

Australian Capital Territory

Motor Accident Injuries (COVID-19) Guidelines 2020

Disallowable instrument DI2020–94

made under the

Motor Accident Injuries Act 2019, section 487 (MAI guidelines)

1 Name of instrument

This instrument is the *Motor Accident Injuries (COVID-19) Guidelines 2020*.

2 Commencement

This instrument commences on the day after its notification.

3 Guidelines

I make the COVID-19 Guidelines attached to this instrument.

Lisa Holmes
MAI Commissioner
MAI Commission
12 May 2020

COVID-19 Guidelines

1. INTRODUCTION

The COVID-19 guidelines (guidelines) are part of the MAI guidelines made under section 487 of the *Motor Accident Injuries Act 2019* (MAI Act). A public health emergency has been declared in the ACT under the *Public Health Act 1997* as a result of the COVID-19 pandemic. The *Public Health (Emergency) Declaration 2020 (No 1)* was made on 16 March 2020 and is effective to 7 July 2020. These guidelines have been developed to apply in light of the potential impacts of the COVID-19 pandemic on business continuity and health-related services.

The guidelines deal with matters not already covered by the MAI guidelines and in some instances modify guidelines made for various purposes under the MAI Act. To the extent that the COVID-19 guidelines are inconsistent with the relevant guidelines made under section 487 of the MAI Act, the COVID-19 guidelines will prevail. These guidelines will have effect until repealed.

Other than section 2, the section headings in this document refer to particular MAI guidelines.

2. MEDICAL AND OTHER ASSESSMENTS

A number of MAI guidelines provide for the circumstances and procedures for referring injured people for medical and other assessments. This section applies to all referrals under the MAI Act and guidelines for such assessments.

An insurer should consider whether it is essential to refer an injured person for an assessment of their injuries or their fitness for work during the COVID-19 pandemic, if the assessment requires physical attendance at an appointment with a medical or allied health professional by the injured person. An insurer should explore other alternatives such as a telehealth appointment or a desk top review of existing medical reports or vocational information.

If the insurer considers it to be essential for the injured person to attend a medical or vocational assessment then an insurer should take reasonable steps for the assessment to be conducted at business premises within the ACT (for any injured person that resides in the ACT or surrounds). In arranging any appointment an injured person should also be informed of the COVID-19 procedures and policies for the health practitioner.

3. DEFINED BENEFIT APPLICATION GUIDELINES

3.1. Giving a receipt notice, late receipt notice, or required additional information notice.

Paragraph 6.1.1 of the Defined Benefit Application Guidelines is replaced as follows:

An insurer should aim to provide a receipt notice, late receipt notice or a required additional information notice, within 5 business days of an application being received. If a notice is delayed beyond this timeframe relating to disruptions with the insurer's business as a result of COVID-19, it must be given to an applicant no later than 7 business days after the day the application was received. The notice is to be given in writing, with electronic means preferred.

Where posting is required, a notice given, under section 60 of the MAI Act, by post will be taken to be given on the day it is posted by the insurer, and not on the day that it would have been delivered to the applicant.

3.2. Late applications

The period to make an application for defined benefits is 13 weeks beginning on the date of the motor accident. A late application may be made after this period has passed, provided that a full and satisfactory explanation is provided by the applicant. In considering a late application under section 59(2) that is made within 3 months after the 13 week period during 2020, an insurer may have regard to the following circumstances:

The injured person was self-isolating, or caring for another family member that was self-isolating, restricting the person's ability to attend a medical practice or obtain the medical report for the application, and the individual was able to demonstrate reasonable attempts to access medical services through telehealth and other means made available in response to COVID-19.

4. TREATMENT AND CARE GUIDELINES

4.1. Timeframe to give a recovery plan to an injured person and their doctor

Paragraph 4.2.2(A) is inserted into the Treatment and Care Guidelines after paragraph 4.2.2 as follows.:

If an insurer delays giving a recovery plan to the injured person in light of COVID-19 because they are unable to access all necessary medical reports and assessments an insurer should prepare an interim approval plan for treatment and care. The interim approval plan should cover the treatment and care that the insurer considers reasonable for the injuries and the treatment is able to be accessed in light of COVID-19 restrictions and having regard to information the insurer has about the person's injuries. The insurer need not consult with the injured person and their doctor on the interim approval plan. The interim approval plan will have effect for one month.

Paragraph 4.2.3 of the Treatment and Care Guidelines is replaced as follows:

An injured person and their doctor will have no longer than 10 business days to consider a draft recovery plan. If no further information is provided in response to the draft plan, the insurer must provide the final plan at the end of the consideration period. If further information is provided in response to the draft plan, then the final plan is to be given to the injured person and their doctor no later than 5 business days after the insurer receives all necessary information to settle the final plan.

Paragraph 4.2.4 of the Treatment and Care Guidelines is replaced as follows:

If an insurer proposes, following a review of a plan, to amend a recovery plan they should provide an injured person and their doctor with no longer than 10 business days to consider draft amendments to the plan. If no further information is provided in response to the proposed amendments, the insurer must provide the amended plan at the end of the consideration period. If further information is provided in response to the amendments, the amended plan should then be given to an injured person and their doctor and settled no later than 5 business days after an insurer receives all necessary information to settle the amended plan.

5. INCOME REPLACEMENT BENEFIT GUIDELINES

5.1. Worker stood down from employment

As a result of COVID-19 there have been workers stood down from employment under the terms of section 524 or part 6-4C of the *Fair Work Act 2009* (Cth), or a relevant enterprise agreement. A person stood down remains an employee and, therefore, in paid work within the meaning of section 78 of the MAI Act. Further, under section 525 of the Fair Work Act, a person who is on authorised paid, unpaid leave or other authorised absence is not taken to be stood down even though a stand down has been directed under section 524(1).

An insurer may need to obtain further information from the injured person to establish their status (eg. have they been stood down; are on partial stand-down as part of JobKeeper, etc) and work out the injured person's pre-injury weekly income under section 81 of the MAI Act and the Income Replacement Benefit Guidelines. Section 101(4) of the MAI Act should not be applied where an employer has stand down arrangements in effect. In the event the injured person had started a new work arrangement and was then stood down, an insurer should use either the weekly amount agreed to be paid (section 86) or look back at the injured person's pre-injury weekly income under section 81.

5.2. Fitness for work certificates

Under paragraph 10.3 of the Income Replacement Benefit Guidelines, a fitness for work certificate can cover a prospective period of longer than one month if the person giving the certificate states reasons why the certificate should cover a longer period, and the insurer is satisfied the certificate for the longer period should be accepted.

Longer certificates reduce the risks of injured people and GPs potentially being exposed to COVID-19 and insurers should discuss obtaining longer certificates with all parties, where appropriate. A GP may also issue a fitness for work certificate following a telehealth consultation, if the GP considers this to be appropriate.

Paragraph 10.5.1 of the Income Replacement Benefit Guidelines are modified as follows:

An insurer may suspend income replacement payments five business days after a person's fitness for work certificate expires. An insurer should put steps in place to ensure payments are not suspended in circumstances where there is a delay in obtaining a fitness for work certificate from a registered medical practitioner and the insurer has agreed to an extension with the injured person for the provision of a certificate prior to the expiry date of a certificate. If a fitness for work certificate is not provided by an agreed extension date then the insurer may suspend income replacement payments from the extension date.