



ACT
Government

Chief Minister, Treasury and
Economic Development

Freedom of Information Disclosure Log Publication Coversheet

The following information is provided pursuant to section 28 of the *Freedom of Information Act 2016*.

Application Details	
Ref. No.	CMTEDD FOI 2026-015
Date of Application	16 January 2026
Date of Decision	25 February 2026
Processing time (in working days)	27
Fees	Waived
Decision on Access	Partial Release
Information Requested (summary)	Access to documents in relation to the Motor Accident Injuries (Quality of Life Benefit) Guidelines 2025 (the identified instrument).
Publication Details	
Original application	<input checked="" type="checkbox"/> Published <input type="checkbox"/> N/A
Decision notice	<input checked="" type="checkbox"/> Published <input type="checkbox"/> N/A
Documents and schedule	<input checked="" type="checkbox"/> Published <input type="checkbox"/> N/A
Decision made by Ombudsman	N/A
Additional information identified by Ombudsman	N/A
Decision made by ACAT	N/A
Additional information identified by ACAT	N/A

From: no-reply@act.gov.au
To: [CMTEDD FOI](#)
Subject: Freedom of Information request
Date: Friday, 16 January 2026 12:54:24 PM

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Please find online enquiry details below. Please ensure this enquiry is responded to within fourteen working days.

Your details

All fields are optional, however an email address OR full postal address must be provided for us to process your request. An email address and telephone contact number will assist us to contact you quickly if we need to discuss your request.

Title:
First Name:
Last Name:
Business/Organisation:
Address:
Suburb:
Postcode:
State/Territory:
Phone/mobile:
Email address:

A large grey rectangular area redacting the user's personal details in the form fields.

Request for information

(Please provide as much detail as possible, for example subject matter and relevant dates, and also provide details of documents that you are not interested in.)

Under the Freedom of Information Act 2016 I want to access the following document/s (*required field):

Under the ACT Freedom of Information Act 2016 (the FOI Act) we request access to all documents relation to the consultation process, submissions and decision making in connection with the Motor Accident Injuries (Quality of Life Benefit) Guidelines 2025 (the identified instrument). The scope of these documents include, but are not limited to, the following: - Any internal or external documents outlining the consultation process for the identified instrument; - Records of steps, timelines, or methodologies used to engage stakeholders during consultations; - A complete list of stakeholders invited to provide submissions for all applicable rounds of consultations; - Copies of any and all submissions and responses received for all applicable rounds of consultation; and - Any summaries, assessments or analysis of submissions, as prepared by the Department or relevant officials.

I do not want to access the following documents in relation to my request::

Thank you.
Freedom of Information Coordinator



ACT
Government

Chief Minister, Treasury and
Economic Development

Our ref: CMTEDDFOI 2026-015



FREEDOM OF INFORMATION REQUEST – NOTICE OF DECISION

I refer to your application under section 30 of the *Freedom of Information Act 2016* (the Act), received by the Chief Minister, Treasury and Economic Development Directorate (CMTEDD) on 16 January 2026. Specifically, you have sought access to the following information:

“..we request access to all documents relation to the consultation process, submissions and decision making in connection with the Motor Accident Injuries (Quality of Life Benefit) Guidelines 2025 (the identified instrument).

The scope of these documents include, but are not limited to, the following:

- Any internal or external documents outlining the consultation process for the identified instrument;*
- Records of steps, timelines, or methodologies used to engage stakeholders during consultations;*
- A complete list of stakeholders invited to provide submissions for all applicable rounds of consultations;*
- Copies of any and all submissions and responses received for all applicable rounds of consultation; and*
- Any summaries, assessments or analysis of submissions, as prepared by the Department or relevant officials.”*

Authority

I am an Information Officer appointed by the CMTEDD Director-General under section 18 of the Act to deal with access applications made under Part 5 of the Act.

Timeframes

In accordance with section 40 of the Act, CMTEDD is required to provide a decision on your access application within 30 days.

As this matter required third party consultation, the decision due date was extended by 15 working days, in accordance with section 40(2) of the Act.

Therefore, a decision is due by **24 March 2026**.

Decision on access

Searches of CMTEDD records have identified **13** documents within the scope of your request.

I have decided to grant **full access** to two documents.

I have decided to grant **partial access** to 11 documents.

The records identified as relevant to your application are listed in the schedule enclosed at **Attachment A**. This provides a description of each document that falls within the scope of your request and the access decision for each of those documents.

Release of documents

The information being released to you is provided at **Attachment B**.

Statement of Reasons

In accordance with section 54(2) of the Act a statement of reasons outlining my decisions is below. In reaching my access decisions, I have taken the following into account:

- the Act
- the information that falls within the scope of your request
- the *Human Rights Act 2004*
- third party views
- information that is publicly available
- ACT Ombudsman FOI Guidelines

As a decision maker, I am required to determine whether the information within scope is in the public interest to release. To make this decision, I am required to:

- assess whether the information would be contrary to public interest to disclose as per **Schedule 1** of the Act.
- perform the public interest test as set out in section 17 of the Act by balancing the factors favouring disclosure and factors favouring nondisclosure in **Schedule 2** of the Act.

Exemptions claimed

Schedule 1: Information taken to be contrary to the public interest.

My reasons for deciding not to grant access to the information or components of information found within documents are as follows:

- *No relevant sections identified.*

Public Interest Test

The Act has a presumption in favour of disclosure. As a decision maker I am required to decide where, on balance, public interest lies. As part of this process, I must consider factors favouring disclosure and nondisclosure.

In *Hogan v Hinch* (2011) 243 CLR 506, [31] French CJ stated that when 'used in a statute, the term [public interest] derives its content from "the subject matter and the scope and purpose" of the enactment in which it appears'. Section 17(1) of the Act sets out the test,

to be applied to determine whether disclosure of information would be contrary to the public interest. These factors are found in subsection 17(2) and Schedule 2 of the Act.

Schedule 2: Factors to be considered when deciding the public interest

Taking into consideration the information within scope of your request, I have identified that the following public interest factors are relevant to determine if release of the information contained within these documents is within the 'public interest'.

Factors favouring disclosure (Section 2.1)

- *Section 2.1(a)(ii) - contribute to positive and informed debate on important issues or matters of public interest.*
- *Section 2.1(a)(viii) - reveal the reason for a government decision and any background or contextual information that informed the decision.*

I consider release of the information contained in these documents could reasonably promote open discussion and enhance the government's accountability regarding Motor Accident Injuries Guidelines 2025 (the identified instrument). The release of this information could also reasonably provide some background information on government decisions made in relation to the updated MAI instrument.

I am satisfied that these factors favouring disclosure carry some weight. However, these factors are to be balanced against the factors favouring nondisclosure.

Factors favouring nondisclosure (Section 2.2)

- *Section 2.2(a)(ii) - prejudice the protection of an individual's right to privacy or any other right under the Human Rights Act 2004.*
- *Section 2.2(a)(xi) - prejudice trade secrets, business affairs or research of an agency or person.*

Having reviewed the documents, I consider the protection of an individual's right to privacy is a significant factor. I have decided that their right to privacy in relation to their personal information has a higher weighting not to disclose, than the public interest has in disclosing this information. I am of the view that disclosure of names, signatures and contact information (such as email addresses and mobile phone numbers), where they are not already publicly available could prejudice their individual rights to privacy under the *Human Rights Act 2004*.

I have also considered the impact of disclosing information which relates to business affairs. In the case of *Re Mangan and The Treasury* [2005] AATA 898 the term 'business affairs' was interpreted as meaning 'the totality of the money-making affairs of an organisation or undertaking as distinct from its private or internal affairs'. Schedule 2 section 2.2(a)(xi) allows for government information to be withheld from release if disclosure of the information could reasonably be expected to prejudice the trade secrets, business affairs or research of an agency or person. In this instance I have applied this provision to a particular email address of one of a company contacted as part of the third party consultation. I note that this email address is not publicly available and that releasing it could negatively impact on the operations of that inbox, which was not intended to be publicly available, as such I see little value in releasing this email address.

Having applied the test outlined in section 17 of the Act and deciding that release of some information contained in the documents is not in the public interest to release, I have chosen to redact this specific information in accordance with section 50(2). Noting the pro-disclosure intent of the Act, I am satisfied that redacting only the information that I believe is not in the public interest to release will ensure that the intent of the Act is met and will provide you with access to the majority of the information held by CMTEDD within the scope of your request.

Charges

Processing charges are applicable for this request because the total number of pages to be released to you exceeds the charging threshold of 50 pages. However, the charges have been waived.

Online publishing – Disclosure Log

Under section 28 of the Act, CMTEDD maintains an online record of access applications called a [disclosure log](#).

Your original access application and my decision will be published on the CMTEDD disclosure log. Your personal contact details will not be published.

Ombudsman Review

My decision on your access request is a reviewable decision as identified in Schedule 3 of the Act. You have the right to seek Ombudsman review of this outcome under section 73 of the Act within 20 working days from the day that my decision is provided to you, or a longer period allowed by the Ombudsman.

We recommend using this form [Applying for an Ombudsman Review](#) to ensure you provide all of the required information. Alternatively, you may write to the Ombudsman at:

The ACT Ombudsman
GPO Box 442
CANBERRA ACT 2601

Via email: actfoi@ombudsman.gov.au

ACT Civil and Administrative Tribunal (ACAT) Review

Under section 84 of the Act, if a decision is made under section 82(1) on an Ombudsman review, you may apply to the ACAT for review of the Ombudsman decision. Further information may be obtained from the ACAT at:

ACT Civil and Administrative Tribunal
GPO Box 370
Canberra City ACT 2601
Telephone: (02) 6207 1740
<http://www.acat.act.gov.au/>

Should you have any queries in relation to your request please contact the CMTEDD FOI Team by telephone on 6207 7754 or email CMTEDDFOI@act.gov.au.

Yours sincerely

Handwritten signature of Emma Hotham, consisting of the letters 'EH' in a stylized, cursive font.

Emma Hotham

Information Officer

Chief Minister, Treasury and Economic Development Directorate

24 February 2026



ACT
Government

Chief Minister, Treasury and
Economic Development

FREEDOM OF INFORMATION REQUEST SCHEDULE

WHAT ARE THE PARAMETERS OF THE REQUEST	Reference NO.
<p><i>“...we request access to all documents relation to the consultation process, submissions and decision making in connection with the Motor Accident Injuries (Quality of Life Benefit) Guidelines 2025 (the identified instrument). The scope of these documents include, but are not limited to, the following:</i></p> <ul style="list-style-type: none"> - Any internal or external documents outlining the consultation process for the identified instrument; - Records of steps, timelines, or methodologies used to engage stakeholders during consultations; - A complete list of stakeholders invited to provide submissions for all applicable rounds of consultations; - Copies of any and all submissions and responses received for all applicable rounds of consultation; and - Any summaries, assessments or analysis of submissions, as prepared by the Department or relevant officials.” 	<p>CMTEDDFOI 2026-015</p>

Ref No	Page number	Description	Date	Status	Reason for Exemption	Online Release Status
1	1-10	Email Correspondence: Guideline updates consultation	17 March 2025	Partial Release	Sch 2 s2.2 (a)(ii) and s2.2 (a)(xi)	Yes
2	11-20	Email Correspondence: Guidelines updates - insurers	17 March 2025	Partial Release	Sch 2 s2.2 (a)(ii) and s2.2 (a)(xi)	Yes
3	21-30	Email Correspondence: Motor Accident Injuries Guidelines update - lawyers	17 March 2025	Full Release		Yes
4	31-34	ICA Submission MAI Guidelines Update	9 April 2025	Partial Release	Sch 2 s2.2 (a)(ii)	Yes
5	35-36	Email Correspondence: Law Society Comments on Guidelines update	11 April 2025	Partial Release	Sch 2 s2.2 (a)(ii)	Yes
6	37-55	Email Correspondence: Consultation Draft - Updated Quality of Life Benefit Guidelines	17 September 2025	Partial Release	Sch 2 s2.2 (a)(ii) and s2.2 (a)(xi)	Yes
7	56-74	Email Correspondence: Consultation Draft- Motor Accident Injuries (Quality of Life Benefit) Guidelines	17 September 2025	Partial Release	Sch 2 s2.2 (a)(ii)	Yes

8	75-93	Email Correspondence: QOL consultation update to insurers	17 September 2025	Partial Release	Sch 2 s2.2 (a)(ii) and s2.2 (a)(xi)	Yes
9	94-112	Email Correspondence: QOL consultation update to Lawyers	17 September 2025	Partial Release	Sch 2 s2.2 (a)(ii)	Yes
10	113-119	Email Correspondence: FW_ Consultation Draft - Updated Quality of Life Benefit Guidelines	8 October 2025	Partial Release	Sch 2 s2.2 (a)(ii) and s2.2 (a)(xi)	Yes
11	120-139	Email Correspondence: MAIC to ACT Law Society - FW_ Consultation Draft- Motor Accident Injuries (Quality of Life Benefit) Guidelines	13 October 2025	Partial Release	Sch 2 s2.2 (a)(ii)	Yes
12	140-142	Email Correspondence: ACTLS to MAIC - RE_ Consultation Draft- Motor Accident Injuries (Quality of Life Benefit) Guidelines	17 October 2025	Partial Release	Sch 2 s2.2 (a)(ii)	Yes
13	143-160	Quality of Life Guidelines - Consultation Draft - September 2025	September 2025	Full Release		Yes
Total						
No of Docs						
13						

GUIDELINES UPDATE (MARCH 2025)- CONSULTATION DRAFT

The Motor Accident Injuries Commission has identified a few updates to four guidelines that are minor in nature. An extract approach has been undertaken rather than providing whole guidelines that have very few proposed amendments for the purpose of consultation. It is noted that following consultation, each of the guidelines will be re-made rather than amended. Underlined text is proposed to be added. Strike-through text is proposed to be removed. Typos and grammar changes have not been highlighted.

A: Treatment and Care Guidelines

- Updating preamble to make it clearer that the guidelines are legislative requirements.

1. INTRODUCTION

The treatment and care guidelines (guidelines) are part of the MAI guidelines made under section 487 of the *Motor Accident Injuries Act 2019* (MAI Act). The purpose of the guidelines is to set out requirements for ~~provide guidance about~~ approving and making payments for treatment and care benefits.

Specifically, this material details an insurer's ~~is designed to guide insurers as to their~~ obligations to pay benefits for the treatment and care of an injured person including making decisions about whether the treatment and care is considered reasonable and necessary, approving treatment and care in a recovery plan, and verifying treatment and care expenses.

- Using the treating practitioner as the primary source of information about an injured person's injuries and making it clear that existing treatment and care for injuries not related to the motor accident can be considered in developing a recovery plan.

3.1 Circumstances that an insurer may ask for an assessment of a person's injuries

3.1.1 An insurer may ask for an assessment of an injured person's injuries:

- if the insurer requires additional information to prepare or review a treatment and care request or treatment in a recovery plan;
- to make a decision about the approval of treatment and care expenses;
- to resolve conflicting medical information or a dispute about a person's treatment and care needs; or
- to determine whether, or the extent that, the person's injuries resulted from a motor accident.

An independent health assessment may also be referred to by an insurer as an "Independent Medical Examination" or to the doctor as an "Independent Medical Examiner", generally IME for

short. This is not the person defined by section 14 of the MAI Act, but a long-standing term used by insurers and medical report providers, where an independent assessment is considered necessary.

3.1.2 An insurer may also ask for an assessment for an Australian citizen or permanent resident intending to reside overseas that will be entitled to periodic payments.

3.1.3 ~~To minimise the frequency of medical appointments for an injured person an insurer~~ An insurer must first request and consider any relevant additional information available from a treating practitioner prior to asking for an assessment of an injured person's injuries. –An examination, where practicable, should occur close to the injured person's jurisdiction/location. Where a public health emergency declaration is in place for the ACT (or another jurisdiction where the injured person resides, or the health practitioner is located) an insurer should consider whether it is essential for the person to physically attend an assessment. In these circumstances, the insurer should explore other avenues for conducting the assessment, such as through a telehealth appointment or a desk top review of existing medical reports or vocational reports. An insurer must take steps to ensure assessments are necessary and appropriate and should not arrange unnecessarily frequent examinations. A request will ordinarily be considered necessary and appropriate if the treating practitioner has not responded to a request for information from the insurer after 10 business days, or the information provided by the treating practitioner is inadequate.

- To clarify that a registered health practitioner can conduct an assessment of an injured person's treatment and care needs if the assessment is within the scope of the practitioner's area of professional practice.

3.2 The conduct of an assessment

3.2.1 An assessment of an injured person's injuries is to be conducted by a health practitioner selected by an insurer. The health practitioner ~~is to should~~ be appropriately qualified and experienced, with the assessment being arranged or sought to be within the scope of the practitioner's area of practice. For example, an occupational therapist could undertake cognitive testing of a person if they have a working knowledge of the assessment tool being utilised.

[Note 3.2.1 is to be split with the current third sentence to become 3.2.2, and each paragraph number changed sequentially]

3.2.7 6 An insurer is to meet the cost of an assessment including any reasonable and necessary travel expenses for the person and their parent, guardian or carer to attend the assessment.

- Clarifying that an insurer is to consider existing treatment and care unrelated to the motor accident, and the role of a rehabilitation provider, in developing a recovery plan.

4.1 Information to be considered by an insurer when developing a recovery plan

4.1.1 An insurer must undertake an assessment of the injured person upon receipt of their personal injuries application to identify any barriers to their recovery from injuries sustained as a result of the motor accident. The assessment may include direct contact with the person and must include consideration of available information provided by their treating doctor.

4.1.2 When developing a recovery plan for an injured person an insurer is to consider:

- the nature of the person's injuries and likely process of recovery;
- a person's reasonable and necessary treatment and rehabilitation needs, including the likelihood that treatment and rehabilitation will enhance a return to normal activities;
- any existing supports or other treatment and care the person is receiving for injuries or conditions not directly related to the motor accident;
- employment engaged in by the person after the motor accident;
- any recent medical reports or assessments of reasonable and necessary treatment and care needs for the person;
- any certificate of fitness provided by the person;
- the age of the person; and
- accessibility of services within the person's residential area.

4.1.3 An insurer must develop a recovery plan in consultation with an injured person, their nominated treating doctor or team, and any other health service provider as appropriate. An injured person may also authorise an insurer to contact their employer, to enable the employer to elect to participate in the plan. A copy of a draft recovery plan or a proposed amended plan must be provided to an injured person and their nominated treating doctor to consider, prior to the plan being settled.

4.1.4 An insurer may use the services of an external rehabilitation provider to inform a draft recovery plan. As part of this role the provider should consult the injured person and their treatment providers and also co-ordinate any recommendations to the insurer for the approval of treatment and care in a plan. An insurer may also incorporate a rehabilitation plan settled by an external rehabilitation provider into a recovery plan. In these circumstances, an overlaying recovery plan would still be required containing details of treatment and care approved by the insurer for the currency of the plan, and any remaining information required under clause 4.2.2 of these guidelines.

- Clarifying that an insurer is to assist an injured person in gathering information to make a treatment and care decision including by paying the reasonable costs of medical reports.

6.3 If an insurer does not approve a request to pay treatment and care benefits, including the full reimbursement of an incurred expense, the insurer must give written reasons for their decision and inform the injured person of any review rights. If a request is not approved because the insurer does not have sufficient information to support the request, the application is to be refused on this basis and the written reasons are to list any additional information the insurer would require for a further approval decision. As the reason is not likely to be for one or more of the reasons listed in items 7, 8 or 9 of Schedule 1, part 1.1 of the MAI Act, in these circumstances an insurer is to advise that a further approval decision can be made once the additional information is provided to the insurer, with the insurer then having 10 business days to make this decision from the date they receive the information. The insurer is to assist the injured person in gathering any pertinent information to make a further approval decision, including by paying the reasonable and necessary costs of obtaining a medical opinion or other evidence about the person's injuries.

- Clarifying that an insurer may attribute reasonable and necessary treatment and care for pre-existing injuries.

6.4 Treatment and care that is considered reasonable and necessary

In deciding whether treatment and care is reasonable and necessary an insurer must consider the factors set out in section 120 of the MAI Act.

6.4.1 Directly related to a person's injuries

Treatment and care will be directly related to an injured person's injury if a service relates to an injury caused by the motor accident including the exacerbation of a pre-existing injury. In determining whether treatment and care is directly related to person's injury an insurer may consider:

- the time elapsed since the motor accident,
- the extent an injury relates to the exacerbation of a pre-existing injury, and
- any subsequent injuries or comorbidities.

If it is unclear whether treatment and care being sought is directly related to the person's injuries from the motor accident, an insurer is to seek information about a person's medical history or supports including any treatment and care being provided by another scheme, for pre-existing injuries, subsequent injuries or comorbidities. If the requested information, or a consent to obtain the information from another scheme is not provided in a timely manner, being no later than 10 business days from the request, an insurer may consider the treatment or care is not directly related to a person's injury and refuse the request.

- Clarifying the application of the clinical framework is for health practitioners only

7. CLINICAL FRAMEWORK PRINCIPLES TO BE FOLLOWED BY HEALTH PRACTITIONERS (Section 131)

In approving treatment and care for an injured person to be provided by a health practitioner the insurer must ensure that the treatment and care will be ~~set out in a recovery plan or otherwise approved under these guidelines~~ is carried out in a manner that adopts the principles of the nationally endorsed Clinical Framework for the Delivery of Health Services¹. These principles are to:

- measure and demonstrate the effectiveness of treatment
- adopt a biopsychosocial approach-considering the whole person and their individual circumstances
- empower the injured person to manage their injury
- implement goals focused on optimising function, participation and where applicable return to work or study
- base treatment on best available research

¹ The Clinical Framework for the Delivery of Health Services is supported by the ACT Government and available from the websites of the State Insurance Regulatory Authority and the Transport Accident Commission.

B: Quality of Life Benefit Guidelines

- To update the preamble to make it clearer that the guidelines are legislative requirements and not simply advice or guidance material.

1. INTRODUCTION

The Quality of Life Benefit guidelines (guidelines) are part of the MAI guidelines made under section 487 of the *Motor Accident Injuries Act 2019* (MAI Act). The purpose of the guidelines is to ~~set out requirements provide guidance about~~ for applications and offers for quality of life defined benefit amounts.

Specifically, this material ~~details the insurers' obligations advises insurers of their obligations~~ in providing information and support to potential applicants for quality of life benefits, procedures for arranging Whole Person Impairment (WPI) assessments and making offers for quality of life defined benefit amounts.

- To clarify the location of provider rules and the need to use MAI Commission referral form.

6.3. Selecting an IME provider if more than one authorised

6.3.1 If the MAI Commission has authorised more than one IME provider to arrange WPI assessments, an insurer must put procedures in place to ensure that all authorised IME providers are allocated referrals from an insurer on an equal and sequential basis. For example, if there are two authorised IME providers an insurer should alternate referrals for any given injured person, between the two providers, based on the time and date of a referral. The only exceptions to this rule should be if:

- the allocated provider is unable to provide an assessment for all body systems for the injured person;
- an injured person has previously received a physical or primary psychological assessment from another provider; or
- another provider operates in an interstate or overseas location closer to where the injured person resides or works.

An insurer must keep a register of all referrals to authorised IME providers.

6.4 Arranging appointments with an independent medical examiner provider

6.4.1 An insurer must prepare a written referral to the authorised IME provider. The referral is to be made using a form prescribed by the MAI Commission ~~provided by an authorised IME provider~~. The referral ~~is to~~ should detail the injuries and body systems to be covered by the WPI assessment report and whether the insurer has received either a notice or information for a diagnosis of a psychological or psychiatric disorder.

A prospective update

The MAI Commission has been considering whether further guidelines are required in the context of applications for the assessment of psychological impairments. Stakeholders are invited to comment on possible options.

For the purposes of section 137(3)(c) of the MAI Act, a quality-of-life benefit application for a person requesting a primary psychological assessment must be accompanied by a written notice from a psychiatrist, or clinical psychologist in accordance with subsection 150(3) of the MAI Act. The notice must include a diagnosis of the primary psychological injury based on a recognised diagnostic system and specify the diagnostic criteria upon which the diagnosis is based.

The Commission observes that in some applications the insurer has not been requested to pay treatment and care expenses associated with mental health treatment. If the first time a person sees a psychiatrist or psychologist is for the sole purposes of a report, and these were treatment providers appropriate for the person's injury, this is of concern. Appropriate treatment and care by qualified health professionals is paramount to the person's recovery. Where indicated other disciplines may also be appropriate (for step down or exercise-based programs for ongoing care), along with a General Practitioner.

One option is to extend the time before an application can be considered by a MAI insurer (eg. if an application is made exactly on 26 weeks, a longer period, for example, up to no later 52 weeks may be allowed because further rehabilitation and treatment is required). It is important to establish a treatment regime, noting there can be delays in access.

A second option is for the guidelines to include criteria for an insurer to consider for an application, including the type and length of mental health treatment the injured person has had when determining whether the person is stable and able to be referred for assessment. Alternatively, to outline in the guidelines the mental health treatment a person shall have received or undertaken before considering the report from the psychiatrist or clinical psychologist and forming a reasonable belief as to the person's stability.

C: Significant Occupational Impact Assessment Referral Guidelines

- To provide a timeline for consent, to clarify location of provider rules and need to use MAI Commission form.

3.1 Information required to make a referral

3.1.1 An insurer must provide an information pack about a SOI assessment to an injured person who is likely to meet the conditions for a referral for a SOI assessment under section 209 of the MAI Act if the person was not at fault in the motor accident and not involved in a blameless motor accident and 4 years has passed since the date of the motor accident.

3.1.2 The information pack is to explain the purpose and eligibility requirements for the SOI assessment referral, how the assessment is to be carried out, and information regarding supporting documentation that the injured person will need to provide for an assessment. The pack must also include a consent form for a referral for a SOI assessment. The written consent may be given from 4

years and no later than 5 years after the motor accident, or no later than 3 months after the WPI report is provided by an insurer to the injured person for an assessment undertaken under section 141 (WPI assessment 4 years 6 months after motor accident), whichever is later.

3.3. Selecting an Independent Medical Examination (IME) provider

3.3.1 If the MAI Commission has authorised more than one IME provider to arrange Significant Occupational Impact assessments, the MAI insurer must put procedures in place to ensure that all authorised IME providers are allocated referrals from an insurer on an equal and sequential basis. For example, if there are two authorised IME providers an insurer should alternate referrals for any given injured person between the two providers. The exception to this is where the alternative approved IME provider operates in an interstate or overseas location closer to where the injured person resides. An insurer must keep a register of all referrals to authorised IME providers for SOI assessments.

3.2.1 An insurer must make a referral to an authorised IME provider as soon as practicable once 4 years and 6 months has passed since the date of the motor accident. The referral is to be made using a prescribed MAI Commission form. The insurer should be satisfied the person meets the conditions for a SOI assessment under section 209(1) of the MAI Act, and that the person has given their written consent to the insurer for the referral to be made. The insurer may delay making a referral until they have information relevant to the assessment in their possession including updated information about an injured person's education, training, and vocational and other claims history. Appendix 1 includes a list of information to be provided for a SOI assessment.

D: Defined Benefit Application Guidelines

- Updating preamble to make it clearer the guidelines are legislative requirements.

1. INTRODUCTION

The defined benefit application guidelines (guidelines) are part of the MAI guidelines made under section 487 of the Motor Accident Injuries Act 2019 (MAI Act). The purpose of the guidelines is to set out requirements for the ~~provide guidance about~~ making and handling applications for defined benefits under Part 2.3 of the MAI Act.

Specifically, this material details an insurer's obligations ~~advises insurers of their~~ in providing information and support to potential applicants, accepting applications and administering payments for treatment and care, income replacement and funeral and death benefits

- b) Incorporating procedures for closing applications into the guidelines

Note: The MAI Commission provided guidance to insurers in 2020 on the procedure to be followed by an insurer where a person no longer needs defined benefits or does not engage with an insurer after a certain period. These procedures are proposed for incorporation into the guidelines.

12. ADMINISTRATIVELY CLOSING DEFINED BENEFITS PERSONAL INJURIES APPLICATION

These guidelines make provision for matters an insurer must consider in deciding to administratively close a defined benefits personal injuries application, the procedure to be followed by the insurer before an application is closed and information to be given to an applicant about closing an

application. The closure may be requested by an applicant or initiated by the insurer. An administrative closure does not end the entitlement to defined benefits. At or after five years an insurer is to close the application if there is no further activity.

12.1 Matters to be considered in closing an application

An insurer may close a defined benefits personal injuries application prior to five years from the date of an accident if the insurer believes that it is unlikely that the person will need to access further defined benefits, or make a common law claim, under the MAI Scheme.

In making this decision the insurer must consider whether the injured person:

- has returned to all their activities of work and daily living at their pre-injury capacity;
- has completed all treatment and care set out in a recovery plan, or does not require a plan/ or a further plan;
- requires any other treatment and care outside of a recovery plan;
- has recently incurred any treatment and care expenses or missed any paid work because of their injuries, or made a request for approval or payment of treatment and care; and
- is unlikely to have a permanent impairment from their injuries from the motor accident of 5% or more; has been assessed as having a WPI of less than 5% and the person has accepted or been taken to have accepted the WPI report. Acceptance of a quality of life benefit offer may also be considered.

An application may also be closed if the injured person specifically requests the insurer to close their application, including in circumstances where the person may still require ongoing treatment and care but wishes to access the treatment and care outside of the MAI Scheme.

12.2 Procedure to be followed before an application is closed

An insurer must write to an injured person or their guardian before closing an application.

An insurer may advise the injured person or their guardian through a courtesy telephone conversation of their intention to close an application. If an insurer chooses not to make a call or is unable to contact the injured person by telephone, an insurer must write to the injured person (through the post or email) advising them of the intention to close their application.

In the written correspondence, an insurer must:

- confirm the courtesy telephone conversation (if made) or advise of the intention to close the application;
- outline the arrangements for the approval, or the payment of, any outstanding treatment and care expenses, and note that these will be paid to the provider or injured person;
- advise the injured person that their application may be re-opened if their circumstances change; and
- provide the details of the Defined Benefits Information Service (DBIS) so that the person may obtain independent information on the proposed account closure.

In all circumstances the insurer must allow the injured person a minimum of 14 calendar days from the date of an email or receipt of a letter, to contact the insurer in response to the email/letter prior to closing an application.

12.3 Information to be provided about ongoing entitlements

An insurer must notify the injured person of the closure of their application in writing. This notification is to include information about defined benefits the person may be entitled to if their circumstances change including treatment and care, income replacement and quality of life benefits.

12.4 Providing information to the Motor Accident Injury Register

An application is to be recorded as closed in agreement or lapsed on the Motor Accident Injuries Register (MAIR) and included as part of the return to the MAIR for the month in which the closure occurs. At or around the five-year anniversary of the date of the motor accident an insurer is to update the MAIR to indicate it is at the end of the entitlement period.

From: "Clark, Nicola"
Sent: 17/03/2025 4:32 PM
To: "CTP Regulatory Correspondence" <CTPRegulatoryCorrespondence@suncorp.com.au>;
Sch 2.2(a)(xi) <[REDACTED]>; "Harper, Mark" <Mark.Harper@act.gov.au>
Cc: "Forey, Melanie" <Melanie.Forey@act.gov.au>; "Tripodi, Domenico" <Domenico.Tripodi@act.gov.au>; "Lejins, Erica" <Erica.Lejins@act.gov.au>; "MCKAY, Curtis" <Curtis.MCKAY@suncorp.com.au>; **Sch 2.2(a)(ii)** <[REDACTED]>
Subject: Guidelines updates
Attachments: For consultation - Guidelines Update.pdf

Dear insurers,

As discussed at the recent Quarterly Executive Meetings, please find attached proposed updates to the following MAI Guidelines, along with a discussion on a prospective update for future inclusion in the Quality of Life Benefit Guidelines.

- A: Treatment and Care Guidelines
- B: Quality of Life Benefit Guidelines
- C: Significant Occupational Impact Assessment Referral Guidelines
- D: Defined Benefit Application Guidelines

Generally, the updates are considered to be of a minor nature and intended to provide greater clarity to Guideline users. As discussed, the application closure policy is proposed to be incorporated into the defined benefit application guidelines.

The consultation draft has also been provided to the Law Society and Bar Association for their comments.

We would appreciate any comments or feedback by **Friday 11 April 2025**. If you wish to discuss the changes, you can contact any member of the MAI Regulatory Policy and Supervision Team.

With regards,

Nicola

Nicola Clark

Senior Director

MAI Regulatory Policy and Supervision

Insurance | Economic and Financial Group

Treasury | Chief Minister, Treasury and Economic Development Directorate

ACT Government | GPO Box 158 CANBERRA ACT 2601

T (02) 6207 1189 | Web www.act.gov.au

GUIDELINES UPDATE (MARCH 2025)- CONSULTATION DRAFT

The Motor Accident Injuries Commission has identified a few updates to four guidelines that are minor in nature. An extract approach has been undertaken rather than providing whole guidelines that have very few proposed amendments for the purpose of consultation. It is noted that following consultation, each of the guidelines will be re-made rather than amended. Underlined text is proposed to be added. Strike-through text is proposed to be removed. Typos and grammar changes have not been highlighted.

A: Treatment and Care Guidelines

- Updating preamble to make it clearer that the guidelines are legislative requirements.

1. INTRODUCTION

The treatment and care guidelines (guidelines) are part of the MAI guidelines made under section 487 of the *Motor Accident Injuries Act 2019* (MAI Act). The purpose of the guidelines is to set out requirements for ~~provide guidance about~~ approving and making payments for treatment and care benefits.

Specifically, this material details an insurer's ~~is designed to guide insurers as to their~~ obligations to pay benefits for the treatment and care of an injured person including making decisions about whether the treatment and care is considered reasonable and necessary, approving treatment and care in a recovery plan, and verifying treatment and care expenses.

- Using the treating practitioner as the primary source of information about an injured person's injuries and making it clear that existing treatment and care for injuries not related to the motor accident can be considered in developing a recovery plan.

3.1 Circumstances that an insurer may ask for an assessment of a person's injuries

3.1.1 An insurer may ask for an assessment of an injured person's injuries:

- if the insurer requires additional information to prepare or review a treatment and care request or treatment in a recovery plan;
- to make a decision about the approval of treatment and care expenses;
- to resolve conflicting medical information or a dispute about a person's treatment and care needs; or
- to determine whether, or the extent that, the person's injuries resulted from a motor accident.

An independent health assessment may also be referred to by an insurer as an "Independent Medical Examination" or to the doctor as an "Independent Medical Examiner", generally IME for

short. This is not the person defined by section 14 of the MAI Act, but a long-standing term used by insurers and medical report providers, where an independent assessment is considered necessary.

3.1.2 An insurer may also ask for an assessment for an Australian citizen or permanent resident intending to reside overseas that will be entitled to periodic payments.

3.1.3 ~~To minimise the frequency of medical appointments for an injured person an insurer~~ An insurer must first request and consider any relevant additional information available from a treating practitioner prior to asking for an assessment of an injured person's injuries. –An examination, where practicable, should occur close to the injured person's jurisdiction/location. Where a public health emergency declaration is in place for the ACT (or another jurisdiction where the injured person resides, or the health practitioner is located) an insurer should consider whether it is essential for the person to physically attend an assessment. In these circumstances, the insurer should explore other avenues for conducting the assessment, such as through a telehealth appointment or a desk top review of existing medical reports or vocational reports. An insurer must take steps to ensure assessments are necessary and appropriate and should not arrange unnecessarily frequent examinations. A request will ordinarily be considered necessary and appropriate if the treating practitioner has not responded to a request for information from the insurer after 10 business days, or the information provided by the treating practitioner is inadequate.

- To clarify that a registered health practitioner can conduct an assessment of an injured person's treatment and care needs if the assessment is within the scope of the practitioner's area of professional practice.

3.2 The conduct of an assessment

3.2.1 An assessment of an injured person's injuries is to be conducted by a health practitioner selected by an insurer. The health practitioner ~~is to should~~ be appropriately qualified and experienced, with the assessment being arranged or sought to be within the scope of the practitioner's area of practice. For example, an occupational therapist could undertake cognitive testing of a person if they have a working knowledge of the assessment tool being utilised.

[Note 3.2.1 is to be split with the current third sentence to become 3.2.2, and each paragraph number changed sequentially]

3.2.7 6 An insurer is to meet the cost of an assessment including any reasonable and necessary travel expenses for the person and their parent, guardian or carer to attend the assessment.

- Clarifying that an insurer is to consider existing treatment and care unrelated to the motor accident, and the role of a rehabilitation provider, in developing a recovery plan.

4.1 Information to be considered by an insurer when developing a recovery plan

4.1.1 An insurer must undertake an assessment of the injured person upon receipt of their personal injuries application to identify any barriers to their recovery from injuries sustained as a result of the motor accident. The assessment may include direct contact with the person and must include consideration of available information provided by their treating doctor.

