

This tool has been developed as a guide to assist insurers in making decisions of funding for reasonable & appropriate rehabilitation. The needs of every person can be quite different and the insurer needs to look at each case individually when applying this tool to CTP insurance daims.

IS THERE SUFFICIENT EVIDENCE TO SUPPORT A DIRECT RESTIONS PRETWEEN THE INJURY AND THE ACCIDENT? Consider:

- → There is medical evidence to support a causal link between the injury being treated (including aggravation or exacerbation of any pre-existing countion) and the accident.
- → The treatment is only for injuries or conditions relate to the accident.
- The duration of time, first onset of symptom and rst medical consultation are consistent with
- → The severity of injury is consistent with the mechanism of the accident.

IS THE PROPOSED SERVICE APPROPPLATE OR THE INJURIES? Consider:

- → The service has been recommended by the treating medical practitioner.
- → The service is consistent with the plaimant's current medical and rehabilitation management.
 → The service is consistent with evidence based best practice and any clinical guidelines/ frameworks.
- → There are no contra-n dications to the requested service.
- → There is no sin lar ser ice being concurrently provided.

WILL THE POSOSID SERVICE BENEFIT THE CLAIMANT? Consider:

- → The expected utcomes are functional and have tangible benefits to the claimant e.g. facilitate return to work or facilitate independence with personal care.
- → The expected goals and timeframes are reasonable.
- → The proposed service will facilitate a return to pre-injury condition or maximise function.
- → There have been positive outcomes from the provision of this service previously.

IS THE SERVICE PROVIDER APPROPRIATE? Consider:

- → The provider has appropriate registrations / qualifications / experience in the service being provided.
- → The provider is easily accessible to the claimant.
- → The provider is recommended by the treating doctor.
- → There are no conflict-of-interest issues identified between the insurer and the provider or between the claimant and the provider.
- → The fee requested is reasonable compared with similar services.



Is the request reasonable & appropriate?

YES
to all
questions

Reasonable & appropriate to approve.

Key no kt step.

- → Decision making ocess dequately docum red file.
- Approval is comounicated in writing to the chimal and rehabilitation provider within 10 calendar and rehabilitation of request (for home modification requests see Rehabilitation Standards criteria

The requested rehabilitation may (reasonable to ar rove in the circum lances.

- ecision making process adequately ocumented on file including discussion of any issues and relevant justification for approval.
- → Approval is communicated in writing to the claimant and rehabilitation provider within 10 calendar days of receipt of request (for home modification requests see Rehabilitation Standards criteria #6).

to one or more questions

che ification or further into mathematy may be required (e.g. from habil ation provider, acating doctor or claimant).

- Decision making process adequately
 documented on file
- → Within 10 days of receipt of request, the claimant and rehabilitation provider are advised in writing that further information is required.

The requested rehabilitation may be unreasonable or not appropriate (in part or overall).

- Decision making process adequately documented on file.
- → A decision to partially approve or decline is communicated in writing with an explanation to the claimant and rehabilitation provider within 10 days of receipt of request.

See the Rehabilitation Standards for CTP Insurers for further detail on the management process surrounding rehabilitation requests. Ensure any claims issues have been considered prior to using this tool.

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