is to be undertaken by the LCSA as the relevant insurer

d) the LCSA and licenced insurer are to work collaboratively to ensure the internal reviewer has access to all relevant information relevant to the decision.

Commission proceedings

If the internal review does not resolve the matter, proceedings may be commenced in the Personal Injury Commission. There may be matters where a dispute is lodged either just before or after the LCSA becomes the relevant insurer for treatment and care 5 years after the motor accident, or earlier by agreement.

The licenced insurer will continue to have responsibility to manage and respond to issues that arise in the claim that are not related to treatment and care managed by the LCSA. The correct party to proceedings in the Commission may require consideration of the nature of the dispute.

Note: The Personal Injury Commission decision maker has discretion to provide for the joinder and removal of parties to proceedings, or this may be on the application of the person concerned or a party (see the *Personal Injury Commission Rules* 62 and 63).

8.4 If a claimant makes an application to the Commission, including an application for merit review or medical assessment, the party named as a respondent will need to respond. If the claim has been transitioned to LCSA, then the licenced insurer and LCSA are to consider the nature of the dispute and if required, make an application for the joinder of another party or substitution.

8.5 The LCSA and the licensed insurer must also:

a) provide the merit reviewer / medical assessor with all information the reviewer / assessor may reasonably require, and
b) give effect to merit review decisions.

Part 9: Information and data provision

Provision of information or data

9.1 LCSA must comply with SIRA's reasonable request to provide information or documents relevant to the payment of statutory benefits for treatment and care on a CTP claim. Where necessary, LCSA can also seek to clarify any requests for information from SIRA.

9.2 If SIRA is satisfied that a document provided by LCSA contains an error, SIRA may require LCSA to amend the document.

9.3 LCSA must:

a) code the injured person's injuries by using appropriately trained coders applying the most recent Abbreviated Injury Scale (AIS) Revision (or as otherwise prescribed by the Authority) and claims in accordance with the Authority's Motor Accident Insurance Regulation Injury Coding Standards and agreed timeframes and provide up-to-date and accurate claims data to the claims register, in accordance with the Act and the Universal Claims Database (UCD) Claims Data manual, as amended from time to time, or as otherwise required by the Authority
b) maintain consistent information on the claim file and data submitted to the claims register and record any changes in accordance with the UCD Claims Data manual, as amended from time to time.

9.4 LCSA must comply with any reasonable SIRA requirements for data exchange and centralised claim notification.

9.5 LCSA must update relevant claims register fields in a timely manner for all claims it manages as the relevant insurer.

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Glossary:

Glossary	
Active claim	Means the injured person is currently receiving statutory benefits for treatment and care from the insurer, or has a proposed or likely future need for treatment and care
Authority	Means the State Insurance Regulatory Authority (SIRA) as defined under the *State Insurance and Care Governance Act 2015*
Commission	Means the Personal Injury Commission of New South Wales established by the *Personal Injury Commission Act* 2020
CTP Care	Means the functions exercised by the LCSA as the relevant insurer as provided under sections 3.2 and 3.45(1) of the MAI Act in respect of the payment of treatment and care 5 years after the motor accident concerned
CTP Care Early by Agreement	Means the functions exercised by the LCSA as the relevant insurer as provided under section 3.45 of the MAI Act in respect of the payment of treatment provided during the 5 years after the motor accident concerned after agreement between an insurer and the LCSA
EBA	Means CTP Care Early by Agreement
Inactive claim	Means the injured person is not currently receiving any statutory benefits for treatment and care and there is no proposed or likely future need for treatment and care (and the claim may but not necessarily be referred to as 'closed' or 'inactive' on the insurer claims system)
IRO	Means the Independent Review Office appointed in accordance with Part 2, Schedule 5 to the *Personal Injury Commission Act 2020*
LCSA	The Lifetime Care and Support Authority of NSW as constituted under the *Motor Accidents (Lifetime Care and Support) Act 2006* and performing functions as the 'relevant insurer' under the *Motor Accident Injuries Act 2017*
MAGs	The Motor Accident Guidelines v 8.2 or any later replacement guidelines to v 8.2
Motor accidents legislation	Means *Motor Accident Injuries Act 2017, the regulations and guidelines made under that Act*
Ongoing treatment and care needs	Means current or future treatment and care has been required and approved for the claimant, or there is a dispute progressing at the Personal Injury Commission relating to treatment and care, minor injury or fault
UCD	Means Universal Claims Database, the claims register established under section 10.25 of the Act

Disclaimer

This publication may contain information that relates to the regulation of workers compensation insurance, motor accident compulsory third party (CTP) insurance and home building compensation in NSW. This publication does not represent a comprehensive statement of the law as it applies to particular problems or to individuals, or as a substitute for legal advice.

SIRA, Level 14-15, 231 Elizabeth Street, Sydney NSW 2000

Website www.sira.nsw.gov.au

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