4.1.2 When developing a recovery plan for an injured person an insurer is to consider:

- the nature of the person's injuries and likely process of recovery;
- a person's reasonable and necessary treatment and rehabilitation needs, including the likelihood that treatment and rehabilitation will enhance a return to normal activities;
- any existing supports or other treatment and care the person is receiving for injuries or conditions not directly related to the motor accident;
- employment engaged in by the person after the motor accident;
- any recent medical reports or assessments of reasonable and necessary treatment and care needs for the person;
- any certificate of fitness provided by the person;
- the age of the person; and
- accessibility of services within the person's residential area.

4.1.3 An insurer must develop a recovery plan in consultation with an injured person, their nominated treating doctor or team, and any other health service provider as appropriate. An injured person may also authorise an insurer to contact their employer, to enable the employer to elect to participate in the plan. A copy of a draft recovery plan or a proposed amended plan must be provided to an injured person and their nominated treating doctor to consider, prior to the plan being settled.

4.1.4 An insurer may use the services of an external rehabilitation provider to inform a draft recovery plan. As part of this role the provider should consult the injured person and their treatment providers and also co-ordinate any recommendations to the insurer for the approval of treatment and care in a plan. An insurer may also incorporate a rehabilitation plan settled by an external rehabilitation provider into a recovery plan. In these circumstances, an overlaying recovery plan would still be required containing details of treatment and care approved by the insurer for the currency of the plan, and any remaining information required under clause 4.2.2 of these guidelines.

- Clarifying that an insurer is to assist an injured person in gathering information to make a treatment and care decision including by paying the reasonable costs of medical reports.

6.3 If an insurer does not approve a request to pay treatment and care benefits, including the full reimbursement of an incurred expense, the insurer must give written reasons for their decision and inform the injured person of any review rights. If a request is not approved because the insurer does not have sufficient information to support the request, the application is to be refused on this basis and the written reasons are to list any additional information the insurer would require for a further approval decision. ~~As the reason is not likely to be for one or more of the reasons listed in items 7, 8 or 9 of Schedule 1, part 1.1 of the MAI Act,~~ In these circumstances an insurer is to advise that a further approval decision can be made once the additional information is provided to the insurer, with the insurer then having 10 business days to make this decision from the date they receive the information. The insurer is to assist the injured person in gathering any pertinent information to make a further approval decision, including by paying the reasonable and necessary costs of obtaining a medical opinion or other evidence about the person's injuries.

- Clarifying that an insurer may attribute reasonable and necessary treatment and care for pre-existing injuries.

6.4 Treatment and care that is considered reasonable and necessary

In deciding whether treatment and care is reasonable and necessary an insurer must consider the factors set out in section 120 of the MAI Act.

6.4.1 Directly related to a person's injuries

Treatment and care will be directly related to an injured person's injury if a service relates to an injury caused by the motor accident including the exacerbation of a pre-existing injury. In determining whether treatment and care is directly related to person's injury an insurer may consider:

- the time elapsed since the motor accident,
- the extent an injury relates to the exacerbation of a pre-existing injury, and
- any subsequent injuries or comorbidities.

If it is unclear whether treatment and care being sought is directly related to the person's injuries from the motor accident, an insurer is to seek information about a person's medical history or supports including any treatment and care being provided by another scheme, for pre-existing injuries, subsequent injuries or comorbidities. If the requested information, or a consent to obtain the information from another scheme is not provided in a timely manner, being no later than 10 business days from the request, an insurer may consider the treatment or care is not directly related to a person's injury and refuse the request.

- Clarifying the application of the clinical framework is for health practitioners only

7. CLINICAL FRAMEWORK PRINCIPLES TO BE FOLLOWED BY HEALTH PRACTITIONERS (Section 131)

In approving treatment and care for an injured person to be provided by a health practitioner the insurer must ensure that the treatment and care will be ~~set out in a recovery plan or otherwise approved under these guidelines~~ is carried out in a manner that adopts the principles of the nationally endorsed Clinical Framework for the Delivery of Health Services¹. These principles are to:

- measure and demonstrate the effectiveness of treatment
- adopt a biopsychosocial approach-considering the whole person and their individual circumstances
- empower the injured person to manage their injury
- implement goals focused on optimising function, participation and where applicable return to work or study
- base treatment on best available research

¹ The Clinical Framework for the Delivery of Health Services is supported by the ACT Government and available from the websites of the State Insurance Regulatory Authority and the Transport Accident Commission.

B: Quality of Life Benefit Guidelines

- To update the preamble to make it clearer that the guidelines are legislative requirements and not simply advice or guidance material.

1. INTRODUCTION

The Quality of Life Benefit guidelines (guidelines) are part of the MAI guidelines made under section 487 of the *Motor Accident Injuries Act 2019* (MAI Act). The purpose of the guidelines is to ~~set out requirements provide guidance about~~ for applications and offers for quality of life defined benefit amounts.

Specifically, this material ~~details the insurers' obligations advises insurers of their obligations~~ in providing information and support to potential applicants for quality of life benefits, procedures for arranging Whole Person Impairment (WPI) assessments and making offers for quality of life defined benefit amounts.

- To clarify the location of provider rules and the need to use MAI Commission referral form.

6.3. Selecting an IME provider if more than one authorised

6.3.1 If the MAI Commission has authorised more than one IME provider to arrange WPI assessments, an insurer must put procedures in place to ensure that all authorised IME providers are allocated referrals from an insurer on an equal and sequential basis. For example, if there are two authorised IME providers an insurer should alternate referrals for any given injured person, between the two providers, based on the time and date of a referral. The only exceptions to this rule should be if:

- the allocated provider is unable to provide an assessment for all body systems for the injured person;
- an injured person has previously received a physical or primary psychological assessment from another provider; or
- another provider operates in an interstate or overseas location closer to where the injured person resides or works.

An insurer must keep a register of all referrals to authorised IME providers.

6.4 Arranging appointments with an independent medical examiner provider

6.4.1 An insurer must prepare a written referral to the authorised IME provider. The referral is to be made using a form prescribed by the MAI Commission ~~provided by an authorised IME provider~~. The referral ~~is to~~ should detail the injuries and body systems to be covered by the WPI assessment report and whether the insurer has received either a notice or information for a diagnosis of a psychological or psychiatric disorder.

A prospective update

The MAI Commission has been considering whether further guidelines are required in the context of applications for the assessment of psychological impairments. Stakeholders are invited to comment on possible options.

For the purposes of section 137(3)(c) of the MAI Act, a quality-of-life benefit application for a person requesting a primary psychological assessment must be accompanied by a written notice from a psychiatrist, or clinical psychologist in accordance with subsection 150(3) of the MAI Act. The notice must include a diagnosis of the primary psychological injury based on a recognised diagnostic system and specify the diagnostic criteria upon which the diagnosis is based.

The Commission observes that in some applications the insurer has not been requested to pay treatment and care expenses associated with mental health treatment. If the first time a person sees a psychiatrist or psychologist is for the sole purposes of a report, and these were treatment providers appropriate for the person's injury, this is of concern. Appropriate treatment and care by qualified health professionals is paramount to the person's recovery. Where indicated other disciplines may also be appropriate (for step down or exercise-based programs for ongoing care), along with a General Practitioner.

One option is to extend the time before an application can be considered by a MAI insurer (eg. if an application is made exactly on 26 weeks, a longer period, for example, up to no later 52 weeks may be allowed because further rehabilitation and treatment is required). It is important to establish a treatment regime, noting there can be delays in access.

A second option is for the guidelines to include criteria for an insurer to consider for an application, including the type and length of mental health treatment the injured person has had when determining whether the person is stable and able to be referred for assessment. Alternatively, to outline in the guidelines the mental health treatment a person shall have received or undertaken before considering the report from the psychiatrist or clinical psychologist and forming a reasonable belief as to the person's stability.

C: Significant Occupational Impact Assessment Referral Guidelines

- To provide a timeline for consent, to clarify location of provider rules and need to use MAI Commission form.

3.1 Information required to make a referral

3.1.1 An insurer must provide an information pack about a SOI assessment to an injured person who is likely to meet the conditions for a referral for a SOI assessment under section 209 of the MAI Act if the person was not at fault in the motor accident and not involved in a blameless motor accident and 4 years has passed since the date of the motor accident.

3.1.2 The information pack is to explain the purpose and eligibility requirements for the SOI assessment referral, how the assessment is to be carried out, and information regarding supporting documentation that the injured person will need to provide for an assessment. The pack must also include a consent form for a referral for a SOI assessment. The written consent may be given from 4

years and no later than 5 years after the motor accident, or no later than 3 months after the WPI report is provided by an insurer to the injured person for an assessment undertaken under section 141 (WPI assessment 4 years 6 months after motor accident), whichever is later.

3.3. Selecting an Independent Medical Examination (IME) provider

3.3.1 If the MAI Commission has authorised more than one IME provider to arrange Significant Occupational Impact assessments, the MAI insurer must put procedures in place to ensure that all authorised IME providers are allocated referrals from an insurer on an equal and sequential basis. For example, if there are two authorised IME providers an insurer should alternate referrals for any given injured person between the two providers. The exception to this is where the alternative approved IME provider operates in an interstate or overseas location closer to where the injured person resides. An insurer must keep a register of all referrals to authorised IME providers for SOI assessments.

3.2.1 An insurer must make a referral to an authorised IME provider as soon as practicable once 4 years and 6 months has passed since the date of the motor accident. The referral is to be made using a prescribed MAI Commission form. The insurer should be satisfied the person meets the conditions for a SOI assessment under section 209(1) of the MAI Act, and that the person has given their written consent to the insurer for the referral to be made. The insurer may delay making a referral until they have information relevant to the assessment in their possession including updated information about an injured person's education, training, and vocational and other claims history. Appendix 1 includes a list of information to be provided for a SOI assessment.

D: Defined Benefit Application Guidelines

- Updating preamble to make it clearer the guidelines are legislative requirements.

1. INTRODUCTION

The defined benefit application guidelines (guidelines) are part of the MAI guidelines made under section 487 of the Motor Accident Injuries Act 2019 (MAI Act). The purpose of the guidelines is to set out requirements for the ~~provide guidance about~~ making and handling applications for defined benefits under Part 2.3 of the MAI Act.

Specifically, this material details an insurer's obligations ~~advises insurers of their~~ in providing information and support to potential applicants, accepting applications and administering payments for treatment and care, income replacement and funeral and death benefits

- b) Incorporating procedures for closing applications into the guidelines

Note: The MAI Commission provided guidance to insurers in 2020 on the procedure to be followed by an insurer where a person no longer needs defined benefits or does not engage with an insurer after a certain period. These procedures are proposed for incorporation into the guidelines.

12. ADMINISTRATIVELY CLOSING DEFINED BENEFITS PERSONAL INJURIES APPLICATION

These guidelines make provision for matters an insurer must consider in deciding to administratively close a defined benefits personal injuries application, the procedure to be followed by the insurer before an application is closed and information to be given to an applicant about closing an

application. The closure may be requested by an applicant or initiated by the insurer. An administrative closure does not end the entitlement to defined benefits. At or after five years an insurer is to close the application if there is no further activity.

12.1 Matters to be considered in closing an application

An insurer may close a defined benefits personal injuries application prior to five years from the date of an accident if the insurer believes that it is unlikely that the person will need to access further defined benefits, or make a common law claim, under the MAI Scheme.

In making this decision the insurer must consider whether the injured person:

- has returned to all their activities of work and daily living at their pre-injury capacity;
- has completed all treatment and care set out in a recovery plan, or does not require a plan/ or a further plan;
- requires any other treatment and care outside of a recovery plan;
- has recently incurred any treatment and care expenses or missed any paid work because of their injuries, or made a request for approval or payment of treatment and care; and
- is unlikely to have a permanent impairment from their injuries from the motor accident of 5% or more; has been assessed as having a WPI of less than 5% and the person has accepted or been taken to have accepted the WPI report. Acceptance of a quality of life benefit offer may also be considered.

An application may also be closed if the injured person specifically requests the insurer to close their application, including in circumstances where the person may still require ongoing treatment and care but wishes to access the treatment and care outside of the MAI Scheme.

12.2 Procedure to be followed before an application is closed

An insurer must write to an injured person or their guardian before closing an application.

An insurer may advise the injured person or their guardian through a courtesy telephone conversation of their intention to close an application. If an insurer chooses not to make a call or is unable to contact the injured person by telephone, an insurer must write to the injured person (through the post or email) advising them of the intention to close their application.

In the written correspondence, an insurer must:

- confirm the courtesy telephone conversation (if made) or advise of the intention to close the application;
- outline the arrangements for the approval, or the payment of, any outstanding treatment and care expenses, and note that these will be paid to the provider or injured person;
- advise the injured person that their application may be re-opened if their circumstances change; and
- provide the details of the Defined Benefits Information Service (DBIS) so that the person may obtain independent information on the proposed account closure.

In all circumstances the insurer must allow the injured person a minimum of 14 calendar days from the date of an email or receipt of a letter, to contact the insurer in response to the email/letter prior to closing an application.

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An insurer must notify the injured person of the closure of their application in writing. This notification is to include information about defined benefits the person may be entitled to if their circumstances change including treatment and care, income replacement and quality of life benefits.

12.4 Providing information to the Motor Accident Injury Register

An application is to be recorded as closed in agreement or lapsed on the Motor Accident Injuries Register (MAIR) and included as part of the return to the MAIR for the month in which the closure occurs. At or around the five-year anniversary of the date of the motor accident an insurer is to update the MAIR to indicate it is at the end of the entitlement period.

From: "Clark, Nicola"
Sent: 17/03/2025 4:31 PM
To: "committee@actlawsociety.asn.au" <committee@actlawsociety.asn.au>;
"ceo@actbar.com.au" <ceo@actbar.com.au>
Cc: "Holmes, Lisa" <Lisa.Holmes@act.gov.au>
Subject: Motor Accident Injuries Guidelines update
Attachments: For consultation - Guidelines Update.pdf

Dear ACT Law Society and Bar Association,

The Motor Accident Injuries Commission regularly considers the guidelines that have been made under the *Motor Accident Injuries Act 2019*. The Commission has prepared a consultation document with proposed updates on an extract basis to the following MAI Guidelines, along with a discussion on a prospective update for future inclusion in the Quality of Life Benefit Guidelines.

A: Treatment and Care Guidelines
B: Quality of Life Benefit Guidelines
C: Significant Occupational Impact Assessment Referral Guidelines
D: Defined Benefit Application Guidelines

Generally, the updates are considered to be of a minor nature and intended to provide greater clarity to Guideline users. With respect to the Defined Benefit Application Guidelines, the Commission is taking the opportunity to incorporate its application closure policy that insurers use to manage applications where activity has lapsed or the person is no longer engaging with the insurer.

You may wish to provide comments or feedback. We request if any comments are provided by close of business **Friday 11 April 2025**. My contact details are below if you wish to discuss.

Regards,

Nicola

Nicola Clark

Senior Director
MAI Regulatory Policy and Supervision
Insurance | Economic and Financial Group
Treasury | Chief Minister, Treasury and Economic Development Directorate
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- Updating preamble to make it clearer that the guidelines are legislative requirements.

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- the nature of the person's injuries and likely process of recovery;
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- any existing supports or other treatment and care the person is receiving for injuries or conditions not directly related to the motor accident;
- employment engaged in by the person after the motor accident;
- any recent medical reports or assessments of reasonable and necessary treatment and care needs for the person;
- any certificate of fitness provided by the person;
- the age of the person; and
- accessibility of services within the person's residential area.

4.1.3 An insurer must develop a recovery plan in consultation with an injured person, their nominated treating doctor or team, and any other health service provider as appropriate. An injured person may also authorise an insurer to contact their employer, to enable the employer to elect to participate in the plan. A copy of a draft recovery plan or a proposed amended plan must be provided to an injured person and their nominated treating doctor to consider, prior to the plan being settled.

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6.3 If an insurer does not approve a request to pay treatment and care benefits, including the full reimbursement of an incurred expense, the insurer must give written reasons for their decision and inform the injured person of any review rights. If a request is not approved because the insurer does not have sufficient information to support the request, the application is to be refused on this basis and the written reasons are to list any additional information the insurer would require for a further approval decision. ~~As the reason is not likely to be for one or more of the reasons listed in items 7, 8 or 9 of Schedule 1, part 1.1 of the MAI Act,~~ In these circumstances an insurer is to advise that a further approval decision can be made once the additional information is provided to the insurer, with the insurer then having 10 business days to make this decision from the date they receive the information. The insurer is to assist the injured person in gathering any pertinent information to make a further approval decision, including by paying the reasonable and necessary costs of obtaining a medical opinion or other evidence about the person's injuries.

- Clarifying that an insurer may attribute reasonable and necessary treatment and care for pre-existing injuries.

6.4 Treatment and care that is considered reasonable and necessary

In deciding whether treatment and care is reasonable and necessary an insurer must consider the factors set out in section 120 of the MAI Act.

6.4.1 Directly related to a person's injuries

Treatment and care will be directly related to an injured person's injury if a service relates to an injury caused by the motor accident including the exacerbation of a pre-existing injury. In determining whether treatment and care is directly related to person's injury an insurer may consider:

- the time elapsed since the motor accident,
- the extent an injury relates to the exacerbation of a pre-existing injury, and
- any subsequent injuries or comorbidities.

If it is unclear whether treatment and care being sought is directly related to the person's injuries from the motor accident, an insurer is to seek information about a person's medical history or supports including any treatment and care being provided by another scheme, for pre-existing injuries, subsequent injuries or comorbidities. If the requested information, or a consent to obtain the information from another scheme is not provided in a timely manner, being no later than 10 business days from the request, an insurer may consider the treatment or care is not directly related to a person's injury and refuse the request.

- Clarifying the application of the clinical framework is for health practitioners only

7. CLINICAL FRAMEWORK PRINCIPLES TO BE FOLLOWED BY HEALTH PRACTITIONERS (Section 131)

In approving treatment and care for an injured person to be provided by a health practitioner the insurer must ensure that the treatment and care will be ~~set out in a recovery plan or otherwise approved under these guidelines~~ is carried out in a manner that adopts the principles of the nationally endorsed Clinical Framework for the Delivery of Health Services¹. These principles are to:

- measure and demonstrate the effectiveness of treatment
- adopt a biopsychosocial approach-considering the whole person and their individual circumstances
- empower the injured person to manage their injury
- implement goals focused on optimising function, participation and where applicable return to work or study
- base treatment on best available research

¹ The Clinical Framework for the Delivery of Health Services is supported by the ACT Government and available from the websites of the State Insurance Regulatory Authority and the Transport Accident Commission.

B: Quality of Life Benefit Guidelines

- To update the preamble to make it clearer that the guidelines are legislative requirements and not simply advice or guidance material.

1. INTRODUCTION

The Quality of Life Benefit guidelines (guidelines) are part of the MAI guidelines made under section 487 of the *Motor Accident Injuries Act 2019* (MAI Act). The purpose of the guidelines is to ~~set out requirements provide guidance about~~ for applications and offers for quality of life defined benefit amounts.

Specifically, this material ~~details the insurers' obligations advises insurers of their obligations~~ in providing information and support to potential applicants for quality of life benefits, procedures for arranging Whole Person Impairment (WPI) assessments and making offers for quality of life defined benefit amounts.

- To clarify the location of provider rules and the need to use MAI Commission referral form.

6.3. Selecting an IME provider if more than one authorised

6.3.1 If the MAI Commission has authorised more than one IME provider to arrange WPI assessments, an insurer must put procedures in place to ensure that all authorised IME providers are allocated referrals from an insurer on an equal and sequential basis. For example, if there are two authorised IME providers an insurer should alternate referrals for any given injured person, between the two providers, based on the time and date of a referral. The only exceptions to this rule should be if:

- the allocated provider is unable to provide an assessment for all body systems for the injured person;
- an injured person has previously received a physical or primary psychological assessment from another provider; or
- another provider operates in an interstate or overseas location closer to where the injured person resides or works.

An insurer must keep a register of all referrals to authorised IME providers.

6.4 Arranging appointments with an independent medical examiner provider

6.4.1 An insurer must prepare a written referral to the authorised IME provider. The referral is to be made using a form prescribed by the MAI Commission ~~provided by an authorised IME provider~~. The referral ~~is to~~ should detail the injuries and body systems to be covered by the WPI assessment report and whether the insurer has received either a notice or information for a diagnosis of a psychological or psychiatric disorder.

A prospective update

The MAI Commission has been considering whether further guidelines are required in the context of applications for the assessment of psychological impairments. Stakeholders are invited to comment on possible options.

For the purposes of section 137(3)(c) of the MAI Act, a quality-of-life benefit application for a person requesting a primary psychological assessment must be accompanied by a written notice from a psychiatrist, or clinical psychologist in accordance with subsection 150(3) of the MAI Act. The notice must include a diagnosis of the primary psychological injury based on a recognised diagnostic system and specify the diagnostic criteria upon which the diagnosis is based.

The Commission observes that in some applications the insurer has not been requested to pay treatment and care expenses associated with mental health treatment. If the first time a person sees a psychiatrist or psychologist is for the sole purposes of a report, and these were treatment providers appropriate for the person's injury, this is of concern. Appropriate treatment and care by qualified health professionals is paramount to the person's recovery. Where indicated other disciplines may also be appropriate (for step down or exercise-based programs for ongoing care), along with a General Practitioner.

One option is to extend the time before an application can be considered by a MAI insurer (eg. if an application is made exactly on 26 weeks, a longer period, for example, up to no later 52 weeks may be allowed because further rehabilitation and treatment is required). It is important to establish a treatment regime, noting there can be delays in access.

A second option is for the guidelines to include criteria for an insurer to consider for an application, including the type and length of mental health treatment the injured person has had when determining whether the person is stable and able to be referred for assessment. Alternatively, to outline in the guidelines the mental health treatment a person shall have received or undertaken before considering the report from the psychiatrist or clinical psychologist and forming a reasonable belief as to the person's stability.

C: Significant Occupational Impact Assessment Referral Guidelines

- To provide a timeline for consent, to clarify location of provider rules and need to use MAI Commission form.

3.1 Information required to make a referral

3.1.1 An insurer must provide an information pack about a SOI assessment to an injured person who is likely to meet the conditions for a referral for a SOI assessment under section 209 of the MAI Act if the person was not at fault in the motor accident and not involved in a blameless motor accident and 4 years has passed since the date of the motor accident.

3.1.2 The information pack is to explain the purpose and eligibility requirements for the SOI assessment referral, how the assessment is to be carried out, and information regarding supporting documentation that the injured person will need to provide for an assessment. The pack must also include a consent form for a referral for a SOI assessment. The written consent may be given from 4

years and no later than 5 years after the motor accident, or no later than 3 months after the WPI report is provided by an insurer to the injured person for an assessment undertaken under section 141 (WPI assessment 4 years 6 months after motor accident), whichever is later.

3.3. Selecting an Independent Medical Examination (IME) provider

3.3.1 If the MAI Commission has authorised more than one IME provider to arrange Significant Occupational Impact assessments, the MAI insurer must put procedures in place to ensure that all authorised IME providers are allocated referrals from an insurer on an equal and sequential basis. For example, if there are two authorised IME providers an insurer should alternate referrals for any given injured person between the two providers. The exception to this is where the alternative approved IME provider operates in an interstate or overseas location closer to where the injured person resides. An insurer must keep a register of all referrals to authorised IME providers for SOI assessments.

3.2.1 An insurer must make a referral to an authorised IME provider as soon as practicable once 4 years and 6 months has passed since the date of the motor accident. The referral is to be made using a prescribed MAI Commission form. The insurer should be satisfied the person meets the conditions for a SOI assessment under section 209(1) of the MAI Act, and that the person has given their written consent to the insurer for the referral to be made. The insurer may delay making a referral until they have information relevant to the assessment in their possession including updated information about an injured person's education, training, and vocational and other claims history. Appendix 1 includes a list of information to be provided for a SOI assessment.

D: Defined Benefit Application Guidelines

- Updating preamble to make it clearer the guidelines are legislative requirements.

1. INTRODUCTION

The defined benefit application guidelines (guidelines) are part of the MAI guidelines made under section 487 of the Motor Accident Injuries Act 2019 (MAI Act). The purpose of the guidelines is to set out requirements for the ~~provide guidance about~~ making and handling applications for defined benefits under Part 2.3 of the MAI Act.

Specifically, this material details an insurer's obligations ~~advises insurers of their~~ in providing information and support to potential applicants, accepting applications and administering payments for treatment and care, income replacement and funeral and death benefits

- b) Incorporating procedures for closing applications into the guidelines

Note: The MAI Commission provided guidance to insurers in 2020 on the procedure to be followed by an insurer where a person no longer needs defined benefits or does not engage with an insurer after a certain period. These procedures are proposed for incorporation into the guidelines.

12. ADMINISTRATIVELY CLOSING DEFINED BENEFITS PERSONAL INJURIES APPLICATION

These guidelines make provision for matters an insurer must consider in deciding to administratively close a defined benefits personal injuries application, the procedure to be followed by the insurer before an application is closed and information to be given to an applicant about closing an

application. The closure may be requested by an applicant or initiated by the insurer. An administrative closure does not end the entitlement to defined benefits. At or after five years an insurer is to close the application if there is no further activity.

12.1 Matters to be considered in closing an application

An insurer may close a defined benefits personal injuries application prior to five years from the date of an accident if the insurer believes that it is unlikely that the person will need to access further defined benefits, or make a common law claim, under the MAI Scheme.

In making this decision the insurer must consider whether the injured person:

- has returned to all their activities of work and daily living at their pre-injury capacity;
- has completed all treatment and care set out in a recovery plan, or does not require a plan/ or a further plan;
- requires any other treatment and care outside of a recovery plan;
- has recently incurred any treatment and care expenses or missed any paid work because of their injuries, or made a request for approval or payment of treatment and care; and
- is unlikely to have a permanent impairment from their injuries from the motor accident of 5% or more; has been assessed as having a WPI of less than 5% and the person has accepted or been taken to have accepted the WPI report. Acceptance of a quality of life benefit offer may also be considered.

An application may also be closed if the injured person specifically requests the insurer to close their application, including in circumstances where the person may still require ongoing treatment and care but wishes to access the treatment and care outside of the MAI Scheme.

12.2 Procedure to be followed before an application is closed

An insurer must write to an injured person or their guardian before closing an application.

An insurer may advise the injured person or their guardian through a courtesy telephone conversation of their intention to close an application. If an insurer chooses not to make a call or is unable to contact the injured person by telephone, an insurer must write to the injured person (through the post or email) advising them of the intention to close their application.

In the written correspondence, an insurer must:

- confirm the courtesy telephone conversation (if made) or advise of the intention to close the application;
- outline the arrangements for the approval, or the payment of, any outstanding treatment and care expenses, and note that these will be paid to the provider or injured person;
- advise the injured person that their application may be re-opened if their circumstances change; and
- provide the details of the Defined Benefits Information Service (DBIS) so that the person may obtain independent information on the proposed account closure.

In all circumstances the insurer must allow the injured person a minimum of 14 calendar days from the date of an email or receipt of a letter, to contact the insurer in response to the email/letter prior to closing an application.

12.3 Information to be provided about ongoing entitlements

An insurer must notify the injured person of the closure of their application in writing. This notification is to include information about defined benefits the person may be entitled to if their circumstances change including treatment and care, income replacement and quality of life benefits.

12.4 Providing information to the Motor Accident Injury Register

An application is to be recorded as closed in agreement or lapsed on the Motor Accident Injuries Register (MAIR) and included as part of the return to the MAIR for the month in which the closure occurs. At or around the five-year anniversary of the date of the motor accident an insurer is to update the MAIR to indicate it is at the end of the entitlement period.



Insurance Council
of Australia

10 April 2025

Ms. Nicola Clark
Senior Director
MAI Regulatory Policy and Supervision
MAI Commission
ACT Government
By email: Nicola.Clark@act.gov.au

Dear Ms. Clark,

Re: MAI Guidelines updates

The Insurance Council of Australia (Insurance Council), on behalf of its licensed ACT Motor Accident Injuries Scheme (MAI Scheme) members (Insurers) welcomes the opportunity to provide feedback in relation to updates to the following MAI Guidelines:

- Treatment and Care Guidelines
- Quality of Life Benefit Guidelines
- Significant Occupational Impact Assessment Referral Guidelines
- Defined Benefit Application Guidelines

The Insurance Council appreciates the MAI Commission's commitment to supporting Insurers to understand the legislative requirements in an operational context.

Feedback in relation to the updated clauses in each of the MAI Guidelines is provided below.

Insurers would also like to request that the MAI Commission conducts a more comprehensive review of the Quality of Life Benefit Guidelines rather than limiting feedback to the draft clause amendments included in the document provided for comment. Insurers submit it would also be beneficial to review the *Referral Form - Whole Person Impairment (WPI) Assessment* form at the same time.

We note the reference to the Significant Occupational Impact (SOI) referral form in the draft SOI Guidelines. We understand the SOI referral form has not yet been drafted but the MAI Commission has indicated it is open to feedback about whether an SOI application form or referral are required. We note that all public-facing forms are under review by the MAI Commission and have been sent out for comment. Insurers will provide feedback separately following a review of the updated forms released by the MAI Commission on 8 April 2025.

Treatment and Care Guidelines:

CI 3.1 – Circumstances that an insurer may ask for an assessment of a person's injuries

CI 3.1.1

Insurers note the update to this clause and appreciate the clarification.

CI 3.1.3

Insurers seek clarification on the meaning of "relevant" and "available" in this clause, noting that there is the potential for an Insurer and an injured person to form a different view. Insurers suggest the inclusion of definitions or examples of each of the terms to assist with the interpretation of the terms in the MAI Scheme context.

Insurers appreciate the reference to a 10-business day timeframe but note there may be instances where it is reasonable for providers to require a longer timeframe. Insurers suggest the wording be amended to reflect that Insurers must wait a minimum of 10 business days prior to engaging an independent assessment.

Insurers also query whether it should be mandatory for an Insurer to request further information from a treating practitioner before proceeding to an Independent Medical Examiner (IME). While this step is generally appropriate, it is not suitable in all cases. Requiring it in every instance could introduce unnecessary costs and delays particularly when there is already a clear difference of opinion or a history of disagreement with the treating provider. Insurers submit that in such cases, it may be more efficient and appropriate to proceed directly to an IME.

CI 7 - Clinical Framework principles to be followed by health practitioners (section 131)

Insurers are concerned that the proposed wording implies that Insurers are able to ensure that treatment and care is carried out in line with the Clinical Framework for the Delivery of Health Services. While Insurers are supportive of providers delivering services in alignment with the Clinical Framework for the delivery of Health Services, they are unable to ensure that the service provider does so, given Insurers have no control over Health Service providers.

However, Insurers can consider the Clinical Framework in decision making. We suggest that the requirement should be amended to "When reviewing treatment and care requests Insurers should apply the principles of the Clinical Framework for the delivery of Health Services" or words to that effect.

Quality of Life Benefit Guidelines

CI 6.3 Selecting an IME provider if more than one authorised

CI 6.3.1

Insurers note the requirement to have procedures to ensure that all authorised IME providers are allocated referrals from an Insurer on an equal and sequential basis.

Insurers seek guidance from the MAI Commission on its expectations of Insurers in the event an injured person is unhappy with the allocated provider or requests a particular provider. Specifically, in this situation, would Insurers be permitted to refer outside the sequential basis in these circumstances?

Insurers also seek clarification in relation to the third exception to the rule for selecting an IME, that is, where "another provider operates in an interstate or overseas location closer to where the injured person resides or works".

Insurers would like to understand whether this means they can use a medicolegal company that is not an authorised IME provider for Quality of Life (QoL) assessments that are conducted interstate or overseas? If so, would the exception operate for ACT/NSW?

Prospective update – applications for the assessment of psychological impairments

Insurers appreciate the MAI Commission’s consideration of further guidelines in relation to applications for the assessment of psychological impairments and invitation to provide comment on possible options.

Insurers support the development of specific guidelines for the assessment of psychological impairments and request this be considered in addition to a comprehensive QoL Guideline review.

In relation to the requirement for applications to be accompanied by a written notice from a “psychiatrist or a clinical psychologist”, we note that Insurers often receive written notices from psychologists who are not formally qualified as “clinical psychologists,” but are registered simply as psychologists, and this has resulted in delays and notices being rejected. It would be helpful to have a clear, written definition of what constitutes a “clinical psychologist” for the purposes of these notices. Alternatively, Insurers query whether the “clinical” distinction is necessary at all and if it could be removed to avoid confusion and streamline the process given the limited number of qualified “clinical psychologists” in the ACT.

Insurers would also be assisted with clear guidelines on how they should approach QoL offers when only one type of QoL assessment (e.g., physical) has been completed, and they are awaiting the other component (e.g. primary psychological) because the claimant’s psychological (or alternatively physical) injuries have not stabilised. Direction on whether and how to proceed with offers in these situations would support consistency and provide helpful guidelines for Insurers to refer applicants to.

Insurers also request that the timeframe for sending QoL packs to those with a psychological injury should be addressed. There is a concern that sending the QoL pack at 26 weeks is often too early for those with a psychological injury. Conversely, while Insurers do have the ability to hold off sending the pack, they also have an obligation to disclose, as soon as practicable, all information that an applicant or claimant may reasonably need to understand the process for applying for defined benefits or making a motor accident claim.

Many applicants are well informed through their own investigations of their entitlements under the MAI Act and become aware of QoL prior to being advised by the Insurer. This leads to a breakdown in the relationship with the Insurer if the applicant has not already been advised by the Insurer of the entitlement.

Insurers note the two options suggested by the MAI Commission, however given the above comments Insurers would prefer to more holistically review the QoL Guidelines and develop a more considered guideline for the assessment of psychological impairments.

Significant Occupational Impact Assessment Referral Guidelines

CI 3.2.1

In relation to the ordering of the clauses, Insurers note that clause 3.2.1 appears after “3.3 - Selecting an IME provider”. Insurers query whether this clause will be moved so that it appears under the heading “3.2 Timeframes for assessments”.

Insurers also suggest that the MAI Commission develops a prescribed form for the purposes to Significant Occupational Impact (SOI) referrals. This would ensure consistency in insurer referrals to SOI IME providers.

Defined Benefits Application Guidelines

Part 12 - Administratively closing defined benefits personal injuries application

Insurers seek clarification on whether this part will apply to closing defined benefits applications at 5 years. For example, can Insurers provide an applicant with 14 days' notice prior to closing the claim at 5 years?

CI 12.4

Insurers seek further information in relation to the proposal in clause 12.4 to understand the intent behind this change.

The Motor Accident Injury Register (MAIR) currently contains the code FIN-13 - End of payment period (5 years) to capture claims closed at 5 years. FIN-4 and FIN-8 indicate claims closed before 5 years. Insurers understand the change in clause 12.4 would mean insurers have to close a claim using codes FIN-4 and FIN-8 and then at 5 years, re-open the claim to close using FIN-13. This would require additional claim administration for less granular information on claim closure.

Insurers further note that the MAIR is currently being enhanced and query whether the intention to capture the end date of defined benefits (noting the referencing to updating the MAIR) will be included in the MAIR enhancement. Insurers note that any MAIR change will be a system enhancement for insurers and will require resources and lead time to be completed.

We hope this response is of assistance. The Insurance Council and Insurers would welcome the opportunity to meet with the MAI Commission to discuss this submission. Please do not hesitate to contact Sch 2.2(a)(ii), Senior Adviser, Insurance Lines, at Sch 2.2(a)(ii) or on Sch 2.2(a)(i).

Yours sincerely,

Sch 2.2(a)(ii)

Alexandra Hordern
General Manager, Regulatory & Consumer Policy

From: "Clark, Nicola" <Nicola.Clark@act.gov.au>
Sent: 11/04/2025 5:23 PM
To: "Lejins, Erica" <Erica.Lejins@act.gov.au>
Subject: FW: Motor Accident Injuries Guidelines update

OFFICIAL

FYI

From: Sch 2.2(a)(ii)
Sent: Friday, 11 April 2025 5:04 PM
To: Clark, Nicola <Nicola.Clark@act.gov.au>
Cc: Policy <policy@actlawsociety.asn.au>
Subject: RE: Motor Accident Injuries Guidelines update

You don't often get email from Sch 2.2(a)(ii) [Learn why this is important](#)

OFFICIAL

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear
Nicola

Thank you for the opportunity to comment on the draft Motor Accident Injuries Guidelines.

The ACT Law Society (the Society) has consulted our Civil Litigation Committee whose advice has informed our response.

Part 3.1.3 Draft Guidelines Update

The Society recommends extending the timeframe beyond 10 business days for claimants to obtain necessary information, as treating practitioners often have limited capacity to respond promptly.

