THE MOTOR ACCIDENT INJURIES (MAI) SCHEME

The MAI Scheme provides benefits to anyone injured in a motor accident in the ACT for up to 5 years. Benefits include income replacement and reasonable and necessary treatment and care expenses for injuries caused by the accident including the exacerbation of a pre-existing injury.

As a General Practitioner you have a key role in supporting your patient's recovery under the MAI Scheme. As part of completing a medical report for a patient's application to the MAI Scheme you are asked to agree to be involved in the ongoing management of your patient's treatment and recovery from their motor accident injuries.

WHAT IS A RECOVERY PLAN?

A Recovery Plan (Plan) provides certainty to your patient about the delivery and payment of their medical treatment, rehabilitation, and training services for their motor accident injuries. It is tailored to meet your patient's specific needs and circumstances.

A Plan includes details of your patient's injuries, treatment goals, their capacity for activities, including work, and treatment and care approved by the insurer. A patient can also request treatment and care be approved outside of a Plan.

Your patient's benefits under the MAI Scheme can be suspended if they unreasonably fail to undergo all treatment and care in a Plan.

HOW IS A RECOVERY PLAN DEVELOPED?

An MAI insurer will prepare a draft Plan using information gathered from the medical report accompanying an MAI Scheme application, fitness for work certificates, and other medical reports and records. An insurer may also refer your patient for an assessment of their treatment and care needs with a non-treating health practitioner before settling a draft Plan.

You will receive a draft Plan if your patient is unable to resume their pre-accident activities or work duties within 28 days of the insurer confirming they have received your patient's complete application.

REVIEWING YOUR PATIENT'S RECOVERY PLAN

You can review a draft Plan and make recommendations about reasonable and necessary treatment and care to be included in a final Plan.

Your patient will need to give your recommended changes to the insurer within 15 business days of being sent the draft Plan. If the insurer does not hear back from you or your patient within this timeframe the draft Plan will become your patient's final Plan. Otherwise, after your recommendations are considered by the insurer, a final Plan will be sent to you and your patient.

The insurer reviews the current Plan at least every 13 weeks. They will consult with you and your patient on any updates to the Plan following the above process. If your patient requires different treatment, this can be requested outside of the review cycle.

HOW ARE DISPUTES RESOLVED?

If an insurer does not approve requested treatment and care, they must provide your patient with reasons for their decision. Your patient can seek a formal review to change such decisions through the insurer and then externally through the ACT Civil and Administrative Tribunal (ACAT).

FITNESS FOR WORK CERTIFICATES

The fitness for work certificate is another tool to communicate with your patient and an insurer about your patient's treatment and recovery. A fitness for work certificate should generally only be given for a prospective period of up to one month unless clinical reasoning supports a longer period. As a current certificate is required to cover any period your patient is receiving income replacement, appointments should be scheduled before the expiry of a certificate.

FURTHER INFORMATION AND HELP AVAILABLE

To access free assistance and information for you and your patient you can contact the Defined Benefits Information Service, by CARE Inc, via email on DBIS@carefcs.org or phone 1300 209 642.

You can also visit the MAI Commission website for information and copies of forms: act.gov.au/maic