Proposed Update to Section 150(3) of the *Motor Accident Injuries Act 2019*

The Society supports introducing greater flexibility into the Act and Guidelines where appropriate. In particular, we believe it would be reasonable to allow insurers discretion to extend timeframes in cases where delays in treatment or reporting occur.

Thank you again for the opportunity to provide input.

Kind regards,
Aimee Kable

Sch 2.2(a)(ii)

actlaw
society

GPO Box 1562, Canberra ACT 2601

actlawsociety.asn.au

From: Clark, Nicola <Nicola.Clark@act.gov.au>
Sent: Monday, 17 March 2025 4:32 PM

To: Committee <committee@actlawsociety.asn.au>; ceo@actbar.com.au

Cc: Holmes, Lisa <Lisa.Holmes@act.gov.au>

Subject: Motor Accident Injuries Guidelines update

OFFICIAL

Dear ACT Law Society and Bar Association,

The Motor Accident Injuries Commission regularly considers the guidelines that have been made under the *Motor Accident Injuries Act 2019*. The Commission has prepared a consultation document with proposed updates on an extract basis to the following MAI Guidelines, along with a discussion on a prospective update for future inclusion in the Quality of Life Benefit Guidelines.

A: Treatment and Care Guidelines

B: Quality of Life Benefit Guidelines

C: Significant Occupational Impact Assessment Referral Guidelines

D: Defined Benefit Application Guidelines

Generally, the updates are considered to be of a minor nature and intended to provide greater clarity to Guideline users. With respect to the Defined Benefit Application Guidelines, the Commission is taking the opportunity to incorporate its application closure policy that insurers use to manage applications where activity has lapsed or the person is no longer engaging with the insurer.

You may wish to provide comments or feedback. We request if any comments are provided by close of business **Friday 11 April 2025**. My contact details are below if you wish to discuss.

Regards,

Nicola

Nicola Clark

Senior Director

MAI Regulatory Policy and Supervision

Insurance | Economic and Financial Group

Treasury | Chief Minister, Treasury and Economic Development Directorate

ACT Government | GPO Box 158 CANBERRA ACT 2601

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From: "Lejins, Erica" <Erica.Lejins@act.gov.au>
Sent: 17/09/2025 3:43 PM
To: "CTP Regulatory Correspondence" <ctpregulatorycorrespondence@suncorp.com.au>; "ACT CTP Regulatory Notices" <Sch 2.2(a)(xi)>; "Harper, Mark" <Mark.Harper@act.gov.au>
Cc: <Sch 2.2(a)(ii)>; <Sch 2.2(a)(ii)>; <Sch 2.2(a)(ii)>; <Sch 2.2(a)(ii)>; "MAI Commission" <maic@act.gov.au>
Subject: Consultation Draft - Updated Quality of Life Benefit Guidelines
Attachments: Quality of Life Guidelines - Consultation Draft - September 2025.pdf

OFFICIAL

Dear Insurers,

Earlier this year, the MAI Commission provided for comment a short form review of four updated guidelines. Three of the guidelines were subsequently made on 10 July 2025. The fourth included with the package was the Quality of Life Benefit guidelines. The earlier draft circulated in March 2025 had foreshadowed two options for requests for psychological assessments.

The revised draft now incorporates feedback received in relation to the earlier draft. The incorporation of all feedback required a reframing of the Guidelines, which has also provided the MAI Commission with the opportunity to include updates providing clarity about steps an insurer must undertake to validate a WPI report, the handling of second WPI reports, and final WPI offers. The introduction has been expanded to include a background section to better assist members of the public who may be handling their own defined benefits application with information in one location.

If you wish to provide comments or feedback on the guidelines, we request these by close of business **Friday 10 October 2025**. Your comments can be directed to the MAI Commission inbox. If you wish to discuss the guidelines, you can contact the MAI Commission on 6207 8876.

With regards

Erica Lejins

Director

MAI Regulatory Policy and Supervision

Insurance | Economic and Financial Policy Group

Treasury | Chief Minister, Treasury and Economic Development Directorate

ACT Government | GPO Box 158 CANBERRA ACT 2601

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I acknowledge the Ngunnawal people as the traditional custodians of the ACT and recognise any other people or families with connection to the lands of the ACT and region. I acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

Australian Capital Territory

Motor Accident Injuries (Quality of Life Benefit) Guidelines 2025

Disallowable instrument DI2025

made under the

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

1 Name of instrument

This instrument is the *Motor Accident Injuries (Quality of Life Benefit) Guidelines 2025*.

2 Commencement

This instrument commences on the 7th day after its notification.

3 Guidelines

I make the guidelines attached to this instrument.

4 Revocations

The *Motor Accident Injuries (Quality of Life Benefit) Guidelines 2023* (DI2023-311) is revoked.

MAI Commissioner

MAI Commission

2025

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Quality of Life Benefit Guidelines

1. INTRODUCTION

The Quality of Life Benefit guidelines (guidelines) are part of the MAI guidelines made under section 487 of the *Motor Accident Injuries Act 2019* (MAI Act). The Guidelines detail the insurers' obligations in providing information and support to potential applicants for quality of life benefits, procedures for arranging Whole Person Impairment (WPI) assessments and making offers for quality of life defined benefit amounts. They also detail the process for an injured person to obtain a valid second WPI report.

Background

The quality of life (QOL) benefit is a recognition payment for a person's permanent injuries caused by the accident and may be offered following a WPI assessment carried out in accordance with the *Motor Accident Injuries (WPI Assessment) Guidelines 2019* (WPI Assessment Guidelines). An application for the benefit may be made no earlier than 26 weeks after the motor accident. The injuries sustained in the accident need to have stabilised sufficiently for an assessment. The benefit is payable for WPI assessments of 5 per cent or more, with the benefit amount set out in legislation and based on the WPI figure (a whole number). A person with a WPI assessment of 10 per cent or more from the first WPI report may choose to access common law if they were not at fault.

The first WPI assessment is made on referral by an insurer to an authorised IME provider. The IME provider appoints qualified and experienced independent medical examiners (IMEs) to carry out WPI assessments. This authorisation by the MAI Commission is to facilitate the first WPI assessment. The IME providers have a national presence and are able to select IMEs from around the country.

On referral by the insurer, the IME provider will select the independent medical examiner (IME) relevant for the permanent injuries needing to be assessed. This process is so that the IME undertaking the assessment has not been appointed by either an insurer or a legal representative. There is no process of selecting from several IMEs as it will be subject to availability.

If an injured person is unhappy with the first assessment and wants another assessment, they are able to select and pay for their own private medical examiner (PME) to conduct a second WPI report. There is no requirement to approach the authorised IME provider for a PME. It is important, though, that the PME is qualified and experienced in carrying out ACT WPI assessments. The second report is to meet the same conditions as the first so that it can be relied upon to make the offer for the QOL benefit or to lodge a notice of claim.

2. STATUTORY FRAMEWORK

Division 2.6.2 of the MAI Act makes provision for an injured person to make a quality of life benefits application. A precondition for the application is that the injured person has received a receipt notice or late receipt notice under section 60 of the MAI Act. An injured person cannot make a quality of life benefit application earlier than 26 weeks after a motor accident and not later than 4 years and six months after an accident.

The legislative framework for quality of life benefits includes:

- a. the MAI Act;
- b. the Motor Accident Injuries Regulation 2019 (the Regulation); and
- c. these Guidelines made under the MAI Act.

Also, the WPI Assessment Guidelines apply to any WPI assessment undertaken for the purposes of the MAI Act.

3. INFORMATION AND SUPPORT FOR APPLICANTS FOR QUALITY OF LIFE BENEFITS

3.1 These guidelines make provision for the information and support an insurer is to give a person about making an application for quality of life benefits for the purposes of paragraph 52(2)(e) of the MAI Act. The information pack is intended to assist an injured person in making an informed decision about requesting a WPI assessment.

3.2 The information pack is required to be provided about:

- the eligibility requirements for a quality of life defined benefit or to make a motor accident claim;
- how to apply for a quality of life benefit, and the time frame for making an application;
- the need for a person's injuries to be stable for a permanent impairment to be assessed;
- conditions for requesting a WPI assessment for primary/secondary psychological injuries;
- requirements for requesting a WPI assessment for a primary psychological injury, including the definition of a primary psychological injury, the requirement to have undergone mental health treatment and to provide a notice under subsection 150(3) of the MAI Act and paragraphs 4.2 and 4.3 of these guidelines;
- the definition of a secondary psychological injury and requirements for a secondary psychological injury to be taken into account as part of a physical assessment;
- how an insurer will arrange for an assessment with the independent medical examiner provider, expected waiting times for an assessment and the person's obligations if they request an assessment;
- how a WPI assessment is carried out and where a person can access the MAI guidelines about permanent impairment assessments; and

- arrangements for paying for a WPI assessment, including the circumstances a person will be required to pay an excess for an assessment and the circumstances in which an excess can be returned.

3.3 An insurer must provide an information pack about quality of life payments to an applicant for defined benefits (other than persons mentioned in paragraph 3.6) prior to the injured person first becoming eligible to make a quality of life application. The pack is to be provided no earlier than 24 weeks after the date of an accident. Where the period of 26 weeks after the date of the accident has passed, for example a late application is made and accepted, the insurer should provide the information pack after the insurer has accepted liability for the application. An insurer may provide general information about the benefit, noting the need for treatment to have occurred and stability of injuries that are of a permanent nature.

3.4 To assist an injured person who may request an assessment for a primary psychological injury the insurer may include a template for a notice under subsection 150(3) of the MAI Act when providing the information pack.

3.5 An insurer must consider their duty to act in good faith when determining the timing of the issue of an information pack. This includes the insurer's duty in paragraph 20(4)(a) of the MAI Act to disclose, as soon as practicable, all information that an applicant may need to understand the process for applying for defined benefits.

3.6 The information pack must also be provided on request by any other person who has made a defined benefits application. Information packs may be sent electronically or by post.

3.7 An insurer does not need to provide an information pack at 24 weeks when a person:

- was charged with a serious driving offence or one or more driving offences;
 - is a foreign national and has permanently departed Australia;
- or if -**
- the insurer has denied liability for the person's defined benefits application;
 - the person returned to work at full capacity or their usual activities within 28 days after the motor accident;
 - the insurer reasonably believes that the person's physical or any psychological injuries are not stable; or
 - the insurer reasonably believes that the person's injuries are stable but they are not likely to have a permanent impairment from injuries as a result of the motor accident.

4. QUALITY OF LIFE BENEFITS APPLICATION

4.1 For the purposes of paragraph 137(3)(b) of the MAI Act a quality of life benefits application must include the following details:

- name of the injured person;

- the individual claim identifier provided by the insurer;
- the types of injuries for which an assessment is being sought being physical and/or primary psychological in the applicant's own words;
- an acknowledgement they have received sufficient treatment to inform the insurer of the stability of their injuries;
- details of the person's availability on weekdays for an assessment in the next three months and an acknowledgement an assessment may not occur in that time;
- details of any special needs of the person in attending an assessment – such as accessibility, cultural or language needs;
- whether the person requires an accompanying person to be present at the assessment together with the name, relationship and role of this person; and
- information about any offence the person has been charged with, or convicted or found guilty of, in relation to the accident.

4.2 For the purposes of paragraph 137(3)(c) of the MAI Act, a quality of life benefit application for a person requesting a primary psychological assessment must be accompanied by a written notice in accordance with clause 4.3 from a psychiatrist, or clinical psychologist in accordance with subsection 150(3) of the MAI Act and these guidelines. A psychiatrist is a medical practitioner with specialist registration with the Australian Medical Board in the field of psychiatry. Similarly, a clinical psychologist is a registered psychologist that has been endorsed by the Psychological Board of Australia to practise as a clinical psychologist. Registration is required with the Australian Health Practitioners Registration Authority.

4.3 The notice from the psychiatrist or clinical psychologist must include:

- a diagnosis of the primary psychological injury resulting from the accident based on a recognised diagnostic system and specify the diagnostic criteria upon which the diagnosis is based;
- a list of the type and frequency of treatment, providing comment on the effectiveness of any treatment the person has received for the primary psychological injury resulting from the accident;
- an opinion from the psychiatrist or clinical psychologist as to whether they consider the injury is well stabilised and unlikely to change substantially, with or without mental health treatment intervention, in the next year; and
- a statement from the psychiatrist or clinical psychologist that they reasonably believe the person is likely to have a permanent psychological injury resulting from the accident.

4.4 The following information may also accompany a quality of life benefits application but is not a mandatory requirement to complete the application:

- any medical reports about the status of the person's injuries that have not been provided directly to an insurer by a treating health practitioner of the injured person. This could include any reports about whether a person's injuries are stable or whether a person is likely to have a permanent impairment.

If under section 6.1 of these guidelines, the insurer has inconclusive information about the status of a person's injuries, the above information may also be subsequently requested by an insurer.

4.5 A quality of life benefits application may be made using a prescribed form made available on the MAI Commission's website or provided by an insurer. The application is to be made in writing and may be given to the insurer by electronic means, by personal delivery or by post.

5. APPLICATION FOR A WPI ASSESSMENT FOR A PERSON THAT HAS MADE A SUCCESSFUL WORKERS COMPENSATION CLAIM

5.1 Under Part 5.3 of the MAI Act, a person may apply to an insurer for the motor accident claim for an assessment of their WPI if:

- they have made a successful application for workers compensation benefits; and
- they have given a notice of claim under the *Civil Law (Wrongs) Act 2002*.

5.2 The application should include information about the WPI assessments the injured person is seeking. The application should also be accompanied by an authority to disclose personal health information that covers the exchange of personal health information between:

- the motor accident insurer;
- the injured person's stated workers compensation insurer (if applicable);
- treating health service providers or a treating team;
- an authorised IME provider; and
- an independent medical examiner who conducts a WPI assessment.

5.3 For the purposes of subsection 241(2) of the MAI Act, an insurer must give an acknowledgement notice to the injured person within 5 business days of receiving the application for a WPI assessment.

5.4 Note, under section 240 of the MAI Act, an application for an assessment is not required if the person has had an assessment conducted by a private medical examiner in accordance with the WPI assessment guidelines. The insurer may consider whether the assessment complies with the WPI Assessment Guidelines (including the ACT modifications to AMA5). The report should include a clear assessment of the percentage of WPI, the rationale and reference all medical information used.

6. PROCEDURE FOR ARRANGING A WPI ASSESSMENT

This section, and those in section 7, make provision for the procedures for arranging a WPI assessment under section 147 of the MAI Act.

6.1 Status of a person's injuries

6.1.1 An insurer has 20 business days to consider a quality of life benefits application, to allow for gathering up information and to assess the injuries of the injured person. This period will not commence for a quality of life benefit application that includes a request for a primary psychological assessment until the insurer is satisfied that the requirements of subsection 150(3) of the MAI Act are satisfied.

6.1.2 When assessing the injuries, the insurer may rely on the medical information available to them or seek an independent opinion on whether the injured person's injuries have stabilised. If an insurer seeks an independent opinion (including an examination) they should ensure the injured person is aware:

- it is a medical assessment for only this purpose (e.g. an assessment of their injuries' stabilisation); and
- it is not the WPI assessment arranged by the authorised IME provider.

6.1.3 An insurer must refer an injured person to an authorised IME provider for a WPI assessment if an insurer "reasonably believes":

- the person's injuries have stabilised; and
- the person is likely to have a permanent impairment as a result of the injuries.

6.1.4 An insurer must refer an injured person to an authorised IME provider for a WPI assessment if:

- the insurer "reasonably believes":
 - a person's injuries are stabilised;
 - the person is not likely to have a permanent impairment as a result of the injuries; and
- the injured person pays an excess amount for the assessment to the insurer.

An insurer is to give a written notice consistent with subsection 139(2) of the MAI Act.

6.1.5 An insurer must recommend to an injured person that the WPI assessment be delayed if:

- an insurer "reasonably believes" a person's injuries have not stabilised; and
- it is less than 4 years and 6 months after the date of the motor accident.

An insurer is to give a written notice consistent with subsection 140(2) of the MAI Act. An injured person may still request that an insurer makes an immediate referral for a WPI

assessment, but if the assessment confirms the person's injuries are not stable an insurer is not obliged to pay for a second assessment.

6.1.6 For the purposes of these guidelines, to assess stability an insurer may consider the treatment the injured person has, whether there has been a substantial change in the requested treatment (for example, fewer sessions occurring) and how their condition has settled. The insurer may also consider whether further medical treatment would have a substantive effect on their condition at the time of the application.

6.1.7 An insurer's reasonable belief about the stability of a person's injuries, and the likelihood of a permanent impairment should be based on information the insurer has in their possession about the person's injuries, treatment and recovery following receipt of the application. If this information is inconclusive the insurer should make reasonable inquiries with the person's treating health practitioners. If, after this step, information is still not conclusive, the insurer is to inform the injured person it may be necessary to obtain an independent medical review to establish stability of their physical injuries.

6.1.8 An insurer may consider the clinical evidence but must rely on a notice given by a psychiatrist or clinical psychologist under subsection 150(3) of the MAI Act to form a reasonable belief about the stability of a person's injuries and whether the person is likely to have a permanent primary psychological impairment. The notice is to reference the treatment the injured person has received (which may be from one or more practitioners for the mental health treatment required for the injured person's injury). It is a requirement that the person has received mental health treatment under section 150(3) before an injured person may request a WPI assessment. Generally, a course of treatment would include several sessions over a period of time that is appropriate for the diagnosis. This may be guided by the Recovery Plan put in place by agreement between the injured person, the treating professional, and the MAI insurer.

6.1.9 If an injured person has requested both a physical and a primary psychological assessment, an insurer will not be required to make a referral to an authorised IME provider until requirements in Division 2.6.2 of the MAI Act for making a referral are satisfied for both kinds of injuries or the injured person otherwise makes an informed decision to proceed with a separate referral for one kind of injury only. If a separate referral is made for one kind of injury, then the time frames for making the WPI report available and any quality of life benefit offer under sections 154 to 157 of the MAI Act are to apply as if there is only one WPI report. The injured person should be made aware that if they proceed with the assessment, then any quality of life benefit offer from the assessment will not take into account the other kind of injury, and depending on the outcome of the assessment may also result in the early finalisation of their quality of life benefit application.

6.1.10 If the person has physical injuries to multiple body systems an insurer should also reasonably believe that injuries to all physical body systems and any secondary psychological injuries have stabilised before making a WPI assessment referral.

6.1.11 An insurer must separately assess all physical injuries for a given body system to determine whether any of these injuries are likely to result in a permanent impairment. An insurer must not include physical injuries in a referral without first undertaking this assessment and the injured person must not be required to undergo unnecessary WPI assessment appointments.

6.1.10 If an injured person requests a physical injury be included in a referral, and the insurer reasonably believes the injured person is unlikely to have any permanent injuries for the given body system, then consistent with section 139 of the MAI Act an excess must be requested and paid before the referral is made. That is, if the injured person has physical injuries to multiple body systems, then a section 139(2) assessment is to be applied for each body system, rather than for the WPI assessment as a whole. However, only one excess under section 139(5) is payable. The excess is to be refunded if permanent injuries are subsequently identified.

6.2 The time within which a WPI assessment must be arranged

6.2.1 When an insurer is required to refer an injured person to an authorised IME provider for a WPI assessment they must:

- provide the injured person with a written notification in accordance with section 6.2.2; and
- send a written referral for the injured person to an authorised IME provider for a WPI assessment in accordance with section 6.2.3.

6.2.2 The insurer must provide the injured person with written notification of:

- the injuries and body systems which will be covered by the assessment;
- the person's medical history to be set out in the referral; and
- a list of the medical and health information in their possession which they will be providing to the authorised IME provider for the assessment.

The insurer may give the injured person a completed draft of the IME provider's referral form (without the file attachments that will be given to the IME provider) for these purposes.

This written notice must occur no later than 5 business days after the injured person:

- is eligible for an assessment under section 138 of the MAI Act; or
- confirms and pays an excess for a WPI assessment under subsection 139(3) of the MAI Act; or
- the person requests a WPI assessment under subsection 140(3) of the MAI Act; or
- the person notifies the insurer that their injuries have stabilised in accordance with subparagraph 141(5)(c)(ii) of the MAI Act.

The purpose of notification is for the injured person to be informed of the scope of the assessment and also provide an opportunity for the injured person to provide the

insurer/IME provider with any additional information they may have in their possession which may be relevant to the assessment.

6.2.3 An insurer must then send a written referral for the injured person to an authorised IME provider for a WPI assessment, for all injuries for which a person is likely to have a permanent impairment. This written referral must occur no later than 10 business days after the injured person:

- is eligible for an assessment under section 138 of the MAI Act; or
- confirms and pays an excess for a WPI assessment under subsection 139(3) of the MAI Act; or
- the person requests a WPI assessment under subsection 140(3) of the MAI Act; or
- the person notifies the insurer that their injuries have stabilised in accordance with subparagraph 141(5)(c)(ii) of the MAI Act.

If the injured person indicates additional information is to be provided, the insurer may defer making the written referral. After receipt of the information, the insurer has an additional 5 business days before making the referral. This is to allow the insurer time to consider the relevance of the additional information to the referral and make any necessary inquiries.

6.2.4 An injured person's application for quality of life benefits is suspended for the period a person has outstanding charges in relation to the motor accident for one or more driving offences, or a serious driving offence. A referral to an IME provider should not be made during the suspension period, and the insurer should inform the applicant about the suspension of the application, and circumstances that the application may be revived, in writing.

6.3 Insurer selecting an IME provider if more than one authorised IME provider

6.3.1 If the MAI Commission has authorised more than one IME provider to arrange WPI assessments, an insurer must put procedures in place to ensure that all authorised IME providers are allocated referrals from an insurer on an equal and sequential basis. For example, if there are two authorised IME providers an insurer should alternate referrals for any given injured person, between the two providers, based on the time and date of a referral. The only exception to this rule should be if:

- the allocated provider is unable to provide an assessment for all body systems for the injured person due to specialist availability;
- an injured person has previously received a physical or primary psychological assessment from the other or another authorised IME provider; or
- the other or another authorised IME provider operates in an interstate or overseas location closer to where the injured person resides or works and is able to arrange the assessment.

An insurer must keep a register of all referrals to authorised IME providers.

6.4 Arranging appointments with an independent medical examiner by the authorised IME provider

6.4.1 An insurer must prepare a written referral to the authorised IME provider. The referral is to be made using a form made available by the MAI Commission. The referral is to detail the injuries and body systems to be covered by the WPI assessment report and whether the insurer has received either a notice or information for a diagnosis of a psychological or psychiatric disorder.

6.4.2 The referral must indicate when a person is likely to be available for medical examinations and include details of any special needs, such as an interpreter services, that need to be accommodated for at an appointment.

6.4.3 The IME provider is responsible for arranging one or more independent medical examiners to carry out a WPI assessment of the injured person.

6.4.4 An insurer must also give the authorised IME provider all medical and allied health information, including results of clinical investigations in their possession relevant to the assessment, at least 10 calendar days before an appointment with an examiner. Information should include information about the onset of injury, subsequent treatment, diagnostic imaging and tests, and functional assessments of the person claiming the impairment. All documents should be appropriately indexed and organised in a manner to minimise file review times by the examiner.

6.4.5 If the injured person has requested that an accompanying person be present at the assessment the referral should include the name, relationship to the injured person, and role of this person.

6.4.6 The insurer may arrange for the authorised IME provider to communicate directly with the injured person about appointment bookings. In doing so, the authorised IME provider must inform the insurer of all appointment arrangements including any cancellation, non-attendance or rescheduling of appointments by either the applicant or the authorised IME provider.

6.4.7 An injured person must be given at least 10 business days written notice of any appointment with an independent medical examiner. The insurer is responsible for ensuring the appointment notice is given to the injured person and may make arrangements for the notice to be sent out by the IME provider on their behalf. The notice period may only be reduced or waived on agreement from the injured person and provided the insurer has already given the IME provider all information necessary to undertake an assessment. If a person has complex injuries a single notice may cover multiple appointments. The notice must include the following information about a given appointment:

- the name, specialty, and qualifications of the independent medical examiner;
- the injuries and body system/s covered by the referral noting the appointment is for the purposes of assessing impairment and not for medical treatment;

- the date, time, and location of the appointment, contact details for the examiner's offices and appropriate travel directions or arrangements;
- the likely duration of the appointment;
- how to cancel the appointment;
- the consequences of a late cancellation or a non-attendance for an appointment;
- Information the injured person should bring to the appointment (such as X-rays not in electronic form) or give to the examiner prior to the appointment;
- arrangements for an accompanying person to be present during an appointment, noting that the person is not to participate in the assessment, other than to assist the examiner in communicating with the person, and any accompanying person may be asked to leave the assessment room if requested by an examiner. Where the injured person is a child or a person with an intellectual disability, the examiner may request the support person remain in the room but not communicate with the injured person if there is a concern they are interfering with the assessment;
- arrangements for paying travel expenses; and
- how complaints can be made and how they will be handled.

A notice of an appointment may be sent to an injured person by post or electronically.

6.5 Payment for WPI assessment

6.5.1 An insurer will be responsible for directly paying an IME provider for a WPI assessment report and related costs requested on referral by an insurer. The IME provider will invoice in accordance with the fee schedule agreed by the MAI Commission. An IME provider must be paid within 10 business days of the insurer receiving a properly completed WPI report and invoice.

6.5.2 An insurer is not required to arrange for a referral for an assessment, or make an appointment with an IME provider, if the insurer has not received a payment or contribution for the cost of an assessment from an injured person in the following listed circumstances:

- the insurer believes a person's injuries are stable and the person is not likely to have a permanent impairment (Section 139 of the MAI Act);
- a second assessment is required for a person, because an assessment requested by the person under subsection 140(3) of the MAI Act confirmed the person's injuries had not stabilised; or
- a second assessment is required under subparagraph 141(5)(c)(ii) of the MAI Act because a person who has received an estimated WPI has applied to stay common law proceedings until their injuries have stabilised.

6.5.3 If an excess is paid by a person in accordance with subsection 139(5) of the MAI Act and the WPI assessment report confirms the person's WPI is greater than 0%, the insurer must reimburse the excess to the person within 10 business days of receiving the WPI assessment report.

6.5.4 If the IME provider is required to arrange a further appointment because a person did not attend an earlier appointment and did not give the insurer a reasonable excuse for their non-attendance, the person must pay any cancellation fee charged by the IME provider as a result of the missed appointment.

6.5.5 An insurer must also pay the reasonable and necessary travel expenses for a person to attend a WPI assessment on referral from an insurer, with the exception of a referral for a second assessment required because an assessment requested by the person under subsection 140(3) of the MAI Act confirmed the person's injuries had not stabilised.

6.5.6 If an injured person arranges for a private medical examiner to carry out a second WPI assessment the person will be responsible for paying for the WPI assessment report and for any travel expenses incurred in attending the WPI assessment.

7. VALIDATING A WPI ASSESSMENT REPORT

7.1 Before giving an injured person a copy of a WPI report and any offer of quality of life benefits under sections 154 to 157 of the MAI Act an insurer must first be satisfied that the WPI report reflects an assessment carried out in accordance with the WPI Assessment Guidelines. An insurer must have its own quality assurance process in place to confirm the validity of WPI reports, noting quality assurance is also undertaken by the authorised IME provider.

7.2 A WPI report may not be valid if it does not:

- address whether an injury or condition has reached maximum medical improvement as required by clause 1.15 of the WPI Assessment Guidelines;
- provide a history and findings from the examination;
- provide opinion as to whether the applicant has suffered a permanent impairment from injuries caused by or resulting from the accident;
- provide details and make a deduction from the final level of impairment for any known pre-existing injuries or conditions, or for other assessed injuries not caused by the motor accident;
- exclude any secondary psychological injury from an assessment of primary psychological injuries;
- determine the degree of impairment using the tables, graphs, and the methodology in the WPI Assessment Guidelines and the American Medical Association Edition 5 (referred to as AMA 5) where applicable, and provide a clear calculation of the percentage as a whole number;
- include a statement and certification from the assessor to the effect that:
 - the assessor has completed training in AMA 5 and their specialisation
 - evaluated the person's permanent injuries as a result of a motor accident and

that the WPI assessment has been conducted in accordance with the *Motor Accident Injuries (WPI Assessment) Guidelines 2019*.

7.3 An insurer may seek corrections or compliance clarifications on receipt of a WPI assessment report through requesting a superseding report from the authorised IME provider. In this circumstance, the time frame for giving a notice under sections 154 to 157 of the MAI Act will not commence until the insurer receives a superseding report from the authorised IME provider. The body of the superseding report must include a statement that explains that it supersedes the previous WPI report. The superseding report process is not to be used by an insurer to seek/ask additional questions that were not present in the initial referral, to provide any additional information not made available to the assessor at the time of the assessment, or to question/change any clinical judgments made by the assessor in preparing the WPI report.

8. REQUIREMENTS FOR SECOND WPI REPORTS

8.1 These guidelines make provision for an injured person's responsibilities in relation to obtaining a second WPI report and providing a valid report. Under the MAI Act, a private medical examiner, trained in the WPI Assessment Guidelines, undertakes this assessment.

8.2 An injured person does not have to obtain a second WPI report. The injured person is to notify the insurer that they will be seeking their own WPI report because they disagree with the first WPI report. This has the effect of pausing the benefit.

8.3 The second WPI report must be provided to the insurer within 26 weeks after the date of the notice given under sections 154 to 156. If a notice is given under section 157, a longer due date for providing the second WPI report may apply. The costs of a second WPI report are for the injured person to pay. Note, if the outcome of the assessment is for a higher WPI percentage because the first WPI report is less than 10 per cent, the insurer may reimburse the cost of the report if there is a motor accident claim.

8.3 To obtain a valid second WPI report, the injured person must ensure that the private medical examiner is informed they are to conduct the assessment in accordance with these guidelines, including clause 7.2, the WPI Assessment Guidelines, and the MAI Act. A report not prepared accordingly may be invalid. A second WPI report cannot be obtained before, or at the same time, as the insurer-initiated assessment.

8.3 The second WPI report should be based on the same supporting documents as the insurer-initiated assessment. If there has been an updating or additional reports that were obtained after the insurer-initiated assessment but before the private medical examiner undertakes their assessment, the updating or additional reports are to be provided to the insurer with the second WPI report.

8.4 To facilitate a second WPI report being comparable to an insurer-initiated assessment, the content of a second WPI report should contain the following (to be consistent with clauses 7.2 and 9.5):

- confirm that the assessor is a private medical examiner providing a report for the purposes of section 158 of the Motor Accident Injuries Act
- confirm the date the applicant attended for assessment
- include a history
- include findings on examination and provide confirmation of the diagnosis
- reference relevant medical reports and documents the assessor had in their possession for the assessment, including those referred to in the first WPI report (note, this may be more than one if multiple body systems are involved)
- provide opinion as to whether the applicant has suffered a permanent impairment from injuries caused or resulting from the accident
- provide details of any relevant pre-existing injuries or conditions, the status of these injuries at the time of the accident, and any aggravating events/injuries post the motor accident
- provide opinion as to whether the applicant's presentation is consistent with the medical information and the first assessor's observations
- provide a clear explanation of any calculation of whole person impairment from the injuries in the motor accident including deductions where relevant
- contain a statement that the assessor has completed training in AMA5 and their specialisation and have conducted the assessment in line with the modifications contained in the Motor Accident Injuries (WPI Assessment) Guidelines 2019.

8.5 The second WPI report is to be self-contained and only prepared for the purpose of the WPI assessment. It therefore should not include an Expert Witness Statement or cover any injuries or conditions not referred to in the first WPI report. An injured person should alert the provider to the requirements of clause 8 when arranging the report. Limited additional questions may be answered by the private medical examiner, for example details of any treatment, therapy or referrals recommended for the injured person.

9. FINAL OFFER WPI

9.1 These guidelines make provision for an insurer's responsibilities in relation to second WPI reports including matters an insurer can consider in making a *final offer WPI* under subsection 160(2) of the MAI Act and for giving reasons for a final offer WPI decision.

9.2 Section 160 of the MAI Act applies if the relevant insurer receives a second WPI report from the injured person, and the injured person has not yet made a complying common law claim. If section 160 applies, the insurer must decide the final offer WPI. The insurer's final offer must not be less than the WPI in the original report (first WPI report) if it has not been reviewed by the Independent Medical Examiner (IME) under section 159 of the MAI Act, or if reviewed, must not be less than the notice affirming or increasing the WPI for the first WPI report.

9.3 An insurer must rely on the level of whole person impairment determined by the IME or private medical examiner (the assessors) from an assessment that was carried out in accordance with the *Motor Accident Injuries (WPI Assessment) Guidelines 2019* (WPI Guidelines). An insurer is not required to independently evaluate the level of impairment in a WPI report based on medical evidence they may have in their possession.

9.4 A final WPI offer must be made on the basis of a WPI report for an assessment carried out in accordance with the WPI Guidelines. An insurer may make a final WPI offer, for a WPI between the WPI for the first WPI report and the second WPI report, provided the WPI percentage is a whole number. This could include circumstances where there was inconsistency in clinical judgments made by the two assessors in applying the evaluation methodology or inconsistent presentations by the injured person of their injuries/condition at appointments with the two assessors.

9.5 In making a final WPI offer decision an insurer may disregard a second WPI report, in whole or part, if the insurer is not satisfied that the assessment was carried out in accordance with the WPI Guidelines. An insurer may form its belief about the validity of a report based on reasons given by the IME with a written notice under section 159 of the MAI Act. An insurer may also consider whether the principles of, and administrative processes for, an assessment in Chapter 1 of the WPI Guidelines have been followed in preparing the second WPI report, including by considering matters in Paragraph 7.2 of these guidelines. An insurer may also disregard a second WPI report if the insurer is not satisfied that the second assessor considered relevant information made available to the first assessor or if the second assessment includes injuries or conditions not evaluated in the first assessment. This could be evidenced by the second WPI report:

- not referencing that the second assessor had in their possession relevant medical reports and documents which were referred to in the first WPI report; or
- including, in the final level of impairment, injuries or conditions not identified in the original WPI report as being caused or resulting from the motor accident.

An insurer must have processes in place to give an injured person seeking a second WPI report, any relevant medical reports and documents not already in the injured person's possession, which the insurer provided for the first WPI assessment.

9.6 In making a final offer WPI an insurer is to give reasons in writing as the insurer must decide a WPI to determine the final offer. The reasons need only record the relevant facts and reference evidence such as the assessment and section 159 reports relied upon by the insurer for the determination. If an insurer disregards a second WPI report, in whole or part, the insurer is to state their reasons for doing so. If a second report is disregarded in part, an insurer must not make any adjustments to the assessed degree of impairment in the second report requiring a clinical judgement including for the attribution of any injuries to the motor accident.

10. INFORMATION AND SUPPORT – WPI TAKEN TO BE 10% IN CERTAIN CIRCUMSTANCES

10.1 These guidelines make provision for information and support an insurer is obliged to give a person under paragraph 52(2)(f) of the MAI Act who is taken under section 133 of the MAI Act to have a WPI of 10 per cent. A person who was a child at the time of an accident and at four years and six months after the motor accident is either receiving treatment and care meeting the requirements of the regulation, or a participant in the LTCS scheme, will be taken to have a WPI of 10 per cent.

10.2 An insurer must identify any injured person that is taken to have a WPI of 10 per cent under section 133 of the MAI Act, and contact the person in writing (or a parent/guardian in the case of a minor), one month prior to reaching 4 years and six months from the date of the motor accident. The insurer does not need to contact a person that has received a written notice under subsection 157(2) or 164(2) of the MAI Act and has lodged a notice of claim within the time frames permitted for the notice. An insurer must include information about the person's eligibility to make a common law claim, the time frames for the person to lodge a notice of claim and that the person may wish to seek legal advice as to whether to make a claim for damages.

11. INFORMATION AND SUPPORT – WPI OFFERS

11.1 These guidelines make provision for the information and support an insurer is obliged to give a person that receives a WPI offer about making a motor accident claim for the purposes of paragraph 52(2)(g) of the MAI Act.

11.2 An insurer must include with a written notice given to an injured person under subsection 157(2) or 164(2) of the MAI Act statements about the time frame for the person to lodge a notice of claim, and the insurer is unable to provide legal advice as to whether to make a claim for damages, and may include the contact details of the ACT Law Society for referral to a legal service provider.

From: "Lejins, Erica" <Erica.Lejins@act.gov.au>
Sent: 17/09/2025 3:58 PM
To: "ceo@actbar.com.au" <ceo@actbar.com.au>; "Committee" <committee@actlawsociety.asn.au>
Cc: Sch 2.2(a)(ii); "MAI Commission" <maic@act.gov.au>
Subject: Consultation Draft- Motor Accident Injuries (Quality of Life Benefit) Guidelines
Attachments: Quality of Life Guidelines - Consultation Draft - September 2025.pdf

OFFICIAL

Dear Stakeholders,

Earlier this year, the MAI Commission provided for comment a short form review of four updated guidelines. Three of the guidelines were subsequently made on 10 July 2025. The fourth included with the package was the Quality of Life Benefit guidelines. The earlier draft circulated in March 2025 had foreshadowed two options for requests for psychological assessments.

The revised draft now incorporates feedback received in relation to the earlier draft. The incorporation of all feedback required a reframing of the Guidelines, which has also provided the MAI Commission with the opportunity to include updates providing clarity about steps an insurer must undertake to validate a WPI report, the handling of second WPI reports, and final WPI offers. The introduction has been expanded to include a background section to better assist members of the public who may be handling their own defined benefits application with information in one location.

If you wish to provide comments or feedback on the guidelines, we request these by close of business **Friday 10 October 2025**. Your comments can be directed to the MAI Commission inbox. If you wish to discuss the guidelines, you can contact the MAI Commission on 6207 8876.

With regards

Erica Lejins

Director

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I acknowledge the Ngunnawal people as the traditional custodians of the ACT and recognise any other people or families with connection to the lands of the ACT and region. I acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

Australian Capital Territory

Motor Accident Injuries (Quality of Life Benefit) Guidelines 2025

Disallowable instrument DI2025

made under the

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

1 Name of instrument

This instrument is the *Motor Accident Injuries (Quality of Life Benefit) Guidelines 2025*.

2 Commencement

This instrument commences on the 7th day after its notification.

3 Guidelines

I make the guidelines attached to this instrument.

4 Revocations

The *Motor Accident Injuries (Quality of Life Benefit) Guidelines 2023* (DI2023-311) is revoked.

MAI Commissioner

MAI Commission

2025

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Quality of Life Benefit Guidelines

1. INTRODUCTION

The Quality of Life Benefit guidelines (guidelines) are part of the MAI guidelines made under section 487 of the *Motor Accident Injuries Act 2019* (MAI Act). The Guidelines detail the insurers' obligations in providing information and support to potential applicants for quality of life benefits, procedures for arranging Whole Person Impairment (WPI) assessments and making offers for quality of life defined benefit amounts. They also detail the process for an injured person to obtain a valid second WPI report.

Background

The quality of life (QOL) benefit is a recognition payment for a person's permanent injuries caused by the accident and may be offered following a WPI assessment carried out in accordance with the *Motor Accident Injuries (WPI Assessment) Guidelines 2019* (WPI Assessment Guidelines). An application for the benefit may be made no earlier than 26 weeks after the motor accident. The injuries sustained in the accident need to have stabilised sufficiently for an assessment. The benefit is payable for WPI assessments of 5 per cent or more, with the benefit amount set out in legislation and based on the WPI figure (a whole number). A person with a WPI assessment of 10 per cent or more from the first WPI report may choose to access common law if they were not at fault.

The first WPI assessment is made on referral by an insurer to an authorised IME provider. The IME provider appoints qualified and experienced independent medical examiners (IMEs) to carry out WPI assessments. This authorisation by the MAI Commission is to facilitate the first WPI assessment. The IME providers have a national presence and are able to select IMEs from around the country.

On referral by the insurer, the IME provider will select the independent medical examiner (IME) relevant for the permanent injuries needing to be assessed. This process is so that the IME undertaking the assessment has not been appointed by either an insurer or a legal representative. There is no process of selecting from several IMEs as it will be subject to availability.

If an injured person is unhappy with the first assessment and wants another assessment, they are able to select and pay for their own private medical examiner (PME) to conduct a second WPI report. There is no requirement to approach the authorised IME provider for a PME. It is important, though, that the PME is qualified and experienced in carrying out ACT WPI assessments. The second report is to meet the same conditions as the first so that it can be relied upon to make the offer for the QOL benefit or to lodge a notice of claim.

2. STATUTORY FRAMEWORK

Division 2.6.2 of the MAI Act makes provision for an injured person to make a quality of life benefits application. A precondition for the application is that the injured person has received a receipt notice or late receipt notice under section 60 of the MAI Act. An injured person cannot make a quality of life benefit application earlier than 26 weeks after a motor accident and not later than 4 years and six months after an accident.

The legislative framework for quality of life benefits includes:

- a. the MAI Act;
- b. the Motor Accident Injuries Regulation 2019 (the Regulation); and
- c. these Guidelines made under the MAI Act.

Also, the WPI Assessment Guidelines apply to any WPI assessment undertaken for the purposes of the MAI Act.

3. INFORMATION AND SUPPORT FOR APPLICANTS FOR QUALITY OF LIFE BENEFITS

3.1 These guidelines make provision for the information and support an insurer is to give a person about making an application for quality of life benefits for the purposes of paragraph 52(2)(e) of the MAI Act. The information pack is intended to assist an injured person in making an informed decision about requesting a WPI assessment.

3.2 The information pack is required to be provided about:

- the eligibility requirements for a quality of life defined benefit or to make a motor accident claim;
- how to apply for a quality of life benefit, and the time frame for making an application;
- the need for a person's injuries to be stable for a permanent impairment to be assessed;
- conditions for requesting a WPI assessment for primary/secondary psychological injuries;
- requirements for requesting a WPI assessment for a primary psychological injury, including the definition of a primary psychological injury, the requirement to have undergone mental health treatment and to provide a notice under subsection 150(3) of the MAI Act and paragraphs 4.2 and 4.3 of these guidelines;
- the definition of a secondary psychological injury and requirements for a secondary psychological injury to be taken into account as part of a physical assessment;
- how an insurer will arrange for an assessment with the independent medical examiner provider, expected waiting times for an assessment and the person's obligations if they request an assessment;
- how a WPI assessment is carried out and where a person can access the MAI guidelines about permanent impairment assessments; and

- arrangements for paying for a WPI assessment, including the circumstances a person will be required to pay an excess for an assessment and the circumstances in which an excess can be returned.

3.3 An insurer must provide an information pack about quality of life payments to an applicant for defined benefits (other than persons mentioned in paragraph 3.6) prior to the injured person first becoming eligible to make a quality of life application. The pack is to be provided no earlier than 24 weeks after the date of an accident. Where the period of 26 weeks after the date of the accident has passed, for example a late application is made and accepted, the insurer should provide the information pack after the insurer has accepted liability for the application. An insurer may provide general information about the benefit, noting the need for treatment to have occurred and stability of injuries that are of a permanent nature.

3.4 To assist an injured person who may request an assessment for a primary psychological injury the insurer may include a template for a notice under subsection 150(3) of the MAI Act when providing the information pack.

3.5 An insurer must consider their duty to act in good faith when determining the timing of the issue of an information pack. This includes the insurer's duty in paragraph 20(4)(a) of the MAI Act to disclose, as soon as practicable, all information that an applicant may need to understand the process for applying for defined benefits.

3.6 The information pack must also be provided on request by any other person who has made a defined benefits application. Information packs may be sent electronically or by post.

3.7 An insurer does not need to provide an information pack at 24 weeks when a person:

- was charged with a serious driving offence or one or more driving offences;
 - is a foreign national and has permanently departed Australia;
- or if -**
- the insurer has denied liability for the person's defined benefits application;
 - the person returned to work at full capacity or their usual activities within 28 days after the motor accident;
 - the insurer reasonably believes that the person's physical or any psychological injuries are not stable; or
 - the insurer reasonably believes that the person's injuries are stable but they are not likely to have a permanent impairment from injuries as a result of the motor accident.

4. QUALITY OF LIFE BENEFITS APPLICATION

4.1 For the purposes of paragraph 137(3)(b) of the MAI Act a quality of life benefits application must include the following details:

- name of the injured person;

- the individual claim identifier provided by the insurer;
- the types of injuries for which an assessment is being sought being physical and/or primary psychological in the applicant's own words;
- an acknowledgement they have received sufficient treatment to inform the insurer of the stability of their injuries;
- details of the person's availability on weekdays for an assessment in the next three months and an acknowledgement an assessment may not occur in that time;
- details of any special needs of the person in attending an assessment – such as accessibility, cultural or language needs;
- whether the person requires an accompanying person to be present at the assessment together with the name, relationship and role of this person; and
- information about any offence the person has been charged with, or convicted or found guilty of, in relation to the accident.

4.2 For the purposes of paragraph 137(3)(c) of the MAI Act, a quality of life benefit application for a person requesting a primary psychological assessment must be accompanied by a written notice in accordance with clause 4.3 from a psychiatrist, or clinical psychologist in accordance with subsection 150(3) of the MAI Act and these guidelines. A psychiatrist is a medical practitioner with specialist registration with the Australian Medical Board in the field of psychiatry. Similarly, a clinical psychologist is a registered psychologist that has been endorsed by the Psychological Board of Australia to practise as a clinical psychologist. Registration is required with the Australian Health Practitioners Registration Authority.

4.3 The notice from the psychiatrist or clinical psychologist must include:

- a diagnosis of the primary psychological injury resulting from the accident based on a recognised diagnostic system and specify the diagnostic criteria upon which the diagnosis is based;
- a list of the type and frequency of treatment, providing comment on the effectiveness of any treatment the person has received for the primary psychological injury resulting from the accident;
- an opinion from the psychiatrist or clinical psychologist as to whether they consider the injury is well stabilised and unlikely to change substantially, with or without mental health treatment intervention, in the next year; and
- a statement from the psychiatrist or clinical psychologist that they reasonably believe the person is likely to have a permanent psychological injury resulting from the accident.

4.4 The following information may also accompany a quality of life benefits application but is not a mandatory requirement to complete the application:

- any medical reports about the status of the person's injuries that have not been provided directly to an insurer by a treating health practitioner of the injured person. This could include any reports about whether a person's injuries are stable or whether a person is likely to have a permanent impairment.

If under section 6.1 of these guidelines, the insurer has inconclusive information about the status of a person's injuries, the above information may also be subsequently requested by an insurer.

4.5 A quality of life benefits application may be made using a prescribed form made available on the MAI Commission's website or provided by an insurer. The application is to be made in writing and may be given to the insurer by electronic means, by personal delivery or by post.

5. APPLICATION FOR A WPI ASSESSMENT FOR A PERSON THAT HAS MADE A SUCCESSFUL WORKERS COMPENSATION CLAIM

5.1 Under Part 5.3 of the MAI Act, a person may apply to an insurer for the motor accident claim for an assessment of their WPI if:

- they have made a successful application for workers compensation benefits; and
- they have given a notice of claim under the *Civil Law (Wrongs) Act 2002*.

5.2 The application should include information about the WPI assessments the injured person is seeking. The application should also be accompanied by an authority to disclose personal health information that covers the exchange of personal health information between:

- the motor accident insurer;
- the injured person's stated workers compensation insurer (if applicable);
- treating health service providers or a treating team;
- an authorised IME provider; and
- an independent medical examiner who conducts a WPI assessment.

5.3 For the purposes of subsection 241(2) of the MAI Act, an insurer must give an acknowledgement notice to the injured person within 5 business days of receiving the application for a WPI assessment.

5.4 Note, under section 240 of the MAI Act, an application for an assessment is not required if the person has had an assessment conducted by a private medical examiner in accordance with the WPI assessment guidelines. The insurer may consider whether the assessment complies with the WPI Assessment Guidelines (including the ACT modifications to AMA5). The report should include a clear assessment of the percentage of WPI, the rationale and reference all medical information used.

6. PROCEDURE FOR ARRANGING A WPI ASSESSMENT

This section, and those in section 7, make provision for the procedures for arranging a WPI assessment under section 147 of the MAI Act.

6.1 Status of a person's injuries

6.1.1 An insurer has 20 business days to consider a quality of life benefits application, to allow for gathering up information and to assess the injuries of the injured person. This period will not commence for a quality of life benefit application that includes a request for a primary psychological assessment until the insurer is satisfied that the requirements of subsection 150(3) of the MAI Act are satisfied.

6.1.2 When assessing the injuries, the insurer may rely on the medical information available to them or seek an independent opinion on whether the injured person's injuries have stabilised. If an insurer seeks an independent opinion (including an examination) they should ensure the injured person is aware:

- it is a medical assessment for only this purpose (e.g. an assessment of their injuries' stabilisation); and
- it is not the WPI assessment arranged by the authorised IME provider.

6.1.3 An insurer must refer an injured person to an authorised IME provider for a WPI assessment if an insurer "reasonably believes":

- the person's injuries have stabilised; and
- the person is likely to have a permanent impairment as a result of the injuries.

6.1.4 An insurer must refer an injured person to an authorised IME provider for a WPI assessment if:

- the insurer "reasonably believes":
 - a person's injuries are stabilised;
 - the person is not likely to have a permanent impairment as a result of the injuries; and
- the injured person pays an excess amount for the assessment to the insurer.

An insurer is to give a written notice consistent with subsection 139(2) of the MAI Act.

6.1.5 An insurer must recommend to an injured person that the WPI assessment be delayed if:

- an insurer "reasonably believes" a person's injuries have not stabilised; and
- it is less than 4 years and 6 months after the date of the motor accident.

An insurer is to give a written notice consistent with subsection 140(2) of the MAI Act. An injured person may still request that an insurer makes an immediate referral for a WPI

assessment, but if the assessment confirms the person's injuries are not stable an insurer is not obliged to pay for a second assessment.

6.1.6 For the purposes of these guidelines, to assess stability an insurer may consider the treatment the injured person has, whether there has been a substantial change in the requested treatment (for example, fewer sessions occurring) and how their condition has settled. The insurer may also consider whether further medical treatment would have a substantive effect on their condition at the time of the application.

6.1.7 An insurer's reasonable belief about the stability of a person's injuries, and the likelihood of a permanent impairment should be based on information the insurer has in their possession about the person's injuries, treatment and recovery following receipt of the application. If this information is inconclusive the insurer should make reasonable inquiries with the person's treating health practitioners. If, after this step, information is still not conclusive, the insurer is to inform the injured person it may be necessary to obtain an independent medical review to establish stability of their physical injuries.

6.1.8 An insurer may consider the clinical evidence but must rely on a notice given by a psychiatrist or clinical psychologist under subsection 150(3) of the MAI Act to form a reasonable belief about the stability of a person's injuries and whether the person is likely to have a permanent primary psychological impairment. The notice is to reference the treatment the injured person has received (which may be from one or more practitioners for the mental health treatment required for the injured person's injury). It is a requirement that the person has received mental health treatment under section 150(3) before an injured person may request a WPI assessment. Generally, a course of treatment would include several sessions over a period of time that is appropriate for the diagnosis. This may be guided by the Recovery Plan put in place by agreement between the injured person, the treating professional, and the MAI insurer.

6.1.9 If an injured person has requested both a physical and a primary psychological assessment, an insurer will not be required to make a referral to an authorised IME provider until requirements in Division 2.6.2 of the MAI Act for making a referral are satisfied for both kinds of injuries or the injured person otherwise makes an informed decision to proceed with a separate referral for one kind of injury only. If a separate referral is made for one kind of injury, then the time frames for making the WPI report available and any quality of life benefit offer under sections 154 to 157 of the MAI Act are to apply as if there is only one WPI report. The injured person should be made aware that if they proceed with the assessment, then any quality of life benefit offer from the assessment will not take into account the other kind of injury, and depending on the outcome of the assessment may also result in the early finalisation of their quality of life benefit application.

6.1.10 If the person has physical injuries to multiple body systems an insurer should also reasonably believe that injuries to all physical body systems and any secondary psychological injuries have stabilised before making a WPI assessment referral.

6.1.11 An insurer must separately assess all physical injuries for a given body system to determine whether any of these injuries are likely to result in a permanent impairment. An insurer must not include physical injuries in a referral without first undertaking this assessment and the injured person must not be required to undergo unnecessary WPI assessment appointments.

6.1.10 If an injured person requests a physical injury be included in a referral, and the insurer reasonably believes the injured person is unlikely to have any permanent injuries for the given body system, then consistent with section 139 of the MAI Act an excess must be requested and paid before the referral is made. That is, if the injured person has physical injuries to multiple body systems, then a section 139(2) assessment is to be applied for each body system, rather than for the WPI assessment as a whole. However, only one excess under section 139(5) is payable. The excess is to be refunded if permanent injuries are subsequently identified.

6.2 The time within which a WPI assessment must be arranged

6.2.1 When an insurer is required to refer an injured person to an authorised IME provider for a WPI assessment they must:

- provide the injured person with a written notification in accordance with section 6.2.2; and
- send a written referral for the injured person to an authorised IME provider for a WPI assessment in accordance with section 6.2.3.

6.2.2 The insurer must provide the injured person with written notification of:

- the injuries and body systems which will be covered by the assessment;
- the person's medical history to be set out in the referral; and
- a list of the medical and health information in their possession which they will be providing to the authorised IME provider for the assessment.

The insurer may give the injured person a completed draft of the IME provider's referral form (without the file attachments that will be given to the IME provider) for these purposes.

This written notice must occur no later than 5 business days after the injured person:

- is eligible for an assessment under section 138 of the MAI Act; or
- confirms and pays an excess for a WPI assessment under subsection 139(3) of the MAI Act; or
- the person requests a WPI assessment under subsection 140(3) of the MAI Act; or
- the person notifies the insurer that their injuries have stabilised in accordance with subparagraph 141(5)(c)(ii) of the MAI Act.

The purpose of notification is for the injured person to be informed of the scope of the assessment and also provide an opportunity for the injured person to provide the

insurer/IME provider with any additional information they may have in their possession which may be relevant to the assessment.

6.2.3 An insurer must then send a written referral for the injured person to an authorised IME provider for a WPI assessment, for all injuries for which a person is likely to have a permanent impairment. This written referral must occur no later than 10 business days after the injured person:

- is eligible for an assessment under section 138 of the MAI Act; or
- confirms and pays an excess for a WPI assessment under subsection 139(3) of the MAI Act; or
- the person requests a WPI assessment under subsection 140(3) of the MAI Act; or
- the person notifies the insurer that their injuries have stabilised in accordance with subparagraph 141(5)(c)(ii) of the MAI Act.

If the injured person indicates additional information is to be provided, the insurer may defer making the written referral. After receipt of the information, the insurer has an additional 5 business days before making the referral. This is to allow the insurer time to consider the relevance of the additional information to the referral and make any necessary inquiries.

6.2.4 An injured person's application for quality of life benefits is suspended for the period a person has outstanding charges in relation to the motor accident for one or more driving offences, or a serious driving offence. A referral to an IME provider should not be made during the suspension period, and the insurer should inform the applicant about the suspension of the application, and circumstances that the application may be revived, in writing.

6.3 Insurer selecting an IME provider if more than one authorised IME provider

6.3.1 If the MAI Commission has authorised more than one IME provider to arrange WPI assessments, an insurer must put procedures in place to ensure that all authorised IME providers are allocated referrals from an insurer on an equal and sequential basis. For example, if there are two authorised IME providers an insurer should alternate referrals for any given injured person, between the two providers, based on the time and date of a referral. The only exception to this rule should be if:

- the allocated provider is unable to provide an assessment for all body systems for the injured person due to specialist availability;
- an injured person has previously received a physical or primary psychological assessment from the other or another authorised IME provider; or
- the other or another authorised IME provider operates in an interstate or overseas location closer to where the injured person resides or works and is able to arrange the assessment.

An insurer must keep a register of all referrals to authorised IME providers.

6.4 Arranging appointments with an independent medical examiner by the authorised IME provider

6.4.1 An insurer must prepare a written referral to the authorised IME provider. The referral is to be made using a form made available by the MAI Commission. The referral is to detail the injuries and body systems to be covered by the WPI assessment report and whether the insurer has received either a notice or information for a diagnosis of a psychological or psychiatric disorder.

6.4.2 The referral must indicate when a person is likely to be available for medical examinations and include details of any special needs, such as an interpreter services, that need to be accommodated for at an appointment.

6.4.3 The IME provider is responsible for arranging one or more independent medical examiners to carry out a WPI assessment of the injured person.

6.4.4 An insurer must also give the authorised IME provider all medical and allied health information, including results of clinical investigations in their possession relevant to the assessment, at least 10 calendar days before an appointment with an examiner. Information should include information about the onset of injury, subsequent treatment, diagnostic imaging and tests, and functional assessments of the person claiming the impairment. All documents should be appropriately indexed and organised in a manner to minimise file review times by the examiner.

6.4.5 If the injured person has requested that an accompanying person be present at the assessment the referral should include the name, relationship to the injured person, and role of this person.

6.4.6 The insurer may arrange for the authorised IME provider to communicate directly with the injured person about appointment bookings. In doing so, the authorised IME provider must inform the insurer of all appointment arrangements including any cancellation, non-attendance or rescheduling of appointments by either the applicant or the authorised IME provider.

6.4.7 An injured person must be given at least 10 business days written notice of any appointment with an independent medical examiner. The insurer is responsible for ensuring the appointment notice is given to the injured person and may make arrangements for the notice to be sent out by the IME provider on their behalf. The notice period may only be reduced or waived on agreement from the injured person and provided the insurer has already given the IME provider all information necessary to undertake an assessment. If a person has complex injuries a single notice may cover multiple appointments. The notice must include the following information about a given appointment:

- the name, specialty, and qualifications of the independent medical examiner;
- the injuries and body system/s covered by the referral noting the appointment is for the purposes of assessing impairment and not for medical treatment;

- the date, time, and location of the appointment, contact details for the examiner's offices and appropriate travel directions or arrangements;
- the likely duration of the appointment;
- how to cancel the appointment;
- the consequences of a late cancellation or a non-attendance for an appointment;
- Information the injured person should bring to the appointment (such as X-rays not in electronic form) or give to the examiner prior to the appointment;
- arrangements for an accompanying person to be present during an appointment, noting that the person is not to participate in the assessment, other than to assist the examiner in communicating with the person, and any accompanying person may be asked to leave the assessment room if requested by an examiner. Where the injured person is a child or a person with an intellectual disability, the examiner may request the support person remain in the room but not communicate with the injured person if there is a concern they are interfering with the assessment;
- arrangements for paying travel expenses; and
- how complaints can be made and how they will be handled.

A notice of an appointment may be sent to an injured person by post or electronically.

6.5 Payment for WPI assessment

6.5.1 An insurer will be responsible for directly paying an IME provider for a WPI assessment report and related costs requested on referral by an insurer. The IME provider will invoice in accordance with the fee schedule agreed by the MAI Commission. An IME provider must be paid within 10 business days of the insurer receiving a properly completed WPI report and invoice.

6.5.2 An insurer is not required to arrange for a referral for an assessment, or make an appointment with an IME provider, if the insurer has not received a payment or contribution for the cost of an assessment from an injured person in the following listed circumstances:

- the insurer believes a person's injuries are stable and the person is not likely to have a permanent impairment (Section 139 of the MAI Act);
- a second assessment is required for a person, because an assessment requested by the person under subsection 140(3) of the MAI Act confirmed the person's injuries had not stabilised; or
- a second assessment is required under subparagraph 141(5)(c)(ii) of the MAI Act because a person who has received an estimated WPI has applied to stay common law proceedings until their injuries have stabilised.

6.5.3 If an excess is paid by a person in accordance with subsection 139(5) of the MAI Act and the WPI assessment report confirms the person's WPI is greater than 0%, the insurer must reimburse the excess to the person within 10 business days of receiving the WPI assessment report.

6.5.4 If the IME provider is required to arrange a further appointment because a person did not attend an earlier appointment and did not give the insurer a reasonable excuse for their non-attendance, the person must pay any cancellation fee charged by the IME provider as a result of the missed appointment.

6.5.5 An insurer must also pay the reasonable and necessary travel expenses for a person to attend a WPI assessment on referral from an insurer, with the exception of a referral for a second assessment required because an assessment requested by the person under subsection 140(3) of the MAI Act confirmed the person's injuries had not stabilised.

6.5.6 If an injured person arranges for a private medical examiner to carry out a second WPI assessment the person will be responsible for paying for the WPI assessment report and for any travel expenses incurred in attending the WPI assessment.

7. VALIDATING A WPI ASSESSMENT REPORT

7.1 Before giving an injured person a copy of a WPI report and any offer of quality of life benefits under sections 154 to 157 of the MAI Act an insurer must first be satisfied that the WPI report reflects an assessment carried out in accordance with the WPI Assessment Guidelines. An insurer must have its own quality assurance process in place to confirm the validity of WPI reports, noting quality assurance is also undertaken by the authorised IME provider.

7.2 A WPI report may not be valid if it does not:

- address whether an injury or condition has reached maximum medical improvement as required by clause 1.15 of the WPI Assessment Guidelines;
- provide a history and findings from the examination;
- provide opinion as to whether the applicant has suffered a permanent impairment from injuries caused by or resulting from the accident;
- provide details and make a deduction from the final level of impairment for any known pre-existing injuries or conditions, or for other assessed injuries not caused by the motor accident;
- exclude any secondary psychological injury from an assessment of primary psychological injuries;
- determine the degree of impairment using the tables, graphs, and the methodology in the WPI Assessment Guidelines and the American Medical Association Edition 5 (referred to as AMA 5) where applicable, and provide a clear calculation of the percentage as a whole number;
- include a statement and certification from the assessor to the effect that:
 - the assessor has completed training in AMA 5 and their specialisation
 - evaluated the person's permanent injuries as a result of a motor accident and

that the WPI assessment has been conducted in accordance with the *Motor Accident Injuries (WPI Assessment) Guidelines 2019*.

7.3 An insurer may seek corrections or compliance clarifications on receipt of a WPI assessment report through requesting a superseding report from the authorised IME provider. In this circumstance, the time frame for giving a notice under sections 154 to 157 of the MAI Act will not commence until the insurer receives a superseding report from the authorised IME provider. The body of the superseding report must include a statement that explains that it supersedes the previous WPI report. The superseding report process is not to be used by an insurer to seek/ask additional questions that were not present in the initial referral, to provide any additional information not made available to the assessor at the time of the assessment, or to question/change any clinical judgments made by the assessor in preparing the WPI report.

8. REQUIREMENTS FOR SECOND WPI REPORTS

8.1 These guidelines make provision for an injured person's responsibilities in relation to obtaining a second WPI report and providing a valid report. Under the MAI Act, a private medical examiner, trained in the WPI Assessment Guidelines, undertakes this assessment.

8.2 An injured person does not have to obtain a second WPI report. The injured person is to notify the insurer that they will be seeking their own WPI report because they disagree with the first WPI report. This has the effect of pausing the benefit.

8.3 The second WPI report must be provided to the insurer within 26 weeks after the date of the notice given under sections 154 to 156. If a notice is given under section 157, a longer due date for providing the second WPI report may apply. The costs of a second WPI report are for the injured person to pay. Note, if the outcome of the assessment is for a higher WPI percentage because the first WPI report is less than 10 per cent, the insurer may reimburse the cost of the report if there is a motor accident claim.

8.3 To obtain a valid second WPI report, the injured person must ensure that the private medical examiner is informed they are to conduct the assessment in accordance with these guidelines, including clause 7.2, the WPI Assessment Guidelines, and the MAI Act. A report not prepared accordingly may be invalid. A second WPI report cannot be obtained before, or at the same time, as the insurer-initiated assessment.

8.3 The second WPI report should be based on the same supporting documents as the insurer-initiated assessment. If there has been an updating or additional reports that were obtained after the insurer-initiated assessment but before the private medical examiner undertakes their assessment, the updating or additional reports are to be provided to the insurer with the second WPI report.

8.4 To facilitate a second WPI report being comparable to an insurer-initiated assessment, the content of a second WPI report should contain the following (to be consistent with clauses 7.2 and 9.5):

- confirm that the assessor is a private medical examiner providing a report for the purposes of section 158 of the Motor Accident Injuries Act
- confirm the date the applicant attended for assessment
- include a history
- include findings on examination and provide confirmation of the diagnosis
- reference relevant medical reports and documents the assessor had in their possession for the assessment, including those referred to in the first WPI report (note, this may be more than one if multiple body systems are involved)
- provide opinion as to whether the applicant has suffered a permanent impairment from injuries caused or resulting from the accident
- provide details of any relevant pre-existing injuries or conditions, the status of these injuries at the time of the accident, and any aggravating events/injuries post the motor accident
- provide opinion as to whether the applicant's presentation is consistent with the medical information and the first assessor's observations
- provide a clear explanation of any calculation of whole person impairment from the injuries in the motor accident including deductions where relevant
- contain a statement that the assessor has completed training in AMA5 and their specialisation and have conducted the assessment in line with the modifications contained in the Motor Accident Injuries (WPI Assessment) Guidelines 2019.

8.5 The second WPI report is to be self-contained and only prepared for the purpose of the WPI assessment. It therefore should not include an Expert Witness Statement or cover any injuries or conditions not referred to in the first WPI report. An injured person should alert the provider to the requirements of clause 8 when arranging the report. Limited additional questions may be answered by the private medical examiner, for example details of any treatment, therapy or referrals recommended for the injured person.

9. FINAL OFFER WPI

9.1 These guidelines make provision for an insurer's responsibilities in relation to second WPI reports including matters an insurer can consider in making a *final offer WPI* under subsection 160(2) of the MAI Act and for giving reasons for a final offer WPI decision.

9.2 Section 160 of the MAI Act applies if the relevant insurer receives a second WPI report from the injured person, and the injured person has not yet made a complying common law claim. If section 160 applies, the insurer must decide the final offer WPI. The insurer's final offer must not be less than the WPI in the original report (first WPI report) if it has not been reviewed by the Independent Medical Examiner (IME) under section 159 of the MAI Act, or if reviewed, must not be less than the notice affirming or increasing the WPI for the first WPI report.

9.3 An insurer must rely on the level of whole person impairment determined by the IME or private medical examiner (the assessors) from an assessment that was carried out in accordance with the *Motor Accident Injuries (WPI Assessment) Guidelines 2019* (WPI Guidelines). An insurer is not required to independently evaluate the level of impairment in a WPI report based on medical evidence they may have in their possession.

9.4 A final WPI offer must be made on the basis of a WPI report for an assessment carried out in accordance with the WPI Guidelines. An insurer may make a final WPI offer, for a WPI between the WPI for the first WPI report and the second WPI report, provided the WPI percentage is a whole number. This could include circumstances where there was inconsistency in clinical judgments made by the two assessors in applying the evaluation methodology or inconsistent presentations by the injured person of their injuries/condition at appointments with the two assessors.

9.5 In making a final WPI offer decision an insurer may disregard a second WPI report, in whole or part, if the insurer is not satisfied that the assessment was carried out in accordance with the WPI Guidelines. An insurer may form its belief about the validity of a report based on reasons given by the IME with a written notice under section 159 of the MAI Act. An insurer may also consider whether the principles of, and administrative processes for, an assessment in Chapter 1 of the WPI Guidelines have been followed in preparing the second WPI report, including by considering matters in Paragraph 7.2 of these guidelines. An insurer may also disregard a second WPI report if the insurer is not satisfied that the second assessor considered relevant information made available to the first assessor or if the second assessment includes injuries or conditions not evaluated in the first assessment. This could be evidenced by the second WPI report:

- not referencing that the second assessor had in their possession relevant medical reports and documents which were referred to in the first WPI report; or
- including, in the final level of impairment, injuries or conditions not identified in the original WPI report as being caused or resulting from the motor accident.

An insurer must have processes in place to give an injured person seeking a second WPI report, any relevant medical reports and documents not already in the injured person's possession, which the insurer provided for the first WPI assessment.

9.6 In making a final offer WPI an insurer is to give reasons in writing as the insurer must decide a WPI to determine the final offer. The reasons need only record the relevant facts and reference evidence such as the assessment and section 159 reports relied upon by the insurer for the determination. If an insurer disregards a second WPI report, in whole or part, the insurer is to state their reasons for doing so. If a second report is disregarded in part, an insurer must not make any adjustments to the assessed degree of impairment in the second report requiring a clinical judgement including for the attribution of any injuries to the motor accident.

10. INFORMATION AND SUPPORT – WPI TAKEN TO BE 10% IN CERTAIN CIRCUMSTANCES

10.1 These guidelines make provision for information and support an insurer is obliged to give a person under paragraph 52(2)(f) of the MAI Act who is taken under section 133 of the MAI Act to have a WPI of 10 per cent. A person who was a child at the time of an accident and at four years and six months after the motor accident is either receiving treatment and care meeting the requirements of the regulation, or a participant in the LTCS scheme, will be taken to have a WPI of 10 per cent.

10.2 An insurer must identify any injured person that is taken to have a WPI of 10 per cent under section 133 of the MAI Act, and contact the person in writing (or a parent/guardian in the case of a minor), one month prior to reaching 4 years and six months from the date of the motor accident. The insurer does not need to contact a person that has received a written notice under subsection 157(2) or 164(2) of the MAI Act and has lodged a notice of claim within the time frames permitted for the notice. An insurer must include information about the person's eligibility to make a common law claim, the time frames for the person to lodge a notice of claim and that the person may wish to seek legal advice as to whether to make a claim for damages.

11. INFORMATION AND SUPPORT – WPI OFFERS

11.1 These guidelines make provision for the information and support an insurer is obliged to give a person that receives a WPI offer about making a motor accident claim for the purposes of paragraph 52(2)(g) of the MAI Act.

11.2 An insurer must include with a written notice given to an injured person under subsection 157(2) or 164(2) of the MAI Act statements about the time frame for the person to lodge a notice of claim, and the insurer is unable to provide legal advice as to whether to make a claim for damages, and may include the contact details of the ACT Law Society for referral to a legal service provider.

From: "Lejins, Erica"
Sent: 17/09/2025 3:43 PM
To: "CTP Regulatory Correspondence" <ctpregulatorycorrespondence@suncorp.com.au>; "ACT CTP Regulatory Notices" <Sch 2.2(a)(xi)>; "Harper, Mark" <Mark.Harper@act.gov.au>
Cc: <Sch 2.2(a)(ii)>; <Sch 2.2(a)(ii)>; "MAI Commission" <maic@act.gov.au>
Subject: Consultation Draft - Updated Quality of Life Benefit Guidelines
Attachments: Quality of Life Guidelines - Consultation Draft - September 2025.pdf

Dear Insurers,

Earlier this year, the MAI Commission provided for comment a short form review of four updated guidelines. Three of the guidelines were subsequently made on 10 July 2025. The fourth included with the package was the Quality of Life Benefit guidelines. The earlier draft circulated in March 2025 had foreshadowed two options for requests for psychological assessments.

The revised draft now incorporates feedback received in relation to the earlier draft. The incorporation of all feedback required a reframing of the Guidelines, which has also provided the MAI Commission with the opportunity to include updates providing clarity about steps an insurer must undertake to validate a WPI report, the handling of second WPI reports, and final WPI offers. The introduction has been expanded to include a background section to better assist members of the public who may be handling their own defined benefits application with information in one location.

If you wish to provide comments or feedback on the guidelines, we request these by close of business **Friday 10 October 2025**. Your comments can be directed to the MAI Commission inbox. If you wish to discuss the guidelines, you can contact the MAI Commission on 6207 8876.

With regards

Erica Lejins

Director

MAI Regulatory Policy and Supervision

Insurance | Economic and Financial Policy Group

Treasury | Chief Minister, Treasury and Economic Development Directorate

ACT Government | GPO Box 158 CANBERRA ACT 2601

T (02) 6205 5496 | Web www.act.gov.au

I acknowledge the Ngunnawal people as the traditional custodians of the ACT and recognise any other people or families with connection to the lands of the ACT and region. I acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

Australian Capital Territory

Motor Accident Injuries (Quality of Life Benefit) Guidelines 2025

Disallowable instrument DI2025

made under the

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

1 Name of instrument

This instrument is the *Motor Accident Injuries (Quality of Life Benefit) Guidelines 2025*.

2 Commencement

This instrument commences on the 7th day after its notification.

3 Guidelines

I make the guidelines attached to this instrument.

4 Revocations

The *Motor Accident Injuries (Quality of Life Benefit) Guidelines 2023* (DI2023-311) is revoked.

MAI Commissioner

MAI Commission

2025

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Quality of Life Benefit Guidelines

1. INTRODUCTION

The Quality of Life Benefit guidelines (guidelines) are part of the MAI guidelines made under section 487 of the *Motor Accident Injuries Act 2019* (MAI Act). The Guidelines detail the insurers' obligations in providing information and support to potential applicants for quality of life benefits, procedures for arranging Whole Person Impairment (WPI) assessments and making offers for quality of life defined benefit amounts. They also detail the process for an injured person to obtain a valid second WPI report.

Background

The quality of life (QOL) benefit is a recognition payment for a person's permanent injuries caused by the accident and may be offered following a WPI assessment carried out in accordance with the *Motor Accident Injuries (WPI Assessment) Guidelines 2019* (WPI Assessment Guidelines). An application for the benefit may be made no earlier than 26 weeks after the motor accident. The injuries sustained in the accident need to have stabilised sufficiently for an assessment. The benefit is payable for WPI assessments of 5 per cent or more, with the benefit amount set out in legislation and based on the WPI figure (a whole number). A person with a WPI assessment of 10 per cent or more from the first WPI report may choose to access common law if they were not at fault.

The first WPI assessment is made on referral by an insurer to an authorised IME provider. The IME provider appoints qualified and experienced independent medical examiners (IMEs) to carry out WPI assessments. This authorisation by the MAI Commission is to facilitate the first WPI assessment. The IME providers have a national presence and are able to select IMEs from around the country.

On referral by the insurer, the IME provider will select the independent medical examiner (IME) relevant for the permanent injuries needing to be assessed. This process is so that the IME undertaking the assessment has not been appointed by either an insurer or a legal representative. There is no process of selecting from several IMEs as it will be subject to availability.

If an injured person is unhappy with the first assessment and wants another assessment, they are able to select and pay for their own private medical examiner (PME) to conduct a second WPI report. There is no requirement to approach the authorised IME provider for a PME. It is important, though, that the PME is qualified and experienced in carrying out ACT WPI assessments. The second report is to meet the same conditions as the first so that it can be relied upon to make the offer for the QOL benefit or to lodge a notice of claim.

2. STATUTORY FRAMEWORK

Division 2.6.2 of the MAI Act makes provision for an injured person to make a quality of life benefits application. A precondition for the application is that the injured person has received a receipt notice or late receipt notice under section 60 of the MAI Act. An injured person cannot make a quality of life benefit application earlier than 26 weeks after a motor accident and not later than 4 years and six months after an accident.

The legislative framework for quality of life benefits includes:

- a. the MAI Act;
- b. the Motor Accident Injuries Regulation 2019 (the Regulation); and
- c. these Guidelines made under the MAI Act.

Also, the WPI Assessment Guidelines apply to any WPI assessment undertaken for the purposes of the MAI Act.

3. INFORMATION AND SUPPORT FOR APPLICANTS FOR QUALITY OF LIFE BENEFITS

3.1 These guidelines make provision for the information and support an insurer is to give a person about making an application for quality of life benefits for the purposes of paragraph 52(2)(e) of the MAI Act. The information pack is intended to assist an injured person in making an informed decision about requesting a WPI assessment.

3.2 The information pack is required to be provided about:

- the eligibility requirements for a quality of life defined benefit or to make a motor accident claim;
- how to apply for a quality of life benefit, and the time frame for making an application;
- the need for a person's injuries to be stable for a permanent impairment to be assessed;
- conditions for requesting a WPI assessment for primary/secondary psychological injuries;
- requirements for requesting a WPI assessment for a primary psychological injury, including the definition of a primary psychological injury, the requirement to have undergone mental health treatment and to provide a notice under subsection 150(3) of the MAI Act and paragraphs 4.2 and 4.3 of these guidelines;
- the definition of a secondary psychological injury and requirements for a secondary psychological injury to be taken into account as part of a physical assessment;
- how an insurer will arrange for an assessment with the independent medical examiner provider, expected waiting times for an assessment and the person's obligations if they request an assessment;
- how a WPI assessment is carried out and where a person can access the MAI guidelines about permanent impairment assessments; and

- arrangements for paying for a WPI assessment, including the circumstances a person will be required to pay an excess for an assessment and the circumstances in which an excess can be returned.

3.3 An insurer must provide an information pack about quality of life payments to an applicant for defined benefits (other than persons mentioned in paragraph 3.6) prior to the injured person first becoming eligible to make a quality of life application. The pack is to be provided no earlier than 24 weeks after the date of an accident. Where the period of 26 weeks after the date of the accident has passed, for example a late application is made and accepted, the insurer should provide the information pack after the insurer has accepted liability for the application. An insurer may provide general information about the benefit, noting the need for treatment to have occurred and stability of injuries that are of a permanent nature.

3.4 To assist an injured person who may request an assessment for a primary psychological injury the insurer may include a template for a notice under subsection 150(3) of the MAI Act when providing the information pack.

3.5 An insurer must consider their duty to act in good faith when determining the timing of the issue of an information pack. This includes the insurer's duty in paragraph 20(4)(a) of the MAI Act to disclose, as soon as practicable, all information that an applicant may need to understand the process for applying for defined benefits.

3.6 The information pack must also be provided on request by any other person who has made a defined benefits application. Information packs may be sent electronically or by post.

3.7 An insurer does not need to provide an information pack at 24 weeks when a person:

- was charged with a serious driving offence or one or more driving offences;
- is a foreign national and has permanently departed Australia;
- or if -**
- the insurer has denied liability for the person's defined benefits application;
- the person returned to work at full capacity or their usual activities within 28 days after the motor accident;
- the insurer reasonably believes that the person's physical or any psychological injuries are not stable; or
- the insurer reasonably believes that the person's injuries are stable but they are not likely to have a permanent impairment from injuries as a result of the motor accident.

4. QUALITY OF LIFE BENEFITS APPLICATION

4.1 For the purposes of paragraph 137(3)(b) of the MAI Act a quality of life benefits application must include the following details:

- name of the injured person;

- the individual claim identifier provided by the insurer;
- the types of injuries for which an assessment is being sought being physical and/or primary psychological in the applicant's own words;
- an acknowledgement they have received sufficient treatment to inform the insurer of the stability of their injuries;
- details of the person's availability on weekdays for an assessment in the next three months and an acknowledgement an assessment may not occur in that time;
- details of any special needs of the person in attending an assessment – such as accessibility, cultural or language needs;
- whether the person requires an accompanying person to be present at the assessment together with the name, relationship and role of this person; and
- information about any offence the person has been charged with, or convicted or found guilty of, in relation to the accident.

4.2 For the purposes of paragraph 137(3)(c) of the MAI Act, a quality of life benefit application for a person requesting a primary psychological assessment must be accompanied by a written notice in accordance with clause 4.3 from a psychiatrist, or clinical psychologist in accordance with subsection 150(3) of the MAI Act and these guidelines. A psychiatrist is a medical practitioner with specialist registration with the Australian Medical Board in the field of psychiatry. Similarly, a clinical psychologist is a registered psychologist that has been endorsed by the Psychological Board of Australia to practise as a clinical psychologist. Registration is required with the Australian Health Practitioners Registration Authority.

4.3 The notice from the psychiatrist or clinical psychologist must include:

- a diagnosis of the primary psychological injury resulting from the accident based on a recognised diagnostic system and specify the diagnostic criteria upon which the diagnosis is based;
- a list of the type and frequency of treatment, providing comment on the effectiveness of any treatment the person has received for the primary psychological injury resulting from the accident;
- an opinion from the psychiatrist or clinical psychologist as to whether they consider the injury is well stabilised and unlikely to change substantially, with or without mental health treatment intervention, in the next year; and
- a statement from the psychiatrist or clinical psychologist that they reasonably believe the person is likely to have a permanent psychological injury resulting from the accident.

4.4 The following information may also accompany a quality of life benefits application but is not a mandatory requirement to complete the application:

- any medical reports about the status of the person's injuries that have not been provided directly to an insurer by a treating health practitioner of the injured person. This could include any reports about whether a person's injuries are stable or whether a person is likely to have a permanent impairment.

If under section 6.1 of these guidelines, the insurer has inconclusive information about the status of a person's injuries, the above information may also be subsequently requested by an insurer.

4.5 A quality of life benefits application may be made using a prescribed form made available on the MAI Commission's website or provided by an insurer. The application is to be made in writing and may be given to the insurer by electronic means, by personal delivery or by post.

5. APPLICATION FOR A WPI ASSESSMENT FOR A PERSON THAT HAS MADE A SUCCESSFUL WORKERS COMPENSATION CLAIM

5.1 Under Part 5.3 of the MAI Act, a person may apply to an insurer for the motor accident claim for an assessment of their WPI if:

- they have made a successful application for workers compensation benefits; and
- they have given a notice of claim under the *Civil Law (Wrongs) Act 2002*.

5.2 The application should include information about the WPI assessments the injured person is seeking. The application should also be accompanied by an authority to disclose personal health information that covers the exchange of personal health information between:

- the motor accident insurer;
- the injured person's stated workers compensation insurer (if applicable);
- treating health service providers or a treating team;
- an authorised IME provider; and
- an independent medical examiner who conducts a WPI assessment.

5.3 For the purposes of subsection 241(2) of the MAI Act, an insurer must give an acknowledgement notice to the injured person within 5 business days of receiving the application for a WPI assessment.

5.4 Note, under section 240 of the MAI Act, an application for an assessment is not required if the person has had an assessment conducted by a private medical examiner in accordance with the WPI assessment guidelines. The insurer may consider whether the assessment complies with the WPI Assessment Guidelines (including the ACT modifications to AMA5). The report should include a clear assessment of the percentage of WPI, the rationale and reference all medical information used.

6. PROCEDURE FOR ARRANGING A WPI ASSESSMENT

This section, and those in section 7, make provision for the procedures for arranging a WPI assessment under section 147 of the MAI Act.

6.1 Status of a person's injuries

6.1.1 An insurer has 20 business days to consider a quality of life benefits application, to allow for gathering up information and to assess the injuries of the injured person. This period will not commence for a quality of life benefit application that includes a request for a primary psychological assessment until the insurer is satisfied that the requirements of subsection 150(3) of the MAI Act are satisfied.

6.1.2 When assessing the injuries, the insurer may rely on the medical information available to them or seek an independent opinion on whether the injured person's injuries have stabilised. If an insurer seeks an independent opinion (including an examination) they should ensure the injured person is aware:

- it is a medical assessment for only this purpose (e.g. an assessment of their injuries' stabilisation); and
- it is not the WPI assessment arranged by the authorised IME provider.

6.1.3 An insurer must refer an injured person to an authorised IME provider for a WPI assessment if an insurer "reasonably believes":

- the person's injuries have stabilised; and
- the person is likely to have a permanent impairment as a result of the injuries.

6.1.4 An insurer must refer an injured person to an authorised IME provider for a WPI assessment if:

- the insurer "reasonably believes":
 - a person's injuries are stabilised;
 - the person is not likely to have a permanent impairment as a result of the injuries; and
- the injured person pays an excess amount for the assessment to the insurer.

An insurer is to give a written notice consistent with subsection 139(2) of the MAI Act.

6.1.5 An insurer must recommend to an injured person that the WPI assessment be delayed if:

- an insurer "reasonably believes" a person's injuries have not stabilised; and
- it is less than 4 years and 6 months after the date of the motor accident.

An insurer is to give a written notice consistent with subsection 140(2) of the MAI Act. An injured person may still request that an insurer makes an immediate referral for a WPI

assessment, but if the assessment confirms the person's injuries are not stable an insurer is not obliged to pay for a second assessment.

6.1.6 For the purposes of these guidelines, to assess stability an insurer may consider the treatment the injured person has, whether there has been a substantial change in the requested treatment (for example, fewer sessions occurring) and how their condition has settled. The insurer may also consider whether further medical treatment would have a substantive effect on their condition at the time of the application.

6.1.7 An insurer's reasonable belief about the stability of a person's injuries, and the likelihood of a permanent impairment should be based on information the insurer has in their possession about the person's injuries, treatment and recovery following receipt of the application. If this information is inconclusive the insurer should make reasonable inquiries with the person's treating health practitioners. If, after this step, information is still not conclusive, the insurer is to inform the injured person it may be necessary to obtain an independent medical review to establish stability of their physical injuries.

6.1.8 An insurer may consider the clinical evidence but must rely on a notice given by a psychiatrist or clinical psychologist under subsection 150(3) of the MAI Act to form a reasonable belief about the stability of a person's injuries and whether the person is likely to have a permanent primary psychological impairment. The notice is to reference the treatment the injured person has received (which may be from one or more practitioners for the mental health treatment required for the injured person's injury). It is a requirement that the person has received mental health treatment under section 150(3) before an injured person may request a WPI assessment. Generally, a course of treatment would include several sessions over a period of time that is appropriate for the diagnosis. This may be guided by the Recovery Plan put in place by agreement between the injured person, the treating professional, and the MAI insurer.

6.1.9 If an injured person has requested both a physical and a primary psychological assessment, an insurer will not be required to make a referral to an authorised IME provider until requirements in Division 2.6.2 of the MAI Act for making a referral are satisfied for both kinds of injuries or the injured person otherwise makes an informed decision to proceed with a separate referral for one kind of injury only. If a separate referral is made for one kind of injury, then the time frames for making the WPI report available and any quality of life benefit offer under sections 154 to 157 of the MAI Act are to apply as if there is only one WPI report. The injured person should be made aware that if they proceed with the assessment, then any quality of life benefit offer from the assessment will not take into account the other kind of injury, and depending on the outcome of the assessment may also result in the early finalisation of their quality of life benefit application.

6.1.10 If the person has physical injuries to multiple body systems an insurer should also reasonably believe that injuries to all physical body systems and any secondary psychological injuries have stabilised before making a WPI assessment referral.

6.1.11 An insurer must separately assess all physical injuries for a given body system to determine whether any of these injuries are likely to result in a permanent impairment. An insurer must not include physical injuries in a referral without first undertaking this assessment and the injured person must not be required to undergo unnecessary WPI assessment appointments.

6.1.10 If an injured person requests a physical injury be included in a referral, and the insurer reasonably believes the injured person is unlikely to have any permanent injuries for the given body system, then consistent with section 139 of the MAI Act an excess must be requested and paid before the referral is made. That is, if the injured person has physical injuries to multiple body systems, then a section 139(2) assessment is to be applied for each body system, rather than for the WPI assessment as a whole. However, only one excess under section 139(5) is payable. The excess is to be refunded if permanent injuries are subsequently identified.

6.2 The time within which a WPI assessment must be arranged

6.2.1 When an insurer is required to refer an injured person to an authorised IME provider for a WPI assessment they must:

- provide the injured person with a written notification in accordance with section 6.2.2; and
- send a written referral for the injured person to an authorised IME provider for a WPI assessment in accordance with section 6.2.3.

6.2.2 The insurer must provide the injured person with written notification of:

- the injuries and body systems which will be covered by the assessment;
- the person's medical history to be set out in the referral; and
- a list of the medical and health information in their possession which they will be providing to the authorised IME provider for the assessment.

The insurer may give the injured person a completed draft of the IME provider's referral form (without the file attachments that will be given to the IME provider) for these purposes.

This written notice must occur no later than 5 business days after the injured person:

- is eligible for an assessment under section 138 of the MAI Act; or
- confirms and pays an excess for a WPI assessment under subsection 139(3) of the MAI Act; or
- the person requests a WPI assessment under subsection 140(3) of the MAI Act; or
- the person notifies the insurer that their injuries have stabilised in accordance with subparagraph 141(5)(c)(ii) of the MAI Act.

The purpose of notification is for the injured person to be informed of the scope of the assessment and also provide an opportunity for the injured person to provide the

insurer/IME provider with any additional information they may have in their possession which may be relevant to the assessment.

6.2.3 An insurer must then send a written referral for the injured person to an authorised IME provider for a WPI assessment, for all injuries for which a person is likely to have a permanent impairment. This written referral must occur no later than 10 business days after the injured person:

- is eligible for an assessment under section 138 of the MAI Act; or
- confirms and pays an excess for a WPI assessment under subsection 139(3) of the MAI Act; or
- the person requests a WPI assessment under subsection 140(3) of the MAI Act; or
- the person notifies the insurer that their injuries have stabilised in accordance with subparagraph 141(5)(c)(ii) of the MAI Act.

If the injured person indicates additional information is to be provided, the insurer may defer making the written referral. After receipt of the information, the insurer has an additional 5 business days before making the referral. This is to allow the insurer time to consider the relevance of the additional information to the referral and make any necessary inquiries.

6.2.4 An injured person's application for quality of life benefits is suspended for the period a person has outstanding charges in relation to the motor accident for one or more driving offences, or a serious driving offence. A referral to an IME provider should not be made during the suspension period, and the insurer should inform the applicant about the suspension of the application, and circumstances that the application may be revived, in writing.

6.3 Insurer selecting an IME provider if more than one authorised IME provider

6.3.1 If the MAI Commission has authorised more than one IME provider to arrange WPI assessments, an insurer must put procedures in place to ensure that all authorised IME providers are allocated referrals from an insurer on an equal and sequential basis. For example, if there are two authorised IME providers an insurer should alternate referrals for any given injured person, between the two providers, based on the time and date of a referral. The only exception to this rule should be if:

- the allocated provider is unable to provide an assessment for all body systems for the injured person due to specialist availability;
- an injured person has previously received a physical or primary psychological assessment from the other or another authorised IME provider; or
- the other or another authorised IME provider operates in an interstate or overseas location closer to where the injured person resides or works and is able to arrange the assessment.

An insurer must keep a register of all referrals to authorised IME providers.

6.4 Arranging appointments with an independent medical examiner by the authorised IME provider

6.4.1 An insurer must prepare a written referral to the authorised IME provider. The referral is to be made using a form made available by the MAI Commission. The referral is to detail the injuries and body systems to be covered by the WPI assessment report and whether the insurer has received either a notice or information for a diagnosis of a psychological or psychiatric disorder.

6.4.2 The referral must indicate when a person is likely to be available for medical examinations and include details of any special needs, such as an interpreter services, that need to be accommodated for at an appointment.

6.4.3 The IME provider is responsible for arranging one or more independent medical examiners to carry out a WPI assessment of the injured person.

6.4.4 An insurer must also give the authorised IME provider all medical and allied health information, including results of clinical investigations in their possession relevant to the assessment, at least 10 calendar days before an appointment with an examiner. Information should include information about the onset of injury, subsequent treatment, diagnostic imaging and tests, and functional assessments of the person claiming the impairment. All documents should be appropriately indexed and organised in a manner to minimise file review times by the examiner.

6.4.5 If the injured person has requested that an accompanying person be present at the assessment the referral should include the name, relationship to the injured person, and role of this person.

6.4.6 The insurer may arrange for the authorised IME provider to communicate directly with the injured person about appointment bookings. In doing so, the authorised IME provider must inform the insurer of all appointment arrangements including any cancellation, non-attendance or rescheduling of appointments by either the applicant or the authorised IME provider.

6.4.7 An injured person must be given at least 10 business days written notice of any appointment with an independent medical examiner. The insurer is responsible for ensuring the appointment notice is given to the injured person and may make arrangements for the notice to be sent out by the IME provider on their behalf. The notice period may only be reduced or waived on agreement from the injured person and provided the insurer has already given the IME provider all information necessary to undertake an assessment. If a person has complex injuries a single notice may cover multiple appointments. The notice must include the following information about a given appointment:

- the name, specialty, and qualifications of the independent medical examiner;
- the injuries and body system/s covered by the referral noting the appointment is for the purposes of assessing impairment and not for medical treatment;

- the date, time, and location of the appointment, contact details for the examiner's offices and appropriate travel directions or arrangements;
- the likely duration of the appointment;
- how to cancel the appointment;
- the consequences of a late cancellation or a non-attendance for an appointment;
- Information the injured person should bring to the appointment (such as X-rays not in electronic form) or give to the examiner prior to the appointment;
- arrangements for an accompanying person to be present during an appointment, noting that the person is not to participate in the assessment, other than to assist the examiner in communicating with the person, and any accompanying person may be asked to leave the assessment room if requested by an examiner. Where the injured person is a child or a person with an intellectual disability, the examiner may request the support person remain in the room but not communicate with the injured person if there is a concern they are interfering with the assessment;
- arrangements for paying travel expenses; and
- how complaints can be made and how they will be handled.

A notice of an appointment may be sent to an injured person by post or electronically.

6.5 Payment for WPI assessment

6.5.1 An insurer will be responsible for directly paying an IME provider for a WPI assessment report and related costs requested on referral by an insurer. The IME provider will invoice in accordance with the fee schedule agreed by the MAI Commission. An IME provider must be paid within 10 business days of the insurer receiving a properly completed WPI report and invoice.

6.5.2 An insurer is not required to arrange for a referral for an assessment, or make an appointment with an IME provider, if the insurer has not received a payment or contribution for the cost of an assessment from an injured person in the following listed circumstances:

- the insurer believes a person's injuries are stable and the person is not likely to have a permanent impairment (Section 139 of the MAI Act);
- a second assessment is required for a person, because an assessment requested by the person under subsection 140(3) of the MAI Act confirmed the person's injuries had not stabilised; or
- a second assessment is required under subparagraph 141(5)(c)(ii) of the MAI Act because a person who has received an estimated WPI has applied to stay common law proceedings until their injuries have stabilised.

6.5.3 If an excess is paid by a person in accordance with subsection 139(5) of the MAI Act and the WPI assessment report confirms the person's WPI is greater than 0%, the insurer must reimburse the excess to the person within 10 business days of receiving the WPI assessment report.

6.5.4 If the IME provider is required to arrange a further appointment because a person did not attend an earlier appointment and did not give the insurer a reasonable excuse for their non-attendance, the person must pay any cancellation fee charged by the IME provider as a result of the missed appointment.

6.5.5 An insurer must also pay the reasonable and necessary travel expenses for a person to attend a WPI assessment on referral from an insurer, with the exception of a referral for a second assessment required because an assessment requested by the person under subsection 140(3) of the MAI Act confirmed the person's injuries had not stabilised.

6.5.6 If an injured person arranges for a private medical examiner to carry out a second WPI assessment the person will be responsible for paying for the WPI assessment report and for any travel expenses incurred in attending the WPI assessment.

7. VALIDATING A WPI ASSESSMENT REPORT

7.1 Before giving an injured person a copy of a WPI report and any offer of quality of life benefits under sections 154 to 157 of the MAI Act an insurer must first be satisfied that the WPI report reflects an assessment carried out in accordance with the WPI Assessment Guidelines. An insurer must have its own quality assurance process in place to confirm the validity of WPI reports, noting quality assurance is also undertaken by the authorised IME provider.

7.2 A WPI report may not be valid if it does not:

- address whether an injury or condition has reached maximum medical improvement as required by clause 1.15 of the WPI Assessment Guidelines;
- provide a history and findings from the examination;
- provide opinion as to whether the applicant has suffered a permanent impairment from injuries caused by or resulting from the accident;
- provide details and make a deduction from the final level of impairment for any known pre-existing injuries or conditions, or for other assessed injuries not caused by the motor accident;
- exclude any secondary psychological injury from an assessment of primary psychological injuries;
- determine the degree of impairment using the tables, graphs, and the methodology in the WPI Assessment Guidelines and the American Medical Association Edition 5 (referred to as AMA 5) where applicable, and provide a clear calculation of the percentage as a whole number;
- include a statement and certification from the assessor to the effect that:
 - the assessor has completed training in AMA 5 and their specialisation
 - evaluated the person's permanent injuries as a result of a motor accident and

that the WPI assessment has been conducted in accordance with the *Motor Accident Injuries (WPI Assessment) Guidelines 2019*.

7.3 An insurer may seek corrections or compliance clarifications on receipt of a WPI assessment report through requesting a superseding report from the authorised IME provider. In this circumstance, the time frame for giving a notice under sections 154 to 157 of the MAI Act will not commence until the insurer receives a superseding report from the authorised IME provider. The body of the superseding report must include a statement that explains that it supersedes the previous WPI report. The superseding report process is not to be used by an insurer to seek/ask additional questions that were not present in the initial referral, to provide any additional information not made available to the assessor at the time of the assessment, or to question/change any clinical judgments made by the assessor in preparing the WPI report.

8. REQUIREMENTS FOR SECOND WPI REPORTS

8.1 These guidelines make provision for an injured person's responsibilities in relation to obtaining a second WPI report and providing a valid report. Under the MAI Act, a private medical examiner, trained in the WPI Assessment Guidelines, undertakes this assessment.

8.2 An injured person does not have to obtain a second WPI report. The injured person is to notify the insurer that they will be seeking their own WPI report because they disagree with the first WPI report. This has the effect of pausing the benefit.

8.3 The second WPI report must be provided to the insurer within 26 weeks after the date of the notice given under sections 154 to 156. If a notice is given under section 157, a longer due date for providing the second WPI report may apply. The costs of a second WPI report are for the injured person to pay. Note, if the outcome of the assessment is for a higher WPI percentage because the first WPI report is less than 10 per cent, the insurer may reimburse the cost of the report if there is a motor accident claim.

8.3 To obtain a valid second WPI report, the injured person must ensure that the private medical examiner is informed they are to conduct the assessment in accordance with these guidelines, including clause 7.2, the WPI Assessment Guidelines, and the MAI Act. A report not prepared accordingly may be invalid. A second WPI report cannot be obtained before, or at the same time, as the insurer-initiated assessment.

8.3 The second WPI report should be based on the same supporting documents as the insurer-initiated assessment. If there has been an updating or additional reports that were obtained after the insurer-initiated assessment but before the private medical examiner undertakes their assessment, the updating or additional reports are to be provided to the insurer with the second WPI report.

8.4 To facilitate a second WPI report being comparable to an insurer-initiated assessment, the content of a second WPI report should contain the following (to be consistent with clauses 7.2 and 9.5):

- confirm that the assessor is a private medical examiner providing a report for the purposes of section 158 of the Motor Accident Injuries Act
- confirm the date the applicant attended for assessment
- include a history
- include findings on examination and provide confirmation of the diagnosis
- reference relevant medical reports and documents the assessor had in their possession for the assessment, including those referred to in the first WPI report (note, this may be more than one if multiple body systems are involved)
- provide opinion as to whether the applicant has suffered a permanent impairment from injuries caused or resulting from the accident
- provide details of any relevant pre-existing injuries or conditions, the status of these injuries at the time of the accident, and any aggravating events/injuries post the motor accident
- provide opinion as to whether the applicant's presentation is consistent with the medical information and the first assessor's observations
- provide a clear explanation of any calculation of whole person impairment from the injuries in the motor accident including deductions where relevant
- contain a statement that the assessor has completed training in AMA5 and their specialisation and have conducted the assessment in line with the modifications contained in the Motor Accident Injuries (WPI Assessment) Guidelines 2019.

8.5 The second WPI report is to be self-contained and only prepared for the purpose of the WPI assessment. It therefore should not include an Expert Witness Statement or cover any injuries or conditions not referred to in the first WPI report. An injured person should alert the provider to the requirements of clause 8 when arranging the report. Limited additional questions may be answered by the private medical examiner, for example details of any treatment, therapy or referrals recommended for the injured person.

9. FINAL OFFER WPI

9.1 These guidelines make provision for an insurer's responsibilities in relation to second WPI reports including matters an insurer can consider in making a *final offer WPI* under subsection 160(2) of the MAI Act and for giving reasons for a final offer WPI decision.

9.2 Section 160 of the MAI Act applies if the relevant insurer receives a second WPI report from the injured person, and the injured person has not yet made a complying common law claim. If section 160 applies, the insurer must decide the final offer WPI. The insurer's final offer must not be less than the WPI in the original report (first WPI report) if it has not been reviewed by the Independent Medical Examiner (IME) under section 159 of the MAI Act, or if reviewed, must not be less than the notice affirming or increasing the WPI for the first WPI report.

9.3 An insurer must rely on the level of whole person impairment determined by the IME or private medical examiner (the assessors) from an assessment that was carried out in accordance with the *Motor Accident Injuries (WPI Assessment) Guidelines 2019* (WPI Guidelines). An insurer is not required to independently evaluate the level of impairment in a WPI report based on medical evidence they may have in their possession.

9.4 A final WPI offer must be made on the basis of a WPI report for an assessment carried out in accordance with the WPI Guidelines. An insurer may make a final WPI offer, for a WPI between the WPI for the first WPI report and the second WPI report, provided the WPI percentage is a whole number. This could include circumstances where there was inconsistency in clinical judgments made by the two assessors in applying the evaluation methodology or inconsistent presentations by the injured person of their injuries/condition at appointments with the two assessors.

9.5 In making a final WPI offer decision an insurer may disregard a second WPI report, in whole or part, if the insurer is not satisfied that the assessment was carried out in accordance with the WPI Guidelines. An insurer may form its belief about the validity of a report based on reasons given by the IME with a written notice under section 159 of the MAI Act. An insurer may also consider whether the principles of, and administrative processes for, an assessment in Chapter 1 of the WPI Guidelines have been followed in preparing the second WPI report, including by considering matters in Paragraph 7.2 of these guidelines. An insurer may also disregard a second WPI report if the insurer is not satisfied that the second assessor considered relevant information made available to the first assessor or if the second assessment includes injuries or conditions not evaluated in the first assessment. This could be evidenced by the second WPI report:

- not referencing that the second assessor had in their possession relevant medical reports and documents which were referred to in the first WPI report; or
- including, in the final level of impairment, injuries or conditions not identified in the original WPI report as being caused or resulting from the motor accident.

An insurer must have processes in place to give an injured person seeking a second WPI report, any relevant medical reports and documents not already in the injured person's possession, which the insurer provided for the first WPI assessment.

9.6 In making a final offer WPI an insurer is to give reasons in writing as the insurer must decide a WPI to determine the final offer. The reasons need only record the relevant facts and reference evidence such as the assessment and section 159 reports relied upon by the insurer for the determination. If an insurer disregards a second WPI report, in whole or part, the insurer is to state their reasons for doing so. If a second report is disregarded in part, an insurer must not make any adjustments to the assessed degree of impairment in the second report requiring a clinical judgement including for the attribution of any injuries to the motor accident.

10. INFORMATION AND SUPPORT – WPI TAKEN TO BE 10% IN CERTAIN CIRCUMSTANCES

10.1 These guidelines make provision for information and support an insurer is obliged to give a person under paragraph 52(2)(f) of the MAI Act who is taken under section 133 of the MAI Act to have a WPI of 10 per cent. A person who was a child at the time of an accident and at four years and six months after the motor accident is either receiving treatment and care meeting the requirements of the regulation, or a participant in the LTCS scheme, will be taken to have a WPI of 10 per cent.

10.2 An insurer must identify any injured person that is taken to have a WPI of 10 per cent under section 133 of the MAI Act, and contact the person in writing (or a parent/guardian in the case of a minor), one month prior to reaching 4 years and six months from the date of the motor accident. The insurer does not need to contact a person that has received a written notice under subsection 157(2) or 164(2) of the MAI Act and has lodged a notice of claim within the time frames permitted for the notice. An insurer must include information about the person's eligibility to make a common law claim, the time frames for the person to lodge a notice of claim and that the person may wish to seek legal advice as to whether to make a claim for damages.

11. INFORMATION AND SUPPORT – WPI OFFERS

11.1 These guidelines make provision for the information and support an insurer is obliged to give a person that receives a WPI offer about making a motor accident claim for the purposes of paragraph 52(2)(g) of the MAI Act.

11.2 An insurer must include with a written notice given to an injured person under subsection 157(2) or 164(2) of the MAI Act statements about the time frame for the person to lodge a notice of claim, and the insurer is unable to provide legal advice as to whether to make a claim for damages, and may include the contact details of the ACT Law Society for referral to a legal service provider.

From: "Lejins, Erica"
Sent: 18/09/2025 4:13 PM
To: Sch 2.2(a)(ii)
Subject: FW: Consultation Draft- Motor Accident Injuries (Quality of Life Benefit) Guidelines
Attachments: Quality of Life Guidelines - Consultation Draft - September 2025.pdf

Dear Sch 2.2(a)(ii),

Please see the attached request for consultation feedback below. My apologies it was sent to an incorrect email address.

Erica

From: Lejins, Erica
Sent: Wednesday, 17 September 2025 3:59 PM
To: 'ceo@actbar.com.au' <ceo@actbar.com.au>; 'Committee' <committee@actlawsociety.asn.au>
Cc: Sch 2.2(a)(ii); MAI Commission <maic@act.gov.au>
Subject: Consultation Draft- Motor Accident Injuries (Quality of Life Benefit) Guidelines

Dear Stakeholders,

Earlier this year, the MAI Commission provided for comment a short form review of four updated guidelines. Three of the guidelines were subsequently made on 10 July 2025. The fourth included with the package was the Quality of Life Benefit guidelines. The earlier draft circulated in March 2025 had foreshadowed two options for requests for psychological assessments.

The revised draft now incorporates feedback received in relation to the earlier draft. The incorporation of all feedback required a reframing of the Guidelines, which has also provided the MAI Commission with the opportunity to include updates providing clarity about steps an insurer must undertake to validate a WPI report, the handling of second WPI reports, and final WPI offers. The introduction has been expanded to include a background section to better assist members of the public who may be handling their own defined benefits application with information in one location.

If you wish to provide comments or feedback on the guidelines, we request these by close of business **Friday 10 October 2025**. Your comments can be directed to the MAI Commission inbox. If you wish to discuss the guidelines, you can contact the MAI Commission on 6207 8876.

With regards

Erica Lejins

Director

MAI Regulatory Policy and Supervision

Insurance | Economic and Financial Policy Group

Treasury | Chief Minister, Treasury and Economic Development Directorate

ACT Government | GPO Box 158 CANBERRA ACT 2601

T (02) 6205 5496 | Web www.act.gov.au

I acknowledge the Ngunnawal people as the traditional custodians of the ACT and recognise any other people or families with connection to the lands of the ACT and region. I acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

Australian Capital Territory

Motor Accident Injuries (Quality of Life Benefit) Guidelines 2025

Disallowable instrument DI2025

made under the

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

1 Name of instrument

This instrument is the *Motor Accident Injuries (Quality of Life Benefit) Guidelines 2025*.

2 Commencement

This instrument commences on the 7th day after its notification.

3 Guidelines

I make the guidelines attached to this instrument.

4 Revocations

The *Motor Accident Injuries (Quality of Life Benefit) Guidelines 2023* (DI2023-311) is revoked.

MAI Commissioner

MAI Commission

2025

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Quality of Life Benefit Guidelines

1. INTRODUCTION

The Quality of Life Benefit guidelines (guidelines) are part of the MAI guidelines made under section 487 of the *Motor Accident Injuries Act 2019* (MAI Act). The Guidelines detail the insurers' obligations in providing information and support to potential applicants for quality of life benefits, procedures for arranging Whole Person Impairment (WPI) assessments and making offers for quality of life defined benefit amounts. They also detail the process for an injured person to obtain a valid second WPI report.

Background

The quality of life (QOL) benefit is a recognition payment for a person's permanent injuries caused by the accident and may be offered following a WPI assessment carried out in accordance with the *Motor Accident Injuries (WPI Assessment) Guidelines 2019* (WPI Assessment Guidelines). An application for the benefit may be made no earlier than 26 weeks after the motor accident. The injuries sustained in the accident need to have stabilised sufficiently for an assessment. The benefit is payable for WPI assessments of 5 per cent or more, with the benefit amount set out in legislation and based on the WPI figure (a whole number). A person with a WPI assessment of 10 per cent or more from the first WPI report may choose to access common law if they were not at fault.

The first WPI assessment is made on referral by an insurer to an authorised IME provider. The IME provider appoints qualified and experienced independent medical examiners (IMEs) to carry out WPI assessments. This authorisation by the MAI Commission is to facilitate the first WPI assessment. The IME providers have a national presence and are able to select IMEs from around the country.

On referral by the insurer, the IME provider will select the independent medical examiner (IME) relevant for the permanent injuries needing to be assessed. This process is so that the IME undertaking the assessment has not been appointed by either an insurer or a legal representative. There is no process of selecting from several IMEs as it will be subject to availability.

If an injured person is unhappy with the first assessment and wants another assessment, they are able to select and pay for their own private medical examiner (PME) to conduct a second WPI report. There is no requirement to approach the authorised IME provider for a PME. It is important, though, that the PME is qualified and experienced in carrying out ACT WPI assessments. The second report is to meet the same conditions as the first so that it can be relied upon to make the offer for the QOL benefit or to lodge a notice of claim.

2. STATUTORY FRAMEWORK

Division 2.6.2 of the MAI Act makes provision for an injured person to make a quality of life benefits application. A precondition for the application is that the injured person has received a receipt notice or late receipt notice under section 60 of the MAI Act. An injured person cannot make a quality of life benefit application earlier than 26 weeks after a motor accident and not later than 4 years and six months after an accident.

The legislative framework for quality of life benefits includes:

- a. the MAI Act;
- b. the Motor Accident Injuries Regulation 2019 (the Regulation); and
- c. these Guidelines made under the MAI Act.

Also, the WPI Assessment Guidelines apply to any WPI assessment undertaken for the purposes of the MAI Act.

3. INFORMATION AND SUPPORT FOR APPLICANTS FOR QUALITY OF LIFE BENEFITS

3.1 These guidelines make provision for the information and support an insurer is to give a person about making an application for quality of life benefits for the purposes of paragraph 52(2)(e) of the MAI Act. The information pack is intended to assist an injured person in making an informed decision about requesting a WPI assessment.

3.2 The information pack is required to be provided about:

- the eligibility requirements for a quality of life defined benefit or to make a motor accident claim;
- how to apply for a quality of life benefit, and the time frame for making an application;
- the need for a person's injuries to be stable for a permanent impairment to be assessed;
- conditions for requesting a WPI assessment for primary/secondary psychological injuries;
- requirements for requesting a WPI assessment for a primary psychological injury, including the definition of a primary psychological injury, the requirement to have undergone mental health treatment and to provide a notice under subsection 150(3) of the MAI Act and paragraphs 4.2 and 4.3 of these guidelines;
- the definition of a secondary psychological injury and requirements for a secondary psychological injury to be taken into account as part of a physical assessment;
- how an insurer will arrange for an assessment with the independent medical examiner provider, expected waiting times for an assessment and the person's obligations if they request an assessment;
- how a WPI assessment is carried out and where a person can access the MAI guidelines about permanent impairment assessments; and

- arrangements for paying for a WPI assessment, including the circumstances a person will be required to pay an excess for an assessment and the circumstances in which an excess can be returned.

3.3 An insurer must provide an information pack about quality of life payments to an applicant for defined benefits (other than persons mentioned in paragraph 3.6) prior to the injured person first becoming eligible to make a quality of life application. The pack is to be provided no earlier than 24 weeks after the date of an accident. Where the period of 26 weeks after the date of the accident has passed, for example a late application is made and accepted, the insurer should provide the information pack after the insurer has accepted liability for the application. An insurer may provide general information about the benefit, noting the need for treatment to have occurred and stability of injuries that are of a permanent nature.

3.4 To assist an injured person who may request an assessment for a primary psychological injury the insurer may include a template for a notice under subsection 150(3) of the MAI Act when providing the information pack.

3.5 An insurer must consider their duty to act in good faith when determining the timing of the issue of an information pack. This includes the insurer's duty in paragraph 20(4)(a) of the MAI Act to disclose, as soon as practicable, all information that an applicant may need to understand the process for applying for defined benefits.

3.6 The information pack must also be provided on request by any other person who has made a defined benefits application. Information packs may be sent electronically or by post.

3.7 An insurer does not need to provide an information pack at 24 weeks when a person:

- was charged with a serious driving offence or one or more driving offences;
- is a foreign national and has permanently departed Australia;
- or if -**
- the insurer has denied liability for the person's defined benefits application;
- the person returned to work at full capacity or their usual activities within 28 days after the motor accident;
- the insurer reasonably believes that the person's physical or any psychological injuries are not stable; or
- the insurer reasonably believes that the person's injuries are stable but they are not likely to have a permanent impairment from injuries as a result of the motor accident.

4. QUALITY OF LIFE BENEFITS APPLICATION

4.1 For the purposes of paragraph 137(3)(b) of the MAI Act a quality of life benefits application must include the following details:

- name of the injured person;

- the individual claim identifier provided by the insurer;
- the types of injuries for which an assessment is being sought being physical and/or primary psychological in the applicant's own words;
- an acknowledgement they have received sufficient treatment to inform the insurer of the stability of their injuries;
- details of the person's availability on weekdays for an assessment in the next three months and an acknowledgement an assessment may not occur in that time;
- details of any special needs of the person in attending an assessment – such as accessibility, cultural or language needs;
- whether the person requires an accompanying person to be present at the assessment together with the name, relationship and role of this person; and
- information about any offence the person has been charged with, or convicted or found guilty of, in relation to the accident.

4.2 For the purposes of paragraph 137(3)(c) of the MAI Act, a quality of life benefit application for a person requesting a primary psychological assessment must be accompanied by a written notice in accordance with clause 4.3 from a psychiatrist, or clinical psychologist in accordance with subsection 150(3) of the MAI Act and these guidelines. A psychiatrist is a medical practitioner with specialist registration with the Australian Medical Board in the field of psychiatry. Similarly, a clinical psychologist is a registered psychologist that has been endorsed by the Psychological Board of Australia to practise as a clinical psychologist. Registration is required with the Australian Health Practitioners Registration Authority.

4.3 The notice from the psychiatrist or clinical psychologist must include:

- a diagnosis of the primary psychological injury resulting from the accident based on a recognised diagnostic system and specify the diagnostic criteria upon which the diagnosis is based;
- a list of the type and frequency of treatment, providing comment on the effectiveness of any treatment the person has received for the primary psychological injury resulting from the accident;
- an opinion from the psychiatrist or clinical psychologist as to whether they consider the injury is well stabilised and unlikely to change substantially, with or without mental health treatment intervention, in the next year; and
- a statement from the psychiatrist or clinical psychologist that they reasonably believe the person is likely to have a permanent psychological injury resulting from the accident.

4.4 The following information may also accompany a quality of life benefits application but is not a mandatory requirement to complete the application:

- any medical reports about the status of the person's injuries that have not been provided directly to an insurer by a treating health practitioner of the injured person. This could include any reports about whether a person's injuries are stable or whether a person is likely to have a permanent impairment.

If under section 6.1 of these guidelines, the insurer has inconclusive information about the status of a person's injuries, the above information may also be subsequently requested by an insurer.

4.5 A quality of life benefits application may be made using a prescribed form made available on the MAI Commission's website or provided by an insurer. The application is to be made in writing and may be given to the insurer by electronic means, by personal delivery or by post.

5. APPLICATION FOR A WPI ASSESSMENT FOR A PERSON THAT HAS MADE A SUCCESSFUL WORKERS COMPENSATION CLAIM

5.1 Under Part 5.3 of the MAI Act, a person may apply to an insurer for the motor accident claim for an assessment of their WPI if:

- they have made a successful application for workers compensation benefits; and
- they have given a notice of claim under the *Civil Law (Wrongs) Act 2002*.

5.2 The application should include information about the WPI assessments the injured person is seeking. The application should also be accompanied by an authority to disclose personal health information that covers the exchange of personal health information between:

- the motor accident insurer;
- the injured person's stated workers compensation insurer (if applicable);
- treating health service providers or a treating team;
- an authorised IME provider; and
- an independent medical examiner who conducts a WPI assessment.

5.3 For the purposes of subsection 241(2) of the MAI Act, an insurer must give an acknowledgement notice to the injured person within 5 business days of receiving the application for a WPI assessment.

5.4 Note, under section 240 of the MAI Act, an application for an assessment is not required if the person has had an assessment conducted by a private medical examiner in accordance with the WPI assessment guidelines. The insurer may consider whether the assessment complies with the WPI Assessment Guidelines (including the ACT modifications to AMA5). The report should include a clear assessment of the percentage of WPI, the rationale and reference all medical information used.

6. PROCEDURE FOR ARRANGING A WPI ASSESSMENT

This section, and those in section 7, make provision for the procedures for arranging a WPI assessment under section 147 of the MAI Act.

6.1 Status of a person's injuries

6.1.1 An insurer has 20 business days to consider a quality of life benefits application, to allow for gathering up information and to assess the injuries of the injured person. This period will not commence for a quality of life benefit application that includes a request for a primary psychological assessment until the insurer is satisfied that the requirements of subsection 150(3) of the MAI Act are satisfied.

6.1.2 When assessing the injuries, the insurer may rely on the medical information available to them or seek an independent opinion on whether the injured person's injuries have stabilised. If an insurer seeks an independent opinion (including an examination) they should ensure the injured person is aware:

- it is a medical assessment for only this purpose (e.g. an assessment of their injuries' stabilisation); and
- it is not the WPI assessment arranged by the authorised IME provider.

6.1.3 An insurer must refer an injured person to an authorised IME provider for a WPI assessment if an insurer "reasonably believes":

- the person's injuries have stabilised; and
- the person is likely to have a permanent impairment as a result of the injuries.

6.1.4 An insurer must refer an injured person to an authorised IME provider for a WPI assessment if:

- the insurer "reasonably believes":
 - a person's injuries are stabilised;
 - the person is not likely to have a permanent impairment as a result of the injuries; and
- the injured person pays an excess amount for the assessment to the insurer.

An insurer is to give a written notice consistent with subsection 139(2) of the MAI Act.

6.1.5 An insurer must recommend to an injured person that the WPI assessment be delayed if:

- an insurer "reasonably believes" a person's injuries have not stabilised; and
- it is less than 4 years and 6 months after the date of the motor accident.

An insurer is to give a written notice consistent with subsection 140(2) of the MAI Act. An injured person may still request that an insurer makes an immediate referral for a WPI

assessment, but if the assessment confirms the person's injuries are not stable an insurer is not obliged to pay for a second assessment.

6.1.6 For the purposes of these guidelines, to assess stability an insurer may consider the treatment the injured person has, whether there has been a substantial change in the requested treatment (for example, fewer sessions occurring) and how their condition has settled. The insurer may also consider whether further medical treatment would have a substantive effect on their condition at the time of the application.

6.1.7 An insurer's reasonable belief about the stability of a person's injuries, and the likelihood of a permanent impairment should be based on information the insurer has in their possession about the person's injuries, treatment and recovery following receipt of the application. If this information is inconclusive the insurer should make reasonable inquiries with the person's treating health practitioners. If, after this step, information is still not conclusive, the insurer is to inform the injured person it may be necessary to obtain an independent medical review to establish stability of their physical injuries.

6.1.8 An insurer may consider the clinical evidence but must rely on a notice given by a psychiatrist or clinical psychologist under subsection 150(3) of the MAI Act to form a reasonable belief about the stability of a person's injuries and whether the person is likely to have a permanent primary psychological impairment. The notice is to reference the treatment the injured person has received (which may be from one or more practitioners for the mental health treatment required for the injured person's injury). It is a requirement that the person has received mental health treatment under section 150(3) before an injured person may request a WPI assessment. Generally, a course of treatment would include several sessions over a period of time that is appropriate for the diagnosis. This may be guided by the Recovery Plan put in place by agreement between the injured person, the treating professional, and the MAI insurer.

6.1.9 If an injured person has requested both a physical and a primary psychological assessment, an insurer will not be required to make a referral to an authorised IME provider until requirements in Division 2.6.2 of the MAI Act for making a referral are satisfied for both kinds of injuries or the injured person otherwise makes an informed decision to proceed with a separate referral for one kind of injury only. If a separate referral is made for one kind of injury, then the time frames for making the WPI report available and any quality of life benefit offer under sections 154 to 157 of the MAI Act are to apply as if there is only one WPI report. The injured person should be made aware that if they proceed with the assessment, then any quality of life benefit offer from the assessment will not take into account the other kind of injury, and depending on the outcome of the assessment may also result in the early finalisation of their quality of life benefit application.

6.1.10 If the person has physical injuries to multiple body systems an insurer should also reasonably believe that injuries to all physical body systems and any secondary psychological injuries have stabilised before making a WPI assessment referral.

6.1.11 An insurer must separately assess all physical injuries for a given body system to determine whether any of these injuries are likely to result in a permanent impairment. An insurer must not include physical injuries in a referral without first undertaking this assessment and the injured person must not be required to undergo unnecessary WPI assessment appointments.

6.1.10 If an injured person requests a physical injury be included in a referral, and the insurer reasonably believes the injured person is unlikely to have any permanent injuries for the given body system, then consistent with section 139 of the MAI Act an excess must be requested and paid before the referral is made. That is, if the injured person has physical injuries to multiple body systems, then a section 139(2) assessment is to be applied for each body system, rather than for the WPI assessment as a whole. However, only one excess under section 139(5) is payable. The excess is to be refunded if permanent injuries are subsequently identified.

6.2 The time within which a WPI assessment must be arranged

6.2.1 When an insurer is required to refer an injured person to an authorised IME provider for a WPI assessment they must:

- provide the injured person with a written notification in accordance with section 6.2.2; and
- send a written referral for the injured person to an authorised IME provider for a WPI assessment in accordance with section 6.2.3.

6.2.2 The insurer must provide the injured person with written notification of:

- the injuries and body systems which will be covered by the assessment;
- the person's medical history to be set out in the referral; and
- a list of the medical and health information in their possession which they will be providing to the authorised IME provider for the assessment.

The insurer may give the injured person a completed draft of the IME provider's referral form (without the file attachments that will be given to the IME provider) for these purposes.

This written notice must occur no later than 5 business days after the injured person:

- is eligible for an assessment under section 138 of the MAI Act; or
- confirms and pays an excess for a WPI assessment under subsection 139(3) of the MAI Act; or
- the person requests a WPI assessment under subsection 140(3) of the MAI Act; or
- the person notifies the insurer that their injuries have stabilised in accordance with subparagraph 141(5)(c)(ii) of the MAI Act.

The purpose of notification is for the injured person to be informed of the scope of the assessment and also provide an opportunity for the injured person to provide the

insurer/IME provider with any additional information they may have in their possession which may be relevant to the assessment.

6.2.3 An insurer must then send a written referral for the injured person to an authorised IME provider for a WPI assessment, for all injuries for which a person is likely to have a permanent impairment. This written referral must occur no later than 10 business days after the injured person:

- is eligible for an assessment under section 138 of the MAI Act; or
- confirms and pays an excess for a WPI assessment under subsection 139(3) of the MAI Act; or
- the person requests a WPI assessment under subsection 140(3) of the MAI Act; or
- the person notifies the insurer that their injuries have stabilised in accordance with subparagraph 141(5)(c)(ii) of the MAI Act.

If the injured person indicates additional information is to be provided, the insurer may defer making the written referral. After receipt of the information, the insurer has an additional 5 business days before making the referral. This is to allow the insurer time to consider the relevance of the additional information to the referral and make any necessary inquiries.

6.2.4 An injured person's application for quality of life benefits is suspended for the period a person has outstanding charges in relation to the motor accident for one or more driving offences, or a serious driving offence. A referral to an IME provider should not be made during the suspension period, and the insurer should inform the applicant about the suspension of the application, and circumstances that the application may be revived, in writing.

6.3 Insurer selecting an IME provider if more than one authorised IME provider

6.3.1 If the MAI Commission has authorised more than one IME provider to arrange WPI assessments, an insurer must put procedures in place to ensure that all authorised IME providers are allocated referrals from an insurer on an equal and sequential basis. For example, if there are two authorised IME providers an insurer should alternate referrals for any given injured person, between the two providers, based on the time and date of a referral. The only exception to this rule should be if:

- the allocated provider is unable to provide an assessment for all body systems for the injured person due to specialist availability;
- an injured person has previously received a physical or primary psychological assessment from the other or another authorised IME provider; or
- the other or another authorised IME provider operates in an interstate or overseas location closer to where the injured person resides or works and is able to arrange the assessment.

An insurer must keep a register of all referrals to authorised IME providers.

6.4 Arranging appointments with an independent medical examiner by the authorised IME provider

6.4.1 An insurer must prepare a written referral to the authorised IME provider. The referral is to be made using a form made available by the MAI Commission. The referral is to detail the injuries and body systems to be covered by the WPI assessment report and whether the insurer has received either a notice or information for a diagnosis of a psychological or psychiatric disorder.

6.4.2 The referral must indicate when a person is likely to be available for medical examinations and include details of any special needs, such as an interpreter services, that need to be accommodated for at an appointment.

6.4.3 The IME provider is responsible for arranging one or more independent medical examiners to carry out a WPI assessment of the injured person.

6.4.4 An insurer must also give the authorised IME provider all medical and allied health information, including results of clinical investigations in their possession relevant to the assessment, at least 10 calendar days before an appointment with an examiner. Information should include information about the onset of injury, subsequent treatment, diagnostic imaging and tests, and functional assessments of the person claiming the impairment. All documents should be appropriately indexed and organised in a manner to minimise file review times by the examiner.

6.4.5 If the injured person has requested that an accompanying person be present at the assessment the referral should include the name, relationship to the injured person, and role of this person.

6.4.6 The insurer may arrange for the authorised IME provider to communicate directly with the injured person about appointment bookings. In doing so, the authorised IME provider must inform the insurer of all appointment arrangements including any cancellation, non-attendance or rescheduling of appointments by either the applicant or the authorised IME provider.

6.4.7 An injured person must be given at least 10 business days written notice of any appointment with an independent medical examiner. The insurer is responsible for ensuring the appointment notice is given to the injured person and may make arrangements for the notice to be sent out by the IME provider on their behalf. The notice period may only be reduced or waived on agreement from the injured person and provided the insurer has already given the IME provider all information necessary to undertake an assessment. If a person has complex injuries a single notice may cover multiple appointments. The notice must include the following information about a given appointment:

- the name, specialty, and qualifications of the independent medical examiner;
- the injuries and body system/s covered by the referral noting the appointment is for the purposes of assessing impairment and not for medical treatment;

- the date, time, and location of the appointment, contact details for the examiner's offices and appropriate travel directions or arrangements;
- the likely duration of the appointment;
- how to cancel the appointment;
- the consequences of a late cancellation or a non-attendance for an appointment;
- Information the injured person should bring to the appointment (such as X-rays not in electronic form) or give to the examiner prior to the appointment;
- arrangements for an accompanying person to be present during an appointment, noting that the person is not to participate in the assessment, other than to assist the examiner in communicating with the person, and any accompanying person may be asked to leave the assessment room if requested by an examiner. Where the injured person is a child or a person with an intellectual disability, the examiner may request the support person remain in the room but not communicate with the injured person if there is a concern they are interfering with the assessment;
- arrangements for paying travel expenses; and
- how complaints can be made and how they will be handled.

A notice of an appointment may be sent to an injured person by post or electronically.

6.5 Payment for WPI assessment

6.5.1 An insurer will be responsible for directly paying an IME provider for a WPI assessment report and related costs requested on referral by an insurer. The IME provider will invoice in accordance with the fee schedule agreed by the MAI Commission. An IME provider must be paid within 10 business days of the insurer receiving a properly completed WPI report and invoice.

6.5.2 An insurer is not required to arrange for a referral for an assessment, or make an appointment with an IME provider, if the insurer has not received a payment or contribution for the cost of an assessment from an injured person in the following listed circumstances:

- the insurer believes a person's injuries are stable and the person is not likely to have a permanent impairment (Section 139 of the MAI Act);
- a second assessment is required for a person, because an assessment requested by the person under subsection 140(3) of the MAI Act confirmed the person's injuries had not stabilised; or
- a second assessment is required under subparagraph 141(5)(c)(ii) of the MAI Act because a person who has received an estimated WPI has applied to stay common law proceedings until their injuries have stabilised.

6.5.3 If an excess is paid by a person in accordance with subsection 139(5) of the MAI Act and the WPI assessment report confirms the person's WPI is greater than 0%, the insurer must reimburse the excess to the person within 10 business days of receiving the WPI assessment report.

6.5.4 If the IME provider is required to arrange a further appointment because a person did not attend an earlier appointment and did not give the insurer a reasonable excuse for their non-attendance, the person must pay any cancellation fee charged by the IME provider as a result of the missed appointment.

6.5.5 An insurer must also pay the reasonable and necessary travel expenses for a person to attend a WPI assessment on referral from an insurer, with the exception of a referral for a second assessment required because an assessment requested by the person under subsection 140(3) of the MAI Act confirmed the person's injuries had not stabilised.

6.5.6 If an injured person arranges for a private medical examiner to carry out a second WPI assessment the person will be responsible for paying for the WPI assessment report and for any travel expenses incurred in attending the WPI assessment.

7. VALIDATING A WPI ASSESSMENT REPORT

7.1 Before giving an injured person a copy of a WPI report and any offer of quality of life benefits under sections 154 to 157 of the MAI Act an insurer must first be satisfied that the WPI report reflects an assessment carried out in accordance with the WPI Assessment Guidelines. An insurer must have its own quality assurance process in place to confirm the validity of WPI reports, noting quality assurance is also undertaken by the authorised IME provider.

7.2 A WPI report may not be valid if it does not:

- address whether an injury or condition has reached maximum medical improvement as required by clause 1.15 of the WPI Assessment Guidelines;
- provide a history and findings from the examination;
- provide opinion as to whether the applicant has suffered a permanent impairment from injuries caused by or resulting from the accident;
- provide details and make a deduction from the final level of impairment for any known pre-existing injuries or conditions, or for other assessed injuries not caused by the motor accident;
- exclude any secondary psychological injury from an assessment of primary psychological injuries;
- determine the degree of impairment using the tables, graphs, and the methodology in the WPI Assessment Guidelines and the American Medical Association Edition 5 (referred to as AMA 5) where applicable, and provide a clear calculation of the percentage as a whole number;
- include a statement and certification from the assessor to the effect that:
 - the assessor has completed training in AMA 5 and their specialisation
 - evaluated the person's permanent injuries as a result of a motor accident and

that the WPI assessment has been conducted in accordance with the *Motor Accident Injuries (WPI Assessment) Guidelines 2019*.

7.3 An insurer may seek corrections or compliance clarifications on receipt of a WPI assessment report through requesting a superseding report from the authorised IME provider. In this circumstance, the time frame for giving a notice under sections 154 to 157 of the MAI Act will not commence until the insurer receives a superseding report from the authorised IME provider. The body of the superseding report must include a statement that explains that it supersedes the previous WPI report. The superseding report process is not to be used by an insurer to seek/ask additional questions that were not present in the initial referral, to provide any additional information not made available to the assessor at the time of the assessment, or to question/change any clinical judgments made by the assessor in preparing the WPI report.

8. REQUIREMENTS FOR SECOND WPI REPORTS

8.1 These guidelines make provision for an injured person's responsibilities in relation to obtaining a second WPI report and providing a valid report. Under the MAI Act, a private medical examiner, trained in the WPI Assessment Guidelines, undertakes this assessment.

8.2 An injured person does not have to obtain a second WPI report. The injured person is to notify the insurer that they will be seeking their own WPI report because they disagree with the first WPI report. This has the effect of pausing the benefit.

8.3 The second WPI report must be provided to the insurer within 26 weeks after the date of the notice given under sections 154 to 156. If a notice is given under section 157, a longer due date for providing the second WPI report may apply. The costs of a second WPI report are for the injured person to pay. Note, if the outcome of the assessment is for a higher WPI percentage because the first WPI report is less than 10 per cent, the insurer may reimburse the cost of the report if there is a motor accident claim.

8.3 To obtain a valid second WPI report, the injured person must ensure that the private medical examiner is informed they are to conduct the assessment in accordance with these guidelines, including clause 7.2, the WPI Assessment Guidelines, and the MAI Act. A report not prepared accordingly may be invalid. A second WPI report cannot be obtained before, or at the same time, as the insurer-initiated assessment.

8.3 The second WPI report should be based on the same supporting documents as the insurer-initiated assessment. If there has been an updating or additional reports that were obtained after the insurer-initiated assessment but before the private medical examiner undertakes their assessment, the updating or additional reports are to be provided to the insurer with the second WPI report.

8.4 To facilitate a second WPI report being comparable to an insurer-initiated assessment, the content of a second WPI report should contain the following (to be consistent with clauses 7.2 and 9.5):

- confirm that the assessor is a private medical examiner providing a report for the purposes of section 158 of the Motor Accident Injuries Act
- confirm the date the applicant attended for assessment
- include a history
- include findings on examination and provide confirmation of the diagnosis
- reference relevant medical reports and documents the assessor had in their possession for the assessment, including those referred to in the first WPI report (note, this may be more than one if multiple body systems are involved)
- provide opinion as to whether the applicant has suffered a permanent impairment from injuries caused or resulting from the accident
- provide details of any relevant pre-existing injuries or conditions, the status of these injuries at the time of the accident, and any aggravating events/injuries post the motor accident
- provide opinion as to whether the applicant's presentation is consistent with the medical information and the first assessor's observations
- provide a clear explanation of any calculation of whole person impairment from the injuries in the motor accident including deductions where relevant
- contain a statement that the assessor has completed training in AMA5 and their specialisation and have conducted the assessment in line with the modifications contained in the Motor Accident Injuries (WPI Assessment) Guidelines 2019.

8.5 The second WPI report is to be self-contained and only prepared for the purpose of the WPI assessment. It therefore should not include an Expert Witness Statement or cover any injuries or conditions not referred to in the first WPI report. An injured person should alert the provider to the requirements of clause 8 when arranging the report. Limited additional questions may be answered by the private medical examiner, for example details of any treatment, therapy or referrals recommended for the injured person.

9. FINAL OFFER WPI

9.1 These guidelines make provision for an insurer's responsibilities in relation to second WPI reports including matters an insurer can consider in making a *final offer WPI* under subsection 160(2) of the MAI Act and for giving reasons for a final offer WPI decision.

9.2 Section 160 of the MAI Act applies if the relevant insurer receives a second WPI report from the injured person, and the injured person has not yet made a complying common law claim. If section 160 applies, the insurer must decide the final offer WPI. The insurer's final offer must not be less than the WPI in the original report (first WPI report) if it has not been reviewed by the Independent Medical Examiner (IME) under section 159 of the MAI Act, or if reviewed, must not be less than the notice affirming or increasing the WPI for the first WPI report.

9.3 An insurer must rely on the level of whole person impairment determined by the IME or private medical examiner (the assessors) from an assessment that was carried out in accordance with the *Motor Accident Injuries (WPI Assessment) Guidelines 2019* (WPI Guidelines). An insurer is not required to independently evaluate the level of impairment in a WPI report based on medical evidence they may have in their possession.

9.4 A final WPI offer must be made on the basis of a WPI report for an assessment carried out in accordance with the WPI Guidelines. An insurer may make a final WPI offer, for a WPI between the WPI for the first WPI report and the second WPI report, provided the WPI percentage is a whole number. This could include circumstances where there was inconsistency in clinical judgments made by the two assessors in applying the evaluation methodology or inconsistent presentations by the injured person of their injuries/condition at appointments with the two assessors.

9.5 In making a final WPI offer decision an insurer may disregard a second WPI report, in whole or part, if the insurer is not satisfied that the assessment was carried out in accordance with the WPI Guidelines. An insurer may form its belief about the validity of a report based on reasons given by the IME with a written notice under section 159 of the MAI Act. An insurer may also consider whether the principles of, and administrative processes for, an assessment in Chapter 1 of the WPI Guidelines have been followed in preparing the second WPI report, including by considering matters in Paragraph 7.2 of these guidelines. An insurer may also disregard a second WPI report if the insurer is not satisfied that the second assessor considered relevant information made available to the first assessor or if the second assessment includes injuries or conditions not evaluated in the first assessment. This could be evidenced by the second WPI report:

- not referencing that the second assessor had in their possession relevant medical reports and documents which were referred to in the first WPI report; or
- including, in the final level of impairment, injuries or conditions not identified in the original WPI report as being caused or resulting from the motor accident.

An insurer must have processes in place to give an injured person seeking a second WPI report, any relevant medical reports and documents not already in the injured person's possession, which the insurer provided for the first WPI assessment.

9.6 In making a final offer WPI an insurer is to give reasons in writing as the insurer must decide a WPI to determine the final offer. The reasons need only record the relevant facts and reference evidence such as the assessment and section 159 reports relied upon by the insurer for the determination. If an insurer disregards a second WPI report, in whole or part, the insurer is to state their reasons for doing so. If a second report is disregarded in part, an insurer must not make any adjustments to the assessed degree of impairment in the second report requiring a clinical judgement including for the attribution of any injuries to the motor accident.

10. INFORMATION AND SUPPORT – WPI TAKEN TO BE 10% IN CERTAIN CIRCUMSTANCES

10.1 These guidelines make provision for information and support an insurer is obliged to give a person under paragraph 52(2)(f) of the MAI Act who is taken under section 133 of the MAI Act to have a WPI of 10 per cent. A person who was a child at the time of an accident and at four years and six months after the motor accident is either receiving treatment and care meeting the requirements of the regulation, or a participant in the LTCS scheme, will be taken to have a WPI of 10 per cent.

10.2 An insurer must identify any injured person that is taken to have a WPI of 10 per cent under section 133 of the MAI Act, and contact the person in writing (or a parent/guardian in the case of a minor), one month prior to reaching 4 years and six months from the date of the motor accident. The insurer does not need to contact a person that has received a written notice under subsection 157(2) or 164(2) of the MAI Act and has lodged a notice of claim within the time frames permitted for the notice. An insurer must include information about the person's eligibility to make a common law claim, the time frames for the person to lodge a notice of claim and that the person may wish to seek legal advice as to whether to make a claim for damages.

11. INFORMATION AND SUPPORT – WPI OFFERS

11.1 These guidelines make provision for the information and support an insurer is obliged to give a person that receives a WPI offer about making a motor accident claim for the purposes of paragraph 52(2)(g) of the MAI Act.

11.2 An insurer must include with a written notice given to an injured person under subsection 157(2) or 164(2) of the MAI Act statements about the time frame for the person to lodge a notice of claim, and the insurer is unable to provide legal advice as to whether to make a claim for damages, and may include the contact details of the ACT Law Society for referral to a legal service provider.

From: Sch 2.2(a)(ii)
Sent: 08/10/2025 3:58 PM
To: "MAI Commission" <maic@act.gov.au>; "Lejins, Erica" <Erica.Lejins@act.gov.au>
Cc: "Clark, Nicola" <Nicola.Clark@act.gov.au>
Subject: FW: Consultation Draft - Updated Quality of Life Benefit Guidelines
Attachments: ACT CTP Quality of Life Benefit Guidelines submission - 8.10.25 signed.pdf

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Dear Erica,

Please see the attached ICA submission in relation to the updated Quality of Life Benefit Guidelines.

In the end we were able to meet the original due date but thank you for the extension of time.

Please do not hesitate to contact me if you have any questions.

Kind regards,

Sch 2.2(a)(ii)

Insurance Council of Australia
Level 26, 9 Castlereagh St, Sydney, NSW, 2000
insurancecouncil.com.au



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of Australia**



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From: Lejins, Erica
Sent: Thursday, 2 October 2025 9:22 AM
To: Sch 2.2(a)(ii)
Cc: Clark, Nicola ; Tripodi, Domenico
Subject: RE: Consultation Draft - Updated Quality of Life Benefit Guidelines

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OFFICIAL

Dear Sch 2.2(a)(ii)

We are happy to accommodate an extension, to no later than close of business on the 14th October. As I will be on extended leave from the 10th October, could you please ensure that you send your feedback to the maic@act.gov.au inbox. Nicola Clark or Domenico Tripodi are alternative contacts for consultation matters during my leave.

With regards

Erica Lejins

Director

MAI Regulatory Policy and Supervision

Insurance | Economic and Financial Policy Group

Treasury | Chief Minister, Treasury and Economic Development Directorate

ACT Government | GPO Box 158 CANBERRA ACT 2601

T (02) 6205 5496 | Web www.act.gov.au

I acknowledge the Ngunnawal people as the traditional custodians of the ACT and recognise any other people or families with connection to the lands of the ACT and region. I acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

From: Sch 2.2(a)(ii) >
Sent: Wednesday, 1 October 2025 8:25 PM
To: Lejins, Erica <Erica.Lejins@act.gov.au>
Subject: RE: Consultation Draft - Updated Quality of Life Benefit Guidelines

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Dear Erica,

Thank you for the opportunity to provide feedback on the updated Quality of Life Benefit Guidelines.

I am writing to request a short extension to provide the ICA's submission.

Due to a combination of factors including the public holiday on 6 October 2025, team members being on leave and the ICA's Annual Conference on 9 and 10 October 2025, we are concerned we may have

difficulty obtaining the necessary internal sign off to meet the deadline of 10 October 2025. We would be grateful for a short extension to Tuesday 14 October 2025.

I look forward to hearing from you. Thank you for considering this request.

Please do not hesitate to contact me if you would like to discuss.

Kind regards,

Sch 2.2(a)(ii)

Sch 2.2(a)(ii)

Insurance Council of Australia

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From: Lejins, Erica <Erica.Lejins@act.gov.au>

Sent: Wednesday, 17 September 2025 3:44 PM

To: CTP Regulatory Correspondence <Sch 2.2(a)(xi)> ACT CTP
Regulatory Notices <Sch 2.2(a)(xi)>

; Harper, Mark <Mark.Harper@act.gov.au>

Cc: <Sch 2.2(a)(ii)> <Sch 2.2(a)(ii)>

<Sch 2.2(a)(ii)> MAI Commission <maic@act.gov.au>

Subject: Consultation Draft - Updated Quality of Life Benefit Guidelines

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OFFICIAL

Dear Insurers,

Earlier this year, the MAI Commission provided for comment a short form review of four updated guidelines. Three of the guidelines were subsequently made on 10 July 2025. The fourth included with the package was the Quality of Life Benefit guidelines. The earlier draft circulated in March 2025 had foreshadowed two options for requests for psychological assessments.

The revised draft now incorporates feedback received in relation to the earlier draft. The incorporation of all feedback required a reframing of the Guidelines, which has also provided the MAI Commission with the opportunity to include updates providing clarity about steps an insurer must undertake to validate a WPI report, the handling of second WPI reports, and final WPI offers. The introduction has been expanded to include a background section to better assist members of the public who may be handling their own defined benefits application with information in one location.

If you wish to provide comments or feedback on the guidelines, we request these by close of business **Friday 10 October 2025**. Your comments can be directed to the MAI Commission inbox. If you wish to discuss the guidelines, you can contact the MAI Commission on 6207 8876.

With regards

Erica Lejins

Director

MAI Regulatory Policy and Supervision

Insurance | Economic and Financial Policy Group

Treasury | Chief Minister, Treasury and Economic Development Directorate

ACT Government | GPO Box 158 CANBERRA ACT 2601

T (02) 6205 5496 | Web www.act.gov.au

I acknowledge the Ngunnawal people as the traditional custodians of the ACT and recognise any other people or families with connection to the lands of the ACT and region. I acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

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8 October 2025

Ms. Erica Lejins
Director
MAI Regulatory Policy and Supervision
MAI Commission
ACT Government
By email: Erica.Leijins@act.gov.au

Dear Ms. Lejins,

Quality of Life Benefit Guidelines

The Insurance Council of Australia (Insurance Council), on behalf of its licensed ACT Motor Accident Injuries Scheme (MAI Scheme) members (Insurers) welcomes the opportunity to provide feedback in relation to the updated Quality of Life (QoL) Benefit Guidelines (QoL Guidelines).

The Insurance Council appreciates the MAI Commission's commitment to supporting Insurers to understand the legislative requirements in an operational context.

Please see our feedback below in relation to the proposed changes to the QoL Guidelines.

Part 1 - Introduction

We refer to the last sentence in the last paragraph of page 1 which states that "The second report is to meet the same conditions as the first so that it can be relied upon to make the offer for the QoL benefit or to lodge a notice of claim."

Please see our feedback below in relation to this sentence:

- This wording could be interpreted to mean that an injured person can rely solely on their second report to meet the 10% Whole Person Impairment (WPI) threshold for a notice of claim, even if the original assessor has affirmed the original assessment of the injured person's WPI as below the 10% threshold (meaning there would be no common law entitlement).
- To clarify this issue, we recommend rewording the sentence to state that: "The second report is to meet the same conditions as the first, although a second report is obtained by a private medical examiner and is not considered a report by an independent medical examiner for the purposes of Part 2.6 and Chapter 5 of the MAI Act."
- Alternatively, at a minimum, we suggest the second half of the sentence be removed to read: "The second report is to meet the same conditions as the first."

Part 3 – Information and Support for Applicants for Quality of Life Benefits

We note that at clause 3.7 on page 3, the words "at 24 weeks," have been added as follows: "An insurer does not need to provide an information pack at 24 weeks when a person:..."

We provide the following feedback in relation to the inclusion of the words "at 24 weeks" in this sentence:

- This wording may be confusing to a lay person, who may understand it to mean that it only applies at 24 weeks.
- We recommend removing the words “at 24 weeks” and leaving it as it was before to remove this potential confusion.

Part 4 – Quality of Life Benefits Application

We note that the QoL application form has undergone review and that previous iterations of the form did not contain the requirement for an injured person to acknowledge they have received sufficient treatment to inform the Insurer of the stability of their injuries.

Insurers seek clarification from the MAI Commission on whether this requirement will be contained in the updated QoL application form and whether the updated form will be released with the updated QoL Guidelines.

Part 6 – Procedure for Arranging a WPI Assessment

In relation to clause 6.1.9 on page 7, we are concerned about how this paragraph will interplay with sections of the MAI Act. For example, section 150(2) of the MAI Act provides that “the injured person may request separate WPI assessments of –

- (a) the physical injury; and
- (b) the primary psychological injury”

In Insurers’ experience, injured people often have difficulty understanding the requirement in clause 6.1.9 and the proposed amendments may lead to an increase in complaints relating to this clause.

We recommend adding an additional line to the end of clause 6.1.9 to make it clear that the injured person cannot seek a further WPI assessment for the other kind of injury when they have decided to only proceed with one kind of injury, e.g. “Where an injured person makes an informed decision to proceed with an assessment of only one kind of injury, they will not be entitled to seek a further WPI assessment for the other kind of injury at a later stage.”

We further note that clause 6.1.10 on page 8 appears to be incorrectly numbered and should be clause 6.1.12.

In relation to the currently numbered clause 6.1.10 on page 8, which states that “the excess is to be refunded if permanent injuries are subsequently identified”, we provide the following feedback:

- This could be interpreted as an injured person receiving an excess back because an accepted body system is found to have a permanent impairment, while a disputed body part still has no permanent impairment.
- In our view, the excess should be relevant only to any disputed body parts given the insurer has already accepted the other body parts. Therefore, any reimbursement of the excess should only be based on the outcome of the disputed body part.
- Insurers seek clarification on whether the reference to a section 139(2) assessment to be conducted for each body system will require separate section 139(2) notices for each body system. Insurers are concerned that receiving separate section 139(2) notices for each body system could result in a poor experience for the injured person.
- We recommend rewording the last line of this clause as follows: “The excess is to be refunded if permanent injuries are subsequently identified in at least one disputed body part.”

Part 7 – Validating a WPI Assessment Report

We provide feedback below in relation to clause 7.3 on page 13 which states that “The superseding report process is not to be used by an insurer to seek/ask additional questions that were not present in the initial referral, to provide any additional information not made available to the assessor at the time of the assessment, or to question/change any clinical judgments made by the assessor in preparing the WPI report”:

- Insurers have had instances where they have had to question the clinical judgment of the assessor including when the assessor has advised that the injured person was not stable, but the treating providers confirmed they were stable. There have been times when the assessor has subsequently changed their position, and the WPI assessment could proceed.
- Insurers suggest that the words “or to question/change any clinical judgments made by the assessor in preparing the WPI report” are removed to allow for instances such as that described above to occur.

Part 8 – Requirements for Second WPI Reports

We note there appears to be a numbering issue on pages 13 and 14 with “clause 8.3” being listed three times.

In relation to clause 8.3 (second), the last sentence of this paragraph states that “A second WPI report cannot be obtained before, or at the same time, as the insurer-initiated assessment.” Insurers are concerned that the use of the words “insurer-initiated” suggests that the WPI requirement is insurer-led rather than impartial and applicant-led. We suggest this sentence be amended to “A second WPI report cannot be obtained until after a first WPI offer is made by the insurer.”

In relation to clause 8.5, we are concerned that the allowance of “limited additional questions” may be open to abuse and request that any second WPI report be limited to the WPI assessment only.

Commencement date

We note that the amendments to the QoL Guidelines will require updates to letters and procedures as well as staff training. Insurers are unable to make these updates based on draft Guidelines that may change between the draft and commencement. Accordingly, we request a timeframe for commencement longer than the usual seven days and suggest that a period of four weeks would be reasonable.

We hope this submission is of assistance. Please do not hesitate to contact [Sch 2.2\(a\)\(ii\)](#) Senior Adviser, Insurance Lines, at [Sch 2.2\(a\)\(ii\)](#) or on [Sch 2.2\(a\)\(ii\)](#) if you have any questions or would like to discuss anything further.

Yours sincerely,

[Sch 2.2\(a\)\(ii\)](#)

Alexandra Hordern
General Manager, Regulatory & Consumer Policy

From: "Forey, Melanie"
Sent: 13/10/2025 10:35 AM
To: Sch 2.2(a)(ii)
Subject: FW: Consultation Draft- Motor Accident Injuries (Quality of Life Benefit) Guidelines
Attachments: Quality of Life Guidelines - Consultation Draft - September 2025.pdf

Good morning Sch 2.2(a)(ii)

I tried to call you this morning and left a message but then thought it might be easier to email you.

As per below consultation feedback for the attached Quality of Life Guidelines closed on 10 October. I am after confirming please that there are no comments from the ACT Law Society?

Best regards,

Melanie Forey

Assistant Director
 MAI Regulatory Policy and Supervision
 Insurance | Economic and Financial Policy Group
 Treasury | Chief Minister, Treasury and Economic Development Directorate
 ACT Government | act.gov.au | GPO Box 158 CANBERRA ACT 2601

E melanie.forey@act.gov.au | T 02 6207 1843



From: Lejins, Erica
Sent: Thursday, 18 September 2025 4:13 PM
To: Sch 2.2(a)(ii)
Subject: FW: Consultation Draft- Motor Accident Injuries (Quality of Life Benefit) Guidelines

Dear Sch 2.2(a)(ii),

Please see the attached request for consultation feedback below. My apologies it was sent to an incorrect email address.

Erica

From: Lejins, Erica
Sent: Wednesday, 17 September 2025 3:59 PM
To: 'ceo@actbar.com.au' <ceo@actbar.com.au>; 'Committee' <committee@actlawsociety.asn.au>
Cc: Sch 2.2(a)(ii); MAI Commission <maic@act.gov.au>
Subject: Consultation Draft- Motor Accident Injuries (Quality of Life Benefit) Guidelines

Dear Stakeholders,

Earlier this year, the MAI Commission provided for comment a short form review of four updated guidelines. Three of the guidelines were subsequently made on 10 July 2025. The fourth included with the package was the Quality of Life Benefit guidelines. The earlier draft circulated in March 2025 had foreshadowed two options for requests for psychological assessments.

The revised draft now incorporates feedback received in relation to the earlier draft. The incorporation of all feedback required a reframing of the Guidelines, which has also provided the MAI Commission with the opportunity to include updates providing clarity about steps an insurer must undertake to validate a WPI report, the handling of second WPI reports, and final WPI offers. The introduction has been expanded to include a background section to better assist members of the public who may be handling their own defined benefits application with information in one location.

If you wish to provide comments or feedback on the guidelines, we request these by close of business **Friday 10 October 2025**. Your comments can be directed to the MAI Commission inbox. If you wish to discuss the guidelines, you can contact the MAI Commission on 6207 8876.

With regards

Erica Lejins

Director

MAI Regulatory Policy and Supervision

Insurance | Economic and Financial Policy Group

Treasury | Chief Minister, Treasury and Economic Development Directorate

ACT Government | GPO Box 158 CANBERRA ACT 2601

T (02) 6205 5496 | Web www.act.gov.au

I acknowledge the Ngunnawal people as the traditional custodians of the ACT and recognise any other people or families with connection to the lands of the ACT and region. I acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

Australian Capital Territory

Motor Accident Injuries (Quality of Life Benefit) Guidelines 2025

Disallowable instrument DI2025

made under the

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

1 Name of instrument

This instrument is the *Motor Accident Injuries (Quality of Life Benefit) Guidelines 2025*.

2 Commencement

This instrument commences on the 7th day after its notification.

3 Guidelines

I make the guidelines attached to this instrument.

4 Revocations

The *Motor Accident Injuries (Quality of Life Benefit) Guidelines 2023* (DI2023-311) is revoked.

MAI Commissioner

MAI Commission

2025

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Quality of Life Benefit Guidelines

1. INTRODUCTION

The Quality of Life Benefit guidelines (guidelines) are part of the MAI guidelines made under section 487 of the *Motor Accident Injuries Act 2019* (MAI Act). The Guidelines detail the insurers' obligations in providing information and support to potential applicants for quality of life benefits, procedures for arranging Whole Person Impairment (WPI) assessments and making offers for quality of life defined benefit amounts. They also detail the process for an injured person to obtain a valid second WPI report.

Background

The quality of life (QOL) benefit is a recognition payment for a person's permanent injuries caused by the accident and may be offered following a WPI assessment carried out in accordance with the *Motor Accident Injuries (WPI Assessment) Guidelines 2019* (WPI Assessment Guidelines). An application for the benefit may be made no earlier than 26 weeks after the motor accident. The injuries sustained in the accident need to have stabilised sufficiently for an assessment. The benefit is payable for WPI assessments of 5 per cent or more, with the benefit amount set out in legislation and based on the WPI figure (a whole number). A person with a WPI assessment of 10 per cent or more from the first WPI report may choose to access common law if they were not at fault.

The first WPI assessment is made on referral by an insurer to an authorised IME provider. The IME provider appoints qualified and experienced independent medical examiners (IMEs) to carry out WPI assessments. This authorisation by the MAI Commission is to facilitate the first WPI assessment. The IME providers have a national presence and are able to select IMEs from around the country.

On referral by the insurer, the IME provider will select the independent medical examiner (IME) relevant for the permanent injuries needing to be assessed. This process is so that the IME undertaking the assessment has not been appointed by either an insurer or a legal representative. There is no process of selecting from several IMEs as it will be subject to availability.

If an injured person is unhappy with the first assessment and wants another assessment, they are able to select and pay for their own private medical examiner (PME) to conduct a second WPI report. There is no requirement to approach the authorised IME provider for a PME. It is important, though, that the PME is qualified and experienced in carrying out ACT WPI assessments. The second report is to meet the same conditions as the first so that it can be relied upon to make the offer for the QOL benefit or to lodge a notice of claim.

2. STATUTORY FRAMEWORK

Division 2.6.2 of the MAI Act makes provision for an injured person to make a quality of life benefits application. A precondition for the application is that the injured person has received a receipt notice or late receipt notice under section 60 of the MAI Act. An injured person cannot make a quality of life benefit application earlier than 26 weeks after a motor accident and not later than 4 years and six months after an accident.

The legislative framework for quality of life benefits includes:

- a. the MAI Act;
- b. the Motor Accident Injuries Regulation 2019 (the Regulation); and
- c. these Guidelines made under the MAI Act.

Also, the WPI Assessment Guidelines apply to any WPI assessment undertaken for the purposes of the MAI Act.

3. INFORMATION AND SUPPORT FOR APPLICANTS FOR QUALITY OF LIFE BENEFITS

3.1 These guidelines make provision for the information and support an insurer is to give a person about making an application for quality of life benefits for the purposes of paragraph 52(2)(e) of the MAI Act. The information pack is intended to assist an injured person in making an informed decision about requesting a WPI assessment.

3.2 The information pack is required to be provided about:

- the eligibility requirements for a quality of life defined benefit or to make a motor accident claim;
- how to apply for a quality of life benefit, and the time frame for making an application;
- the need for a person's injuries to be stable for a permanent impairment to be assessed;
- conditions for requesting a WPI assessment for primary/secondary psychological injuries;
- requirements for requesting a WPI assessment for a primary psychological injury, including the definition of a primary psychological injury, the requirement to have undergone mental health treatment and to provide a notice under subsection 150(3) of the MAI Act and paragraphs 4.2 and 4.3 of these guidelines;
- the definition of a secondary psychological injury and requirements for a secondary psychological injury to be taken into account as part of a physical assessment;
- how an insurer will arrange for an assessment with the independent medical examiner provider, expected waiting times for an assessment and the person's obligations if they request an assessment;
- how a WPI assessment is carried out and where a person can access the MAI guidelines about permanent impairment assessments; and

- arrangements for paying for a WPI assessment, including the circumstances a person will be required to pay an excess for an assessment and the circumstances in which an excess can be returned.

3.3 An insurer must provide an information pack about quality of life payments to an applicant for defined benefits (other than persons mentioned in paragraph 3.6) prior to the injured person first becoming eligible to make a quality of life application. The pack is to be provided no earlier than 24 weeks after the date of an accident. Where the period of 26 weeks after the date of the accident has passed, for example a late application is made and accepted, the insurer should provide the information pack after the insurer has accepted liability for the application. An insurer may provide general information about the benefit, noting the need for treatment to have occurred and stability of injuries that are of a permanent nature.

3.4 To assist an injured person who may request an assessment for a primary psychological injury the insurer may include a template for a notice under subsection 150(3) of the MAI Act when providing the information pack.

3.5 An insurer must consider their duty to act in good faith when determining the timing of the issue of an information pack. This includes the insurer's duty in paragraph 20(4)(a) of the MAI Act to disclose, as soon as practicable, all information that an applicant may need to understand the process for applying for defined benefits.

3.6 The information pack must also be provided on request by any other person who has made a defined benefits application. Information packs may be sent electronically or by post.

3.7 An insurer does not need to provide an information pack at 24 weeks when a person:

- was charged with a serious driving offence or one or more driving offences;
 - is a foreign national and has permanently departed Australia;
- or if -**
- the insurer has denied liability for the person's defined benefits application;
 - the person returned to work at full capacity or their usual activities within 28 days after the motor accident;
 - the insurer reasonably believes that the person's physical or any psychological injuries are not stable; or
 - the insurer reasonably believes that the person's injuries are stable but they are not likely to have a permanent impairment from injuries as a result of the motor accident.

4. QUALITY OF LIFE BENEFITS APPLICATION

4.1 For the purposes of paragraph 137(3)(b) of the MAI Act a quality of life benefits application must include the following details:

- name of the injured person;

- the individual claim identifier provided by the insurer;
- the types of injuries for which an assessment is being sought being physical and/or primary psychological in the applicant's own words;
- an acknowledgement they have received sufficient treatment to inform the insurer of the stability of their injuries;
- details of the person's availability on weekdays for an assessment in the next three months and an acknowledgement an assessment may not occur in that time;
- details of any special needs of the person in attending an assessment – such as accessibility, cultural or language needs;
- whether the person requires an accompanying person to be present at the assessment together with the name, relationship and role of this person; and
- information about any offence the person has been charged with, or convicted or found guilty of, in relation to the accident.

4.2 For the purposes of paragraph 137(3)(c) of the MAI Act, a quality of life benefit application for a person requesting a primary psychological assessment must be accompanied by a written notice in accordance with clause 4.3 from a psychiatrist, or clinical psychologist in accordance with subsection 150(3) of the MAI Act and these guidelines. A psychiatrist is a medical practitioner with specialist registration with the Australian Medical Board in the field of psychiatry. Similarly, a clinical psychologist is a registered psychologist that has been endorsed by the Psychological Board of Australia to practise as a clinical psychologist. Registration is required with the Australian Health Practitioners Registration Authority.

4.3 The notice from the psychiatrist or clinical psychologist must include:

- a diagnosis of the primary psychological injury resulting from the accident based on a recognised diagnostic system and specify the diagnostic criteria upon which the diagnosis is based;
- a list of the type and frequency of treatment, providing comment on the effectiveness of any treatment the person has received for the primary psychological injury resulting from the accident;
- an opinion from the psychiatrist or clinical psychologist as to whether they consider the injury is well stabilised and unlikely to change substantially, with or without mental health treatment intervention, in the next year; and
- a statement from the psychiatrist or clinical psychologist that they reasonably believe the person is likely to have a permanent psychological injury resulting from the accident.

4.4 The following information may also accompany a quality of life benefits application but is not a mandatory requirement to complete the application:

- any medical reports about the status of the person's injuries that have not been provided directly to an insurer by a treating health practitioner of the injured person. This could include any reports about whether a person's injuries are stable or whether a person is likely to have a permanent impairment.

If under section 6.1 of these guidelines, the insurer has inconclusive information about the status of a person's injuries, the above information may also be subsequently requested by an insurer.

4.5 A quality of life benefits application may be made using a prescribed form made available on the MAI Commission's website or provided by an insurer. The application is to be made in writing and may be given to the insurer by electronic means, by personal delivery or by post.

5. APPLICATION FOR A WPI ASSESSMENT FOR A PERSON THAT HAS MADE A SUCCESSFUL WORKERS COMPENSATION CLAIM

5.1 Under Part 5.3 of the MAI Act, a person may apply to an insurer for the motor accident claim for an assessment of their WPI if:

- they have made a successful application for workers compensation benefits; and
- they have given a notice of claim under the *Civil Law (Wrongs) Act 2002*.

5.2 The application should include information about the WPI assessments the injured person is seeking. The application should also be accompanied by an authority to disclose personal health information that covers the exchange of personal health information between:

- the motor accident insurer;
- the injured person's stated workers compensation insurer (if applicable);
- treating health service providers or a treating team;
- an authorised IME provider; and
- an independent medical examiner who conducts a WPI assessment.

5.3 For the purposes of subsection 241(2) of the MAI Act, an insurer must give an acknowledgement notice to the injured person within 5 business days of receiving the application for a WPI assessment.

5.4 Note, under section 240 of the MAI Act, an application for an assessment is not required if the person has had an assessment conducted by a private medical examiner in accordance with the WPI assessment guidelines. The insurer may consider whether the assessment complies with the WPI Assessment Guidelines (including the ACT modifications to AMA5). The report should include a clear assessment of the percentage of WPI, the rationale and reference all medical information used.

6. PROCEDURE FOR ARRANGING A WPI ASSESSMENT

This section, and those in section 7, make provision for the procedures for arranging a WPI assessment under section 147 of the MAI Act.

6.1 Status of a person's injuries

6.1.1 An insurer has 20 business days to consider a quality of life benefits application, to allow for gathering up information and to assess the injuries of the injured person. This period will not commence for a quality of life benefit application that includes a request for a primary psychological assessment until the insurer is satisfied that the requirements of subsection 150(3) of the MAI Act are satisfied.

6.1.2 When assessing the injuries, the insurer may rely on the medical information available to them or seek an independent opinion on whether the injured person's injuries have stabilised. If an insurer seeks an independent opinion (including an examination) they should ensure the injured person is aware:

- it is a medical assessment for only this purpose (e.g. an assessment of their injuries' stabilisation); and
- it is not the WPI assessment arranged by the authorised IME provider.

6.1.3 An insurer must refer an injured person to an authorised IME provider for a WPI assessment if an insurer "reasonably believes":

- the person's injuries have stabilised; and
- the person is likely to have a permanent impairment as a result of the injuries.

6.1.4 An insurer must refer an injured person to an authorised IME provider for a WPI assessment if:

- the insurer "reasonably believes":
 - a person's injuries are stabilised;
 - the person is not likely to have a permanent impairment as a result of the injuries; and
- the injured person pays an excess amount for the assessment to the insurer.

An insurer is to give a written notice consistent with subsection 139(2) of the MAI Act.

6.1.5 An insurer must recommend to an injured person that the WPI assessment be delayed if:

- an insurer "reasonably believes" a person's injuries have not stabilised; and
- it is less than 4 years and 6 months after the date of the motor accident.

An insurer is to give a written notice consistent with subsection 140(2) of the MAI Act. An injured person may still request that an insurer makes an immediate referral for a WPI

assessment, but if the assessment confirms the person's injuries are not stable an insurer is not obliged to pay for a second assessment.

6.1.6 For the purposes of these guidelines, to assess stability an insurer may consider the treatment the injured person has, whether there has been a substantial change in the requested treatment (for example, fewer sessions occurring) and how their condition has settled. The insurer may also consider whether further medical treatment would have a substantive effect on their condition at the time of the application.

6.1.7 An insurer's reasonable belief about the stability of a person's injuries, and the likelihood of a permanent impairment should be based on information the insurer has in their possession about the person's injuries, treatment and recovery following receipt of the application. If this information is inconclusive the insurer should make reasonable inquiries with the person's treating health practitioners. If, after this step, information is still not conclusive, the insurer is to inform the injured person it may be necessary to obtain an independent medical review to establish stability of their physical injuries.

6.1.8 An insurer may consider the clinical evidence but must rely on a notice given by a psychiatrist or clinical psychologist under subsection 150(3) of the MAI Act to form a reasonable belief about the stability of a person's injuries and whether the person is likely to have a permanent primary psychological impairment. The notice is to reference the treatment the injured person has received (which may be from one or more practitioners for the mental health treatment required for the injured person's injury). It is a requirement that the person has received mental health treatment under section 150(3) before an injured person may request a WPI assessment. Generally, a course of treatment would include several sessions over a period of time that is appropriate for the diagnosis. This may be guided by the Recovery Plan put in place by agreement between the injured person, the treating professional, and the MAI insurer.

6.1.9 If an injured person has requested both a physical and a primary psychological assessment, an insurer will not be required to make a referral to an authorised IME provider until requirements in Division 2.6.2 of the MAI Act for making a referral are satisfied for both kinds of injuries or the injured person otherwise makes an informed decision to proceed with a separate referral for one kind of injury only. If a separate referral is made for one kind of injury, then the time frames for making the WPI report available and any quality of life benefit offer under sections 154 to 157 of the MAI Act are to apply as if there is only one WPI report. The injured person should be made aware that if they proceed with the assessment, then any quality of life benefit offer from the assessment will not take into account the other kind of injury, and depending on the outcome of the assessment may also result in the early finalisation of their quality of life benefit application.

6.1.10 If the person has physical injuries to multiple body systems an insurer should also reasonably believe that injuries to all physical body systems and any secondary psychological injuries have stabilised before making a WPI assessment referral.

6.1.11 An insurer must separately assess all physical injuries for a given body system to determine whether any of these injuries are likely to result in a permanent impairment. An insurer must not include physical injuries in a referral without first undertaking this assessment and the injured person must not be required to undergo unnecessary WPI assessment appointments.

6.1.10 If an injured person requests a physical injury be included in a referral, and the insurer reasonably believes the injured person is unlikely to have any permanent injuries for the given body system, then consistent with section 139 of the MAI Act an excess must be requested and paid before the referral is made. That is, if the injured person has physical injuries to multiple body systems, then a section 139(2) assessment is to be applied for each body system, rather than for the WPI assessment as a whole. However, only one excess under section 139(5) is payable. The excess is to be refunded if permanent injuries are subsequently identified.

6.2 The time within which a WPI assessment must be arranged

6.2.1 When an insurer is required to refer an injured person to an authorised IME provider for a WPI assessment they must:

- provide the injured person with a written notification in accordance with section 6.2.2; and
- send a written referral for the injured person to an authorised IME provider for a WPI assessment in accordance with section 6.2.3.

6.2.2 The insurer must provide the injured person with written notification of:

- the injuries and body systems which will be covered by the assessment;
- the person's medical history to be set out in the referral; and
- a list of the medical and health information in their possession which they will be providing to the authorised IME provider for the assessment.

The insurer may give the injured person a completed draft of the IME provider's referral form (without the file attachments that will be given to the IME provider) for these purposes.

This written notice must occur no later than 5 business days after the injured person:

- is eligible for an assessment under section 138 of the MAI Act; or
- confirms and pays an excess for a WPI assessment under subsection 139(3) of the MAI Act; or
- the person requests a WPI assessment under subsection 140(3) of the MAI Act; or
- the person notifies the insurer that their injuries have stabilised in accordance with subparagraph 141(5)(c)(ii) of the MAI Act.

The purpose of notification is for the injured person to be informed of the scope of the assessment and also provide an opportunity for the injured person to provide the

insurer/IME provider with any additional information they may have in their possession which may be relevant to the assessment.

6.2.3 An insurer must then send a written referral for the injured person to an authorised IME provider for a WPI assessment, for all injuries for which a person is likely to have a permanent impairment. This written referral must occur no later than 10 business days after the injured person:

- is eligible for an assessment under section 138 of the MAI Act; or
- confirms and pays an excess for a WPI assessment under subsection 139(3) of the MAI Act; or
- the person requests a WPI assessment under subsection 140(3) of the MAI Act; or
- the person notifies the insurer that their injuries have stabilised in accordance with subparagraph 141(5)(c)(ii) of the MAI Act.

If the injured person indicates additional information is to be provided, the insurer may defer making the written referral. After receipt of the information, the insurer has an additional 5 business days before making the referral. This is to allow the insurer time to consider the relevance of the additional information to the referral and make any necessary inquiries.

6.2.4 An injured person's application for quality of life benefits is suspended for the period a person has outstanding charges in relation to the motor accident for one or more driving offences, or a serious driving offence. A referral to an IME provider should not be made during the suspension period, and the insurer should inform the applicant about the suspension of the application, and circumstances that the application may be revived, in writing.

6.3 Insurer selecting an IME provider if more than one authorised IME provider

6.3.1 If the MAI Commission has authorised more than one IME provider to arrange WPI assessments, an insurer must put procedures in place to ensure that all authorised IME providers are allocated referrals from an insurer on an equal and sequential basis. For example, if there are two authorised IME providers an insurer should alternate referrals for any given injured person, between the two providers, based on the time and date of a referral. The only exception to this rule should be if:

- the allocated provider is unable to provide an assessment for all body systems for the injured person due to specialist availability;
- an injured person has previously received a physical or primary psychological assessment from the other or another authorised IME provider; or
- the other or another authorised IME provider operates in an interstate or overseas location closer to where the injured person resides or works and is able to arrange the assessment.

An insurer must keep a register of all referrals to authorised IME providers.

6.4 Arranging appointments with an independent medical examiner by the authorised IME provider

6.4.1 An insurer must prepare a written referral to the authorised IME provider. The referral is to be made using a form made available by the MAI Commission. The referral is to detail the injuries and body systems to be covered by the WPI assessment report and whether the insurer has received either a notice or information for a diagnosis of a psychological or psychiatric disorder.

6.4.2 The referral must indicate when a person is likely to be available for medical examinations and include details of any special needs, such as an interpreter services, that need to be accommodated for at an appointment.

6.4.3 The IME provider is responsible for arranging one or more independent medical examiners to carry out a WPI assessment of the injured person.

6.4.4 An insurer must also give the authorised IME provider all medical and allied health information, including results of clinical investigations in their possession relevant to the assessment, at least 10 calendar days before an appointment with an examiner. Information should include information about the onset of injury, subsequent treatment, diagnostic imaging and tests, and functional assessments of the person claiming the impairment. All documents should be appropriately indexed and organised in a manner to minimise file review times by the examiner.

6.4.5 If the injured person has requested that an accompanying person be present at the assessment the referral should include the name, relationship to the injured person, and role of this person.

6.4.6 The insurer may arrange for the authorised IME provider to communicate directly with the injured person about appointment bookings. In doing so, the authorised IME provider must inform the insurer of all appointment arrangements including any cancellation, non-attendance or rescheduling of appointments by either the applicant or the authorised IME provider.

6.4.7 An injured person must be given at least 10 business days written notice of any appointment with an independent medical examiner. The insurer is responsible for ensuring the appointment notice is given to the injured person and may make arrangements for the notice to be sent out by the IME provider on their behalf. The notice period may only be reduced or waived on agreement from the injured person and provided the insurer has already given the IME provider all information necessary to undertake an assessment. If a person has complex injuries a single notice may cover multiple appointments. The notice must include the following information about a given appointment:

- the name, specialty, and qualifications of the independent medical examiner;
- the injuries and body system/s covered by the referral noting the appointment is for the purposes of assessing impairment and not for medical treatment;

- the date, time, and location of the appointment, contact details for the examiner's offices and appropriate travel directions or arrangements;
- the likely duration of the appointment;
- how to cancel the appointment;
- the consequences of a late cancellation or a non-attendance for an appointment;
- Information the injured person should bring to the appointment (such as X-rays not in electronic form) or give to the examiner prior to the appointment;
- arrangements for an accompanying person to be present during an appointment, noting that the person is not to participate in the assessment, other than to assist the examiner in communicating with the person, and any accompanying person may be asked to leave the assessment room if requested by an examiner. Where the injured person is a child or a person with an intellectual disability, the examiner may request the support person remain in the room but not communicate with the injured person if there is a concern they are interfering with the assessment;
- arrangements for paying travel expenses; and
- how complaints can be made and how they will be handled.

A notice of an appointment may be sent to an injured person by post or electronically.

6.5 Payment for WPI assessment

6.5.1 An insurer will be responsible for directly paying an IME provider for a WPI assessment report and related costs requested on referral by an insurer. The IME provider will invoice in accordance with the fee schedule agreed by the MAI Commission. An IME provider must be paid within 10 business days of the insurer receiving a properly completed WPI report and invoice.

6.5.2 An insurer is not required to arrange for a referral for an assessment, or make an appointment with an IME provider, if the insurer has not received a payment or contribution for the cost of an assessment from an injured person in the following listed circumstances:

- the insurer believes a person's injuries are stable and the person is not likely to have a permanent impairment (Section 139 of the MAI Act);
- a second assessment is required for a person, because an assessment requested by the person under subsection 140(3) of the MAI Act confirmed the person's injuries had not stabilised; or
- a second assessment is required under subparagraph 141(5)(c)(ii) of the MAI Act because a person who has received an estimated WPI has applied to stay common law proceedings until their injuries have stabilised.

6.5.3 If an excess is paid by a person in accordance with subsection 139(5) of the MAI Act and the WPI assessment report confirms the person's WPI is greater than 0%, the insurer must reimburse the excess to the person within 10 business days of receiving the WPI assessment report.

6.5.4 If the IME provider is required to arrange a further appointment because a person did not attend an earlier appointment and did not give the insurer a reasonable excuse for their non-attendance, the person must pay any cancellation fee charged by the IME provider as a result of the missed appointment.

6.5.5 An insurer must also pay the reasonable and necessary travel expenses for a person to attend a WPI assessment on referral from an insurer, with the exception of a referral for a second assessment required because an assessment requested by the person under subsection 140(3) of the MAI Act confirmed the person's injuries had not stabilised.

6.5.6 If an injured person arranges for a private medical examiner to carry out a second WPI assessment the person will be responsible for paying for the WPI assessment report and for any travel expenses incurred in attending the WPI assessment.

7. VALIDATING A WPI ASSESSMENT REPORT

7.1 Before giving an injured person a copy of a WPI report and any offer of quality of life benefits under sections 154 to 157 of the MAI Act an insurer must first be satisfied that the WPI report reflects an assessment carried out in accordance with the WPI Assessment Guidelines. An insurer must have its own quality assurance process in place to confirm the validity of WPI reports, noting quality assurance is also undertaken by the authorised IME provider.

7.2 A WPI report may not be valid if it does not:

- address whether an injury or condition has reached maximum medical improvement as required by clause 1.15 of the WPI Assessment Guidelines;
- provide a history and findings from the examination;
- provide opinion as to whether the applicant has suffered a permanent impairment from injuries caused by or resulting from the accident;
- provide details and make a deduction from the final level of impairment for any known pre-existing injuries or conditions, or for other assessed injuries not caused by the motor accident;
- exclude any secondary psychological injury from an assessment of primary psychological injuries;
- determine the degree of impairment using the tables, graphs, and the methodology in the WPI Assessment Guidelines and the American Medical Association Edition 5 (referred to as AMA 5) where applicable, and provide a clear calculation of the percentage as a whole number;
- include a statement and certification from the assessor to the effect that:
 - the assessor has completed training in AMA 5 and their specialisation
 - evaluated the person's permanent injuries as a result of a motor accident and

that the WPI assessment has been conducted in accordance with the *Motor Accident Injuries (WPI Assessment) Guidelines 2019*.

7.3 An insurer may seek corrections or compliance clarifications on receipt of a WPI assessment report through requesting a superseding report from the authorised IME provider. In this circumstance, the time frame for giving a notice under sections 154 to 157 of the MAI Act will not commence until the insurer receives a superseding report from the authorised IME provider. The body of the superseding report must include a statement that explains that it supersedes the previous WPI report. The superseding report process is not to be used by an insurer to seek/ask additional questions that were not present in the initial referral, to provide any additional information not made available to the assessor at the time of the assessment, or to question/change any clinical judgments made by the assessor in preparing the WPI report.

8. REQUIREMENTS FOR SECOND WPI REPORTS

8.1 These guidelines make provision for an injured person's responsibilities in relation to obtaining a second WPI report and providing a valid report. Under the MAI Act, a private medical examiner, trained in the WPI Assessment Guidelines, undertakes this assessment.

8.2 An injured person does not have to obtain a second WPI report. The injured person is to notify the insurer that they will be seeking their own WPI report because they disagree with the first WPI report. This has the effect of pausing the benefit.

8.3 The second WPI report must be provided to the insurer within 26 weeks after the date of the notice given under sections 154 to 156. If a notice is given under section 157, a longer due date for providing the second WPI report may apply. The costs of a second WPI report are for the injured person to pay. Note, if the outcome of the assessment is for a higher WPI percentage because the first WPI report is less than 10 per cent, the insurer may reimburse the cost of the report if there is a motor accident claim.

8.3 To obtain a valid second WPI report, the injured person must ensure that the private medical examiner is informed they are to conduct the assessment in accordance with these guidelines, including clause 7.2, the WPI Assessment Guidelines, and the MAI Act. A report not prepared accordingly may be invalid. A second WPI report cannot be obtained before, or at the same time, as the insurer-initiated assessment.

8.3 The second WPI report should be based on the same supporting documents as the insurer-initiated assessment. If there has been an updating or additional reports that were obtained after the insurer-initiated assessment but before the private medical examiner undertakes their assessment, the updating or additional reports are to be provided to the insurer with the second WPI report.

8.4 To facilitate a second WPI report being comparable to an insurer-initiated assessment, the content of a second WPI report should contain the following (to be consistent with clauses 7.2 and 9.5):

- confirm that the assessor is a private medical examiner providing a report for the purposes of section 158 of the Motor Accident Injuries Act
- confirm the date the applicant attended for assessment
- include a history
- include findings on examination and provide confirmation of the diagnosis
- reference relevant medical reports and documents the assessor had in their possession for the assessment, including those referred to in the first WPI report (note, this may be more than one if multiple body systems are involved)
- provide opinion as to whether the applicant has suffered a permanent impairment from injuries caused or resulting from the accident
- provide details of any relevant pre-existing injuries or conditions, the status of these injuries at the time of the accident, and any aggravating events/injuries post the motor accident
- provide opinion as to whether the applicant's presentation is consistent with the medical information and the first assessor's observations
- provide a clear explanation of any calculation of whole person impairment from the injuries in the motor accident including deductions where relevant
- contain a statement that the assessor has completed training in AMA5 and their specialisation and have conducted the assessment in line with the modifications contained in the Motor Accident Injuries (WPI Assessment) Guidelines 2019.

8.5 The second WPI report is to be self-contained and only prepared for the purpose of the WPI assessment. It therefore should not include an Expert Witness Statement or cover any injuries or conditions not referred to in the first WPI report. An injured person should alert the provider to the requirements of clause 8 when arranging the report. Limited additional questions may be answered by the private medical examiner, for example details of any treatment, therapy or referrals recommended for the injured person.

9. FINAL OFFER WPI

9.1 These guidelines make provision for an insurer's responsibilities in relation to second WPI reports including matters an insurer can consider in making a *final offer WPI* under subsection 160(2) of the MAI Act and for giving reasons for a final offer WPI decision.

9.2 Section 160 of the MAI Act applies if the relevant insurer receives a second WPI report from the injured person, and the injured person has not yet made a complying common law claim. If section 160 applies, the insurer must decide the final offer WPI. The insurer's final offer must not be less than the WPI in the original report (first WPI report) if it has not been reviewed by the Independent Medical Examiner (IME) under section 159 of the MAI Act, or if reviewed, must not be less than the notice affirming or increasing the WPI for the first WPI report.

9.3 An insurer must rely on the level of whole person impairment determined by the IME or private medical examiner (the assessors) from an assessment that was carried out in accordance with the *Motor Accident Injuries (WPI Assessment) Guidelines 2019* (WPI Guidelines). An insurer is not required to independently evaluate the level of impairment in a WPI report based on medical evidence they may have in their possession.

9.4 A final WPI offer must be made on the basis of a WPI report for an assessment carried out in accordance with the WPI Guidelines. An insurer may make a final WPI offer, for a WPI between the WPI for the first WPI report and the second WPI report, provided the WPI percentage is a whole number. This could include circumstances where there was inconsistency in clinical judgments made by the two assessors in applying the evaluation methodology or inconsistent presentations by the injured person of their injuries/condition at appointments with the two assessors.

9.5 In making a final WPI offer decision an insurer may disregard a second WPI report, in whole or part, if the insurer is not satisfied that the assessment was carried out in accordance with the WPI Guidelines. An insurer may form its belief about the validity of a report based on reasons given by the IME with a written notice under section 159 of the MAI Act. An insurer may also consider whether the principles of, and administrative processes for, an assessment in Chapter 1 of the WPI Guidelines have been followed in preparing the second WPI report, including by considering matters in Paragraph 7.2 of these guidelines. An insurer may also disregard a second WPI report if the insurer is not satisfied that the second assessor considered relevant information made available to the first assessor or if the second assessment includes injuries or conditions not evaluated in the first assessment. This could be evidenced by the second WPI report:

- not referencing that the second assessor had in their possession relevant medical reports and documents which were referred to in the first WPI report; or
- including, in the final level of impairment, injuries or conditions not identified in the original WPI report as being caused or resulting from the motor accident.

An insurer must have processes in place to give an injured person seeking a second WPI report, any relevant medical reports and documents not already in the injured person's possession, which the insurer provided for the first WPI assessment.

9.6 In making a final offer WPI an insurer is to give reasons in writing as the insurer must decide a WPI to determine the final offer. The reasons need only record the relevant facts and reference evidence such as the assessment and section 159 reports relied upon by the insurer for the determination. If an insurer disregards a second WPI report, in whole or part, the insurer is to state their reasons for doing so. If a second report is disregarded in part, an insurer must not make any adjustments to the assessed degree of impairment in the second report requiring a clinical judgement including for the attribution of any injuries to the motor accident.

10. INFORMATION AND SUPPORT – WPI TAKEN TO BE 10% IN CERTAIN CIRCUMSTANCES

10.1 These guidelines make provision for information and support an insurer is obliged to give a person under paragraph 52(2)(f) of the MAI Act who is taken under section 133 of the MAI Act to have a WPI of 10 per cent. A person who was a child at the time of an accident and at four years and six months after the motor accident is either receiving treatment and care meeting the requirements of the regulation, or a participant in the LTCS scheme, will be taken to have a WPI of 10 per cent.

10.2 An insurer must identify any injured person that is taken to have a WPI of 10 per cent under section 133 of the MAI Act, and contact the person in writing (or a parent/guardian in the case of a minor), one month prior to reaching 4 years and six months from the date of the motor accident. The insurer does not need to contact a person that has received a written notice under subsection 157(2) or 164(2) of the MAI Act and has lodged a notice of claim within the time frames permitted for the notice. An insurer must include information about the person's eligibility to make a common law claim, the time frames for the person to lodge a notice of claim and that the person may wish to seek legal advice as to whether to make a claim for damages.

11. INFORMATION AND SUPPORT – WPI OFFERS

11.1 These guidelines make provision for the information and support an insurer is obliged to give a person that receives a WPI offer about making a motor accident claim for the purposes of paragraph 52(2)(g) of the MAI Act.

11.2 An insurer must include with a written notice given to an injured person under subsection 157(2) or 164(2) of the MAI Act statements about the time frame for the person to lodge a notice of claim, and the insurer is unable to provide legal advice as to whether to make a claim for damages, and may include the contact details of the ACT Law Society for referral to a legal service provider.

From: Sch 2.2(a)(ii)
Sent: 17/10/2025 10:34 AM
To: "Forey, Melanie" <Melanie.Forey@act.gov.au>
Subject: RE: Consultation Draft- Motor Accident Injuries (Quality of Life Benefit) Guidelines

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Melanie –
I

apologise for the significant delay in responding.

Confirming that we haven't provided comments on this occasion.

Thank you as always for sharing the draft with us for comments, it's greatly appreciated.

Kind regards,
Sch 2.2(a)(ii)



Sch 2.2(a)(ii)

GPO Box 1562, Canberra ACT 2601
actlawsociety.asn.au

From: Forey, Melanie <Melanie.Forey@act.gov.au>
Sent: Monday, 13 October 2025 10:35 AM
To: Sch 2.2(a)(ii)
Subject: FW: Consultation Draft- Motor Accident Injuries (Quality of Life Benefit) Guidelines

OFFICIAL

Good morning Sch 2.2(a)(ii),

I tried to call you this morning and left a message but then thought it might be easier to email you.

As per below consultation feedback for the attached Quality of Life Guidelines closed on 10 October. I am after confirming please that there are no comments from the ACT Law Society?

Best regards,

Melanie Forey

Assistant Director
MAI Regulatory Policy and Supervision
Insurance | Economic and Financial Policy Group
Treasury | Chief Minister, Treasury and Economic Development Directorate
ACT Government | act.gov.au | GPO Box 158 CANBERRA ACT 2601



I acknowledge the Ngunnawal People as traditional custodians of the ACT and recognise any other people or families with connection to the lands of the ACT and region.
I acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.



Artist: Richie Allan

From: Lejins, Erica
Sent: Thursday, 18 September 2025 4:13 PM
To: Sch 2.2(a)(ii)
Subject: FW: Consultation Draft- Motor Accident Injuries (Quality of Life Benefit) Guidelines

Dear Sch 2.2(a)(ii),

Please see the attached request for consultation feedback below. My apologies it was sent to an incorrect email address.

Erica

From: Lejins, Erica
Sent: Wednesday, 17 September 2025 3:59 PM
To: 'ceo@actbar.com.au' <ceo@actbar.com.au>; 'Committee' <committee@actlawsociety.asn.au>
Cc: Sch 2.2(a)(ii); MAI Commission <maic@act.gov.au>
Subject: Consultation Draft- Motor Accident Injuries (Quality of Life Benefit) Guidelines

Dear Stakeholders,

Earlier this year, the MAI Commission provided for comment a short form review of four updated guidelines. Three of the guidelines were subsequently made on 10 July 2025. The fourth included with the package was the Quality of Life Benefit guidelines. The earlier draft circulated in March 2025 had foreshadowed two options for requests for psychological assessments.

The revised draft now incorporates feedback received in relation to the earlier draft. The incorporation of all feedback required a reframing of the Guidelines, which has also provided the MAI Commission with the opportunity to include updates providing clarity about steps an insurer must undertake to validate a WPI report, the handling of second WPI reports, and final WPI offers. The introduction has been expanded to include a background section to better assist members of the public who may be handling their own defined benefits application with information in one location.

If you wish to provide comments or feedback on the guidelines, we request these by close of business **Friday 10 October 2025**. Your comments can be directed to the MAI Commission inbox. If you wish to discuss the guidelines, you can contact the MAI Commission on 6207 8876.

With regards

Erica Lejins

Director
MAI Regulatory Policy and Supervision
Insurance | Economic and Financial Policy Group
Treasury | Chief Minister, Treasury and Economic Development Directorate
ACT Government | GPO Box 158 CANBERRA ACT 2601

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I acknowledge the Ngunnawal people as the traditional custodians of the ACT and recognise any other people or families with connection to the lands of the ACT and region. I acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

This email, and any attachments, may be confidential and also privileged. If you are not the intended recipient, please notify the sender and delete all copies of this transmission along with any attachments immediately. You should not copy or use it for any purpose, nor disclose its contents to any other person.

Australian Capital Territory

Motor Accident Injuries (Quality of Life Benefit) Guidelines 2025

Disallowable instrument DI2025

made under the

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

1 Name of instrument

This instrument is the *Motor Accident Injuries (Quality of Life Benefit) Guidelines 2025*.

2 Commencement

This instrument commences on the 7th day after its notification.

3 Guidelines

I make the guidelines attached to this instrument.

4 Revocations

The *Motor Accident Injuries (Quality of Life Benefit) Guidelines 2023* (DI2023-311) is revoked.

MAI Commissioner

MAI Commission

2025

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Quality of Life Benefit Guidelines

1. INTRODUCTION

The Quality of Life Benefit guidelines (guidelines) are part of the MAI guidelines made under section 487 of the *Motor Accident Injuries Act 2019* (MAI Act). The Guidelines detail the insurers' obligations in providing information and support to potential applicants for quality of life benefits, procedures for arranging Whole Person Impairment (WPI) assessments and making offers for quality of life defined benefit amounts. They also detail the process for an injured person to obtain a valid second WPI report.

Background

The quality of life (QOL) benefit is a recognition payment for a person's permanent injuries caused by the accident and may be offered following a WPI assessment carried out in accordance with the *Motor Accident Injuries (WPI Assessment) Guidelines 2019* (WPI Assessment Guidelines). An application for the benefit may be made no earlier than 26 weeks after the motor accident. The injuries sustained in the accident need to have stabilised sufficiently for an assessment. The benefit is payable for WPI assessments of 5 per cent or more, with the benefit amount set out in legislation and based on the WPI figure (a whole number). A person with a WPI assessment of 10 per cent or more from the first WPI report may choose to access common law if they were not at fault.

The first WPI assessment is made on referral by an insurer to an authorised IME provider. The IME provider appoints qualified and experienced independent medical examiners (IMEs) to carry out WPI assessments. This authorisation by the MAI Commission is to facilitate the first WPI assessment. The IME providers have a national presence and are able to select IMEs from around the country.

On referral by the insurer, the IME provider will select the independent medical examiner (IME) relevant for the permanent injuries needing to be assessed. This process is so that the IME undertaking the assessment has not been appointed by either an insurer or a legal representative. There is no process of selecting from several IMEs as it will be subject to availability.

If an injured person is unhappy with the first assessment and wants another assessment, they are able to select and pay for their own private medical examiner (PME) to conduct a second WPI report. There is no requirement to approach the authorised IME provider for a PME. It is important, though, that the PME is qualified and experienced in carrying out ACT WPI assessments. The second report is to meet the same conditions as the first so that it can be relied upon to make the offer for the QOL benefit or to lodge a notice of claim.

2. STATUTORY FRAMEWORK

Division 2.6.2 of the MAI Act makes provision for an injured person to make a quality of life benefits application. A precondition for the application is that the injured person has received a receipt notice or late receipt notice under section 60 of the MAI Act. An injured person cannot make a quality of life benefit application earlier than 26 weeks after a motor accident and not later than 4 years and six months after an accident.

The legislative framework for quality of life benefits includes:

- a. the MAI Act;
- b. the Motor Accident Injuries Regulation 2019 (the Regulation); and
- c. these Guidelines made under the MAI Act.

Also, the WPI Assessment Guidelines apply to any WPI assessment undertaken for the purposes of the MAI Act.

3. INFORMATION AND SUPPORT FOR APPLICANTS FOR QUALITY OF LIFE BENEFITS

3.1 These guidelines make provision for the information and support an insurer is to give a person about making an application for quality of life benefits for the purposes of paragraph 52(2)(e) of the MAI Act. The information pack is intended to assist an injured person in making an informed decision about requesting a WPI assessment.

3.2 The information pack is required to be provided about:

- the eligibility requirements for a quality of life defined benefit or to make a motor accident claim;
- how to apply for a quality of life benefit, and the time frame for making an application;
- the need for a person's injuries to be stable for a permanent impairment to be assessed;
- conditions for requesting a WPI assessment for primary/secondary psychological injuries;
- requirements for requesting a WPI assessment for a primary psychological injury, including the definition of a primary psychological injury, the requirement to have undergone mental health treatment and to provide a notice under subsection 150(3) of the MAI Act and paragraphs 4.2 and 4.3 of these guidelines;
- the definition of a secondary psychological injury and requirements for a secondary psychological injury to be taken into account as part of a physical assessment;
- how an insurer will arrange for an assessment with the independent medical examiner provider, expected waiting times for an assessment and the person's obligations if they request an assessment;
- how a WPI assessment is carried out and where a person can access the MAI guidelines about permanent impairment assessments; and

- arrangements for paying for a WPI assessment, including the circumstances a person will be required to pay an excess for an assessment and the circumstances in which an excess can be returned.

3.3 An insurer must provide an information pack about quality of life payments to an applicant for defined benefits (other than persons mentioned in paragraph 3.6) prior to the injured person first becoming eligible to make a quality of life application. The pack is to be provided no earlier than 24 weeks after the date of an accident. Where the period of 26 weeks after the date of the accident has passed, for example a late application is made and accepted, the insurer should provide the information pack after the insurer has accepted liability for the application. An insurer may provide general information about the benefit, noting the need for treatment to have occurred and stability of injuries that are of a permanent nature.

3.4 To assist an injured person who may request an assessment for a primary psychological injury the insurer may include a template for a notice under subsection 150(3) of the MAI Act when providing the information pack.

3.5 An insurer must consider their duty to act in good faith when determining the timing of the issue of an information pack. This includes the insurer's duty in paragraph 20(4)(a) of the MAI Act to disclose, as soon as practicable, all information that an applicant may need to understand the process for applying for defined benefits.

3.6 The information pack must also be provided on request by any other person who has made a defined benefits application. Information packs may be sent electronically or by post.

3.7 An insurer does not need to provide an information pack at 24 weeks when a person:

- was charged with a serious driving offence or one or more driving offences;
 - is a foreign national and has permanently departed Australia;
- or if -**
- the insurer has denied liability for the person's defined benefits application;
 - the person returned to work at full capacity or their usual activities within 28 days after the motor accident;
 - the insurer reasonably believes that the person's physical or any psychological injuries are not stable; or
 - the insurer reasonably believes that the person's injuries are stable but they are not likely to have a permanent impairment from injuries as a result of the motor accident.

4. QUALITY OF LIFE BENEFITS APPLICATION

4.1 For the purposes of paragraph 137(3)(b) of the MAI Act a quality of life benefits application must include the following details:

- name of the injured person;

- the individual claim identifier provided by the insurer;
- the types of injuries for which an assessment is being sought being physical and/or primary psychological in the applicant's own words;
- an acknowledgement they have received sufficient treatment to inform the insurer of the stability of their injuries;
- details of the person's availability on weekdays for an assessment in the next three months and an acknowledgement an assessment may not occur in that time;
- details of any special needs of the person in attending an assessment – such as accessibility, cultural or language needs;
- whether the person requires an accompanying person to be present at the assessment together with the name, relationship and role of this person; and
- information about any offence the person has been charged with, or convicted or found guilty of, in relation to the accident.

4.2 For the purposes of paragraph 137(3)(c) of the MAI Act, a quality of life benefit application for a person requesting a primary psychological assessment must be accompanied by a written notice in accordance with clause 4.3 from a psychiatrist, or clinical psychologist in accordance with subsection 150(3) of the MAI Act and these guidelines. A psychiatrist is a medical practitioner with specialist registration with the Australian Medical Board in the field of psychiatry. Similarly, a clinical psychologist is a registered psychologist that has been endorsed by the Psychological Board of Australia to practise as a clinical psychologist. Registration is required with the Australian Health Practitioners Registration Authority.

4.3 The notice from the psychiatrist or clinical psychologist must include:

- a diagnosis of the primary psychological injury resulting from the accident based on a recognised diagnostic system and specify the diagnostic criteria upon which the diagnosis is based;
- a list of the type and frequency of treatment, providing comment on the effectiveness of any treatment the person has received for the primary psychological injury resulting from the accident;
- an opinion from the psychiatrist or clinical psychologist as to whether they consider the injury is well stabilised and unlikely to change substantially, with or without mental health treatment intervention, in the next year; and
- a statement from the psychiatrist or clinical psychologist that they reasonably believe the person is likely to have a permanent psychological injury resulting from the accident.

4.4 The following information may also accompany a quality of life benefits application but is not a mandatory requirement to complete the application:

- any medical reports about the status of the person's injuries that have not been provided directly to an insurer by a treating health practitioner of the injured person. This could include any reports about whether a person's injuries are stable or whether a person is likely to have a permanent impairment.

If under section 6.1 of these guidelines, the insurer has inconclusive information about the status of a person's injuries, the above information may also be subsequently requested by an insurer.

4.5 A quality of life benefits application may be made using a prescribed form made available on the MAI Commission's website or provided by an insurer. The application is to be made in writing and may be given to the insurer by electronic means, by personal delivery or by post.

5. APPLICATION FOR A WPI ASSESSMENT FOR A PERSON THAT HAS MADE A SUCCESSFUL WORKERS COMPENSATION CLAIM

5.1 Under Part 5.3 of the MAI Act, a person may apply to an insurer for the motor accident claim for an assessment of their WPI if:

- they have made a successful application for workers compensation benefits; and
- they have given a notice of claim under the *Civil Law (Wrongs) Act 2002*.

5.2 The application should include information about the WPI assessments the injured person is seeking. The application should also be accompanied by an authority to disclose personal health information that covers the exchange of personal health information between:

- the motor accident insurer;
- the injured person's stated workers compensation insurer (if applicable);
- treating health service providers or a treating team;
- an authorised IME provider; and
- an independent medical examiner who conducts a WPI assessment.

5.3 For the purposes of subsection 241(2) of the MAI Act, an insurer must give an acknowledgement notice to the injured person within 5 business days of receiving the application for a WPI assessment.

5.4 Note, under section 240 of the MAI Act, an application for an assessment is not required if the person has had an assessment conducted by a private medical examiner in accordance with the WPI assessment guidelines. The insurer may consider whether the assessment complies with the WPI Assessment Guidelines (including the ACT modifications to AMA5). The report should include a clear assessment of the percentage of WPI, the rationale and reference all medical information used.

6. PROCEDURE FOR ARRANGING A WPI ASSESSMENT

This section, and those in section 7, make provision for the procedures for arranging a WPI assessment under section 147 of the MAI Act.

6.1 Status of a person's injuries

6.1.1 An insurer has 20 business days to consider a quality of life benefits application, to allow for gathering up information and to assess the injuries of the injured person. This period will not commence for a quality of life benefit application that includes a request for a primary psychological assessment until the insurer is satisfied that the requirements of subsection 150(3) of the MAI Act are satisfied.

6.1.2 When assessing the injuries, the insurer may rely on the medical information available to them or seek an independent opinion on whether the injured person's injuries have stabilised. If an insurer seeks an independent opinion (including an examination) they should ensure the injured person is aware:

- it is a medical assessment for only this purpose (e.g. an assessment of their injuries' stabilisation); and
- it is not the WPI assessment arranged by the authorised IME provider.

6.1.3 An insurer must refer an injured person to an authorised IME provider for a WPI assessment if an insurer "reasonably believes":

- the person's injuries have stabilised; and
- the person is likely to have a permanent impairment as a result of the injuries.

6.1.4 An insurer must refer an injured person to an authorised IME provider for a WPI assessment if:

- the insurer "reasonably believes":
 - a person's injuries are stabilised;
 - the person is not likely to have a permanent impairment as a result of the injuries; and
- the injured person pays an excess amount for the assessment to the insurer.

An insurer is to give a written notice consistent with subsection 139(2) of the MAI Act.

6.1.5 An insurer must recommend to an injured person that the WPI assessment be delayed if:

- an insurer "reasonably believes" a person's injuries have not stabilised; and
- it is less than 4 years and 6 months after the date of the motor accident.

An insurer is to give a written notice consistent with subsection 140(2) of the MAI Act. An injured person may still request that an insurer makes an immediate referral for a WPI

assessment, but if the assessment confirms the person's injuries are not stable an insurer is not obliged to pay for a second assessment.

6.1.6 For the purposes of these guidelines, to assess stability an insurer may consider the treatment the injured person has, whether there has been a substantial change in the requested treatment (for example, fewer sessions occurring) and how their condition has settled. The insurer may also consider whether further medical treatment would have a substantive effect on their condition at the time of the application.

6.1.7 An insurer's reasonable belief about the stability of a person's injuries, and the likelihood of a permanent impairment should be based on information the insurer has in their possession about the person's injuries, treatment and recovery following receipt of the application. If this information is inconclusive the insurer should make reasonable inquiries with the person's treating health practitioners. If, after this step, information is still not conclusive, the insurer is to inform the injured person it may be necessary to obtain an independent medical review to establish stability of their physical injuries.

6.1.8 An insurer may consider the clinical evidence but must rely on a notice given by a psychiatrist or clinical psychologist under subsection 150(3) of the MAI Act to form a reasonable belief about the stability of a person's injuries and whether the person is likely to have a permanent primary psychological impairment. The notice is to reference the treatment the injured person has received (which may be from one or more practitioners for the mental health treatment required for the injured person's injury). It is a requirement that the person has received mental health treatment under section 150(3) before an injured person may request a WPI assessment. Generally, a course of treatment would include several sessions over a period of time that is appropriate for the diagnosis. This may be guided by the Recovery Plan put in place by agreement between the injured person, the treating professional, and the MAI insurer.

6.1.9 If an injured person has requested both a physical and a primary psychological assessment, an insurer will not be required to make a referral to an authorised IME provider until requirements in Division 2.6.2 of the MAI Act for making a referral are satisfied for both kinds of injuries or the injured person otherwise makes an informed decision to proceed with a separate referral for one kind of injury only. If a separate referral is made for one kind of injury, then the time frames for making the WPI report available and any quality of life benefit offer under sections 154 to 157 of the MAI Act are to apply as if there is only one WPI report. The injured person should be made aware that if they proceed with the assessment, then any quality of life benefit offer from the assessment will not take into account the other kind of injury, and depending on the outcome of the assessment may also result in the early finalisation of their quality of life benefit application.

6.1.10 If the person has physical injuries to multiple body systems an insurer should also reasonably believe that injuries to all physical body systems and any secondary psychological injuries have stabilised before making a WPI assessment referral.

6.1.11 An insurer must separately assess all physical injuries for a given body system to determine whether any of these injuries are likely to result in a permanent impairment. An insurer must not include physical injuries in a referral without first undertaking this assessment and the injured person must not be required to undergo unnecessary WPI assessment appointments.

6.1.10 If an injured person requests a physical injury be included in a referral, and the insurer reasonably believes the injured person is unlikely to have any permanent injuries for the given body system, then consistent with section 139 of the MAI Act an excess must be requested and paid before the referral is made. That is, if the injured person has physical injuries to multiple body systems, then a section 139(2) assessment is to be applied for each body system, rather than for the WPI assessment as a whole. However, only one excess under section 139(5) is payable. The excess is to be refunded if permanent injuries are subsequently identified.

6.2 The time within which a WPI assessment must be arranged

6.2.1 When an insurer is required to refer an injured person to an authorised IME provider for a WPI assessment they must:

- provide the injured person with a written notification in accordance with section 6.2.2; and
- send a written referral for the injured person to an authorised IME provider for a WPI assessment in accordance with section 6.2.3.

6.2.2 The insurer must provide the injured person with written notification of:

- the injuries and body systems which will be covered by the assessment;
- the person's medical history to be set out in the referral; and
- a list of the medical and health information in their possession which they will be providing to the authorised IME provider for the assessment.

The insurer may give the injured person a completed draft of the IME provider's referral form (without the file attachments that will be given to the IME provider) for these purposes.

This written notice must occur no later than 5 business days after the injured person:

- is eligible for an assessment under section 138 of the MAI Act; or
- confirms and pays an excess for a WPI assessment under subsection 139(3) of the MAI Act; or
- the person requests a WPI assessment under subsection 140(3) of the MAI Act; or
- the person notifies the insurer that their injuries have stabilised in accordance with subparagraph 141(5)(c)(ii) of the MAI Act.

The purpose of notification is for the injured person to be informed of the scope of the assessment and also provide an opportunity for the injured person to provide the

insurer/IME provider with any additional information they may have in their possession which may be relevant to the assessment.

6.2.3 An insurer must then send a written referral for the injured person to an authorised IME provider for a WPI assessment, for all injuries for which a person is likely to have a permanent impairment. This written referral must occur no later than 10 business days after the injured person:

- is eligible for an assessment under section 138 of the MAI Act; or
- confirms and pays an excess for a WPI assessment under subsection 139(3) of the MAI Act; or
- the person requests a WPI assessment under subsection 140(3) of the MAI Act; or
- the person notifies the insurer that their injuries have stabilised in accordance with subparagraph 141(5)(c)(ii) of the MAI Act.

If the injured person indicates additional information is to be provided, the insurer may defer making the written referral. After receipt of the information, the insurer has an additional 5 business days before making the referral. This is to allow the insurer time to consider the relevance of the additional information to the referral and make any necessary inquiries.

6.2.4 An injured person's application for quality of life benefits is suspended for the period a person has outstanding charges in relation to the motor accident for one or more driving offences, or a serious driving offence. A referral to an IME provider should not be made during the suspension period, and the insurer should inform the applicant about the suspension of the application, and circumstances that the application may be revived, in writing.

6.3 Insurer selecting an IME provider if more than one authorised IME provider

6.3.1 If the MAI Commission has authorised more than one IME provider to arrange WPI assessments, an insurer must put procedures in place to ensure that all authorised IME providers are allocated referrals from an insurer on an equal and sequential basis. For example, if there are two authorised IME providers an insurer should alternate referrals for any given injured person, between the two providers, based on the time and date of a referral. The only exception to this rule should be if:

- the allocated provider is unable to provide an assessment for all body systems for the injured person due to specialist availability;
- an injured person has previously received a physical or primary psychological assessment from the other or another authorised IME provider; or
- the other or another authorised IME provider operates in an interstate or overseas location closer to where the injured person resides or works and is able to arrange the assessment.

An insurer must keep a register of all referrals to authorised IME providers.

6.4 Arranging appointments with an independent medical examiner by the authorised IME provider

6.4.1 An insurer must prepare a written referral to the authorised IME provider. The referral is to be made using a form made available by the MAI Commission. The referral is to detail the injuries and body systems to be covered by the WPI assessment report and whether the insurer has received either a notice or information for a diagnosis of a psychological or psychiatric disorder.

6.4.2 The referral must indicate when a person is likely to be available for medical examinations and include details of any special needs, such as an interpreter services, that need to be accommodated for at an appointment.

6.4.3 The IME provider is responsible for arranging one or more independent medical examiners to carry out a WPI assessment of the injured person.

6.4.4 An insurer must also give the authorised IME provider all medical and allied health information, including results of clinical investigations in their possession relevant to the assessment, at least 10 calendar days before an appointment with an examiner. Information should include information about the onset of injury, subsequent treatment, diagnostic imaging and tests, and functional assessments of the person claiming the impairment. All documents should be appropriately indexed and organised in a manner to minimise file review times by the examiner.

6.4.5 If the injured person has requested that an accompanying person be present at the assessment the referral should include the name, relationship to the injured person, and role of this person.

6.4.6 The insurer may arrange for the authorised IME provider to communicate directly with the injured person about appointment bookings. In doing so, the authorised IME provider must inform the insurer of all appointment arrangements including any cancellation, non-attendance or rescheduling of appointments by either the applicant or the authorised IME provider.

6.4.7 An injured person must be given at least 10 business days written notice of any appointment with an independent medical examiner. The insurer is responsible for ensuring the appointment notice is given to the injured person and may make arrangements for the notice to be sent out by the IME provider on their behalf. The notice period may only be reduced or waived on agreement from the injured person and provided the insurer has already given the IME provider all information necessary to undertake an assessment. If a person has complex injuries a single notice may cover multiple appointments. The notice must include the following information about a given appointment:

- the name, specialty, and qualifications of the independent medical examiner;
- the injuries and body system/s covered by the referral noting the appointment is for the purposes of assessing impairment and not for medical treatment;

- the date, time, and location of the appointment, contact details for the examiner's offices and appropriate travel directions or arrangements;
- the likely duration of the appointment;
- how to cancel the appointment;
- the consequences of a late cancellation or a non-attendance for an appointment;
- Information the injured person should bring to the appointment (such as X-rays not in electronic form) or give to the examiner prior to the appointment;
- arrangements for an accompanying person to be present during an appointment, noting that the person is not to participate in the assessment, other than to assist the examiner in communicating with the person, and any accompanying person may be asked to leave the assessment room if requested by an examiner. Where the injured person is a child or a person with an intellectual disability, the examiner may request the support person remain in the room but not communicate with the injured person if there is a concern they are interfering with the assessment;
- arrangements for paying travel expenses; and
- how complaints can be made and how they will be handled.

A notice of an appointment may be sent to an injured person by post or electronically.

6.5 Payment for WPI assessment

6.5.1 An insurer will be responsible for directly paying an IME provider for a WPI assessment report and related costs requested on referral by an insurer. The IME provider will invoice in accordance with the fee schedule agreed by the MAI Commission. An IME provider must be paid within 10 business days of the insurer receiving a properly completed WPI report and invoice.

6.5.2 An insurer is not required to arrange for a referral for an assessment, or make an appointment with an IME provider, if the insurer has not received a payment or contribution for the cost of an assessment from an injured person in the following listed circumstances:

- the insurer believes a person's injuries are stable and the person is not likely to have a permanent impairment (Section 139 of the MAI Act);
- a second assessment is required for a person, because an assessment requested by the person under subsection 140(3) of the MAI Act confirmed the person's injuries had not stabilised; or
- a second assessment is required under subparagraph 141(5)(c)(ii) of the MAI Act because a person who has received an estimated WPI has applied to stay common law proceedings until their injuries have stabilised.

6.5.3 If an excess is paid by a person in accordance with subsection 139(5) of the MAI Act and the WPI assessment report confirms the person's WPI is greater than 0%, the insurer must reimburse the excess to the person within 10 business days of receiving the WPI assessment report.

6.5.4 If the IME provider is required to arrange a further appointment because a person did not attend an earlier appointment and did not give the insurer a reasonable excuse for their non-attendance, the person must pay any cancellation fee charged by the IME provider as a result of the missed appointment.

6.5.5 An insurer must also pay the reasonable and necessary travel expenses for a person to attend a WPI assessment on referral from an insurer, with the exception of a referral for a second assessment required because an assessment requested by the person under subsection 140(3) of the MAI Act confirmed the person's injuries had not stabilised.

6.5.6 If an injured person arranges for a private medical examiner to carry out a second WPI assessment the person will be responsible for paying for the WPI assessment report and for any travel expenses incurred in attending the WPI assessment.

7. VALIDATING A WPI ASSESSMENT REPORT

7.1 Before giving an injured person a copy of a WPI report and any offer of quality of life benefits under sections 154 to 157 of the MAI Act an insurer must first be satisfied that the WPI report reflects an assessment carried out in accordance with the WPI Assessment Guidelines. An insurer must have its own quality assurance process in place to confirm the validity of WPI reports, noting quality assurance is also undertaken by the authorised IME provider.

7.2 A WPI report may not be valid if it does not:

- address whether an injury or condition has reached maximum medical improvement as required by clause 1.15 of the WPI Assessment Guidelines;
- provide a history and findings from the examination;
- provide opinion as to whether the applicant has suffered a permanent impairment from injuries caused by or resulting from the accident;
- provide details and make a deduction from the final level of impairment for any known pre-existing injuries or conditions, or for other assessed injuries not caused by the motor accident;
- exclude any secondary psychological injury from an assessment of primary psychological injuries;
- determine the degree of impairment using the tables, graphs, and the methodology in the WPI Assessment Guidelines and the American Medical Association Edition 5 (referred to as AMA 5) where applicable, and provide a clear calculation of the percentage as a whole number;
- include a statement and certification from the assessor to the effect that:
 - the assessor has completed training in AMA 5 and their specialisation
 - evaluated the person's permanent injuries as a result of a motor accident and

that the WPI assessment has been conducted in accordance with the *Motor Accident Injuries (WPI Assessment) Guidelines 2019*.

7.3 An insurer may seek corrections or compliance clarifications on receipt of a WPI assessment report through requesting a superseding report from the authorised IME provider. In this circumstance, the time frame for giving a notice under sections 154 to 157 of the MAI Act will not commence until the insurer receives a superseding report from the authorised IME provider. The body of the superseding report must include a statement that explains that it supersedes the previous WPI report. The superseding report process is not to be used by an insurer to seek/ask additional questions that were not present in the initial referral, to provide any additional information not made available to the assessor at the time of the assessment, or to question/change any clinical judgments made by the assessor in preparing the WPI report.

8. REQUIREMENTS FOR SECOND WPI REPORTS

8.1 These guidelines make provision for an injured person's responsibilities in relation to obtaining a second WPI report and providing a valid report. Under the MAI Act, a private medical examiner, trained in the WPI Assessment Guidelines, undertakes this assessment.

8.2 An injured person does not have to obtain a second WPI report. The injured person is to notify the insurer that they will be seeking their own WPI report because they disagree with the first WPI report. This has the effect of pausing the benefit.

8.3 The second WPI report must be provided to the insurer within 26 weeks after the date of the notice given under sections 154 to 156. If a notice is given under section 157, a longer due date for providing the second WPI report may apply. The costs of a second WPI report are for the injured person to pay. Note, if the outcome of the assessment is for a higher WPI percentage because the first WPI report is less than 10 per cent, the insurer may reimburse the cost of the report if there is a motor accident claim.

8.3 To obtain a valid second WPI report, the injured person must ensure that the private medical examiner is informed they are to conduct the assessment in accordance with these guidelines, including clause 7.2, the WPI Assessment Guidelines, and the MAI Act. A report not prepared accordingly may be invalid. A second WPI report cannot be obtained before, or at the same time, as the insurer-initiated assessment.

8.3 The second WPI report should be based on the same supporting documents as the insurer-initiated assessment. If there has been an updating or additional reports that were obtained after the insurer-initiated assessment but before the private medical examiner undertakes their assessment, the updating or additional reports are to be provided to the insurer with the second WPI report.

8.4 To facilitate a second WPI report being comparable to an insurer-initiated assessment, the content of a second WPI report should contain the following (to be consistent with clauses 7.2 and 9.5):

- confirm that the assessor is a private medical examiner providing a report for the purposes of section 158 of the Motor Accident Injuries Act
- confirm the date the applicant attended for assessment
- include a history
- include findings on examination and provide confirmation of the diagnosis
- reference relevant medical reports and documents the assessor had in their possession for the assessment, including those referred to in the first WPI report (note, this may be more than one if multiple body systems are involved)
- provide opinion as to whether the applicant has suffered a permanent impairment from injuries caused or resulting from the accident
- provide details of any relevant pre-existing injuries or conditions, the status of these injuries at the time of the accident, and any aggravating events/injuries post the motor accident
- provide opinion as to whether the applicant's presentation is consistent with the medical information and the first assessor's observations
- provide a clear explanation of any calculation of whole person impairment from the injuries in the motor accident including deductions where relevant
- contain a statement that the assessor has completed training in AMA5 and their specialisation and have conducted the assessment in line with the modifications contained in the Motor Accident Injuries (WPI Assessment) Guidelines 2019.

8.5 The second WPI report is to be self-contained and only prepared for the purpose of the WPI assessment. It therefore should not include an Expert Witness Statement or cover any injuries or conditions not referred to in the first WPI report. An injured person should alert the provider to the requirements of clause 8 when arranging the report. Limited additional questions may be answered by the private medical examiner, for example details of any treatment, therapy or referrals recommended for the injured person.

9. FINAL OFFER WPI

9.1 These guidelines make provision for an insurer's responsibilities in relation to second WPI reports including matters an insurer can consider in making a *final offer WPI* under subsection 160(2) of the MAI Act and for giving reasons for a final offer WPI decision.

9.2 Section 160 of the MAI Act applies if the relevant insurer receives a second WPI report from the injured person, and the injured person has not yet made a complying common law claim. If section 160 applies, the insurer must decide the final offer WPI. The insurer's final offer must not be less than the WPI in the original report (first WPI report) if it has not been reviewed by the Independent Medical Examiner (IME) under section 159 of the MAI Act, or if reviewed, must not be less than the notice affirming or increasing the WPI for the first WPI report.

9.3 An insurer must rely on the level of whole person impairment determined by the IME or private medical examiner (the assessors) from an assessment that was carried out in accordance with the *Motor Accident Injuries (WPI Assessment) Guidelines 2019* (WPI Guidelines). An insurer is not required to independently evaluate the level of impairment in a WPI report based on medical evidence they may have in their possession.

9.4 A final WPI offer must be made on the basis of a WPI report for an assessment carried out in accordance with the WPI Guidelines. An insurer may make a final WPI offer, for a WPI between the WPI for the first WPI report and the second WPI report, provided the WPI percentage is a whole number. This could include circumstances where there was inconsistency in clinical judgments made by the two assessors in applying the evaluation methodology or inconsistent presentations by the injured person of their injuries/condition at appointments with the two assessors.

9.5 In making a final WPI offer decision an insurer may disregard a second WPI report, in whole or part, if the insurer is not satisfied that the assessment was carried out in accordance with the WPI Guidelines. An insurer may form its belief about the validity of a report based on reasons given by the IME with a written notice under section 159 of the MAI Act. An insurer may also consider whether the principles of, and administrative processes for, an assessment in Chapter 1 of the WPI Guidelines have been followed in preparing the second WPI report, including by considering matters in Paragraph 7.2 of these guidelines. An insurer may also disregard a second WPI report if the insurer is not satisfied that the second assessor considered relevant information made available to the first assessor or if the second assessment includes injuries or conditions not evaluated in the first assessment. This could be evidenced by the second WPI report:

- not referencing that the second assessor had in their possession relevant medical reports and documents which were referred to in the first WPI report; or
- including, in the final level of impairment, injuries or conditions not identified in the original WPI report as being caused or resulting from the motor accident.

An insurer must have processes in place to give an injured person seeking a second WPI report, any relevant medical reports and documents not already in the injured person's possession, which the insurer provided for the first WPI assessment.

9.6 In making a final offer WPI an insurer is to give reasons in writing as the insurer must decide a WPI to determine the final offer. The reasons need only record the relevant facts and reference evidence such as the assessment and section 159 reports relied upon by the insurer for the determination. If an insurer disregards a second WPI report, in whole or part, the insurer is to state their reasons for doing so. If a second report is disregarded in part, an insurer must not make any adjustments to the assessed degree of impairment in the second report requiring a clinical judgement including for the attribution of any injuries to the motor accident.

10. INFORMATION AND SUPPORT – WPI TAKEN TO BE 10% IN CERTAIN CIRCUMSTANCES

10.1 These guidelines make provision for information and support an insurer is obliged to give a person under paragraph 52(2)(f) of the MAI Act who is taken under section 133 of the MAI Act to have a WPI of 10 per cent. A person who was a child at the time of an accident and at four years and six months after the motor accident is either receiving treatment and care meeting the requirements of the regulation, or a participant in the LTCS scheme, will be taken to have a WPI of 10 per cent.

10.2 An insurer must identify any injured person that is taken to have a WPI of 10 per cent under section 133 of the MAI Act, and contact the person in writing (or a parent/guardian in the case of a minor), one month prior to reaching 4 years and six months from the date of the motor accident. The insurer does not need to contact a person that has received a written notice under subsection 157(2) or 164(2) of the MAI Act and has lodged a notice of claim within the time frames permitted for the notice. An insurer must include information about the person's eligibility to make a common law claim, the time frames for the person to lodge a notice of claim and that the person may wish to seek legal advice as to whether to make a claim for damages.

11. INFORMATION AND SUPPORT – WPI OFFERS

11.1 These guidelines make provision for the information and support an insurer is obliged to give a person that receives a WPI offer about making a motor accident claim for the purposes of paragraph 52(2)(g) of the MAI Act.

11.2 An insurer must include with a written notice given to an injured person under subsection 157(2) or 164(2) of the MAI Act statements about the time frame for the person to lodge a notice of claim, and the insurer is unable to provide legal advice as to whether to make a claim for damages, and may include the contact details of the ACT Law Society for referral to a legal service provider.