Australian Capital Territory

Motor Accident Injuries (Treatment and Care) Guidelines 2025

Disallowable instrument DI2025-158

made under the

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

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1 Name of instrument

This instrument is the *Motor Accident Injuries (Treatment and Care) 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 Revocation

The *Motor Accident Injuries (Treatment and Care) Guidelines 2023* (DI2023-310) is revoked.

Nicola Clark
MAI Commissioner
MAI Commission
30 June 2025

Treatment and Care Guidelines

Contents

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 about approving and making payments for treatment and care benefits.

Specifically, this material details an insurer's 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.

2. STATUTORY FRAMEWORK

Part 2.5 of the MAI Act provides for the payment of treatment and care benefits for reasonable and necessary treatment and care expenses for a person injured in a motor accident.

The legislative framework for treatment and care benefits includes:

- the MAI Act;
- the Motor Accident Injuries Regulation 2019 (the Regulation); and
- these Guidelines.

Treatment and care is to be tailored to the individual's circumstances and needs, timely and goal focused, and able to be supported by the best available research evidence.

3. ASSESSMENT OF TREATMENT AND CARE NEEDS (Sections 121 and 131)

These guidelines make provision for the conduct of an assessment of an injured person's treatment and care needs under section 121 of the MAI Act. An insurer may suspend treatment and care benefits and income replacement payments if an injured person does not comply with a reasonable request, without a reasonable excuse, for an assessment of their treatment and care needs. Benefits may be suspended until a request is complied with. A whole person impairment assessment under division 2.6.3 of the MAI Act is not an assessment of treatment and care needs.

For the guidelines relating to the approval of treatment and care see sections 4 and 6 of these guidelines, and the provisions of the MAI Act.

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 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 medical report providers and insurers, 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 An insurer must take steps to ensure assessments of an injured person's injuries are necessary and appropriate. Before asking for an assessment, an insurer is to first request and consider any relevant additional information available from a treating practitioner unless the additional information would not be relevant. Information from a treating practitioner would be:

- relevant if it directly related to the injuries for which an assessment was being sought and if available may avoid the need for, or reduce the scope of, the assessment; and

- available if it was already in the possession of, or could be readily obtained from, the treating practitioner.

Additional information would not be relevant if the insurer did not agree with existing information or an opinion from a treating practitioner to support a treatment recommendation.

3.1.4 A referral for an assessment would be considered necessary and appropriate if:

- the treating practitioner does not respond to a request from the insurer for available information after more than 10 business days or a longer agreed period;

- information provided by the treating practitioner to the insurer is inadequate; or

- the insurer's communication with the treating practitioner cannot resolve a dispute.

3.1.5 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.

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 must be appropriately qualified and experienced, with the assessment being 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.

3.2.2 If the assessment is for the purpose of resolving a dispute between the insurer and the injured person, an insurer must, prior to preparing a referral, consult with the injured person about the health practitioner to conduct the assessment and the issues to be referred to the practitioner. The injured person is to be provided with a list of medical and health information in the insurers' possession which the insurer intends to provide to the health practitioner for the assessment, at least 5 business days before the referral is sent. This is to give the injured person an opportunity to provide any other information they may have in their possession to the insurer or health practitioner which may be relevant to the assessment.

3.2.3 To ensure an independent and impartial assessment is made an assessment should generally not be conducted by an existing treating health practitioner of the injured person.

3.2.4 An insurer should prepare a referral to the health practitioner setting out the scope of the assessment and any medical or vocational questions to be answered from the assessment.

3.2.5 An injured person should be given at least two weeks' notice of the assessment, including the reasons for the assessment, and if applicable, why further information has not been requested from an existing treating practitioner, and details of the appointment. An insurer should consult with an injured person when arranging an appointment and take into account the person's work, personal and carer commitments, and their residential area. An insurer should also ensure that any special needs such as accessibility, cultural or language needs can be accommodated for at the appointment.

3.2.6 If it is necessary for the injured person to physically attend an assessment during a public health emergency, then an insurer should take reasonable steps for the assessment to be conducted at business premises within the ACT (for any injured person that resides in the ACT or surrounds) or otherwise within the jurisdiction where the injured person resides. In arranging any appointment an injured person should also be informed of the procedures and policies the health practitioner has in place.

3.2.7 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.

3.3 Information a health practitioner may ask an injured person in relation to a health assessment

A health practitioner conducting the assessment may ask an injured person to provide specific information in the person's possession, such as medical images, that is relevant to the assessment, and any other information the health practitioner reasonably requires for the assessment. If the health practitioner asks for information to be provided before an assessment, the information should be provided to the practitioner at least 5 calendar days prior to the assessment.

3.4 Information a health practitioner may ask an insurer in relation to an assessment

A health practitioner conducting the assessment may ask an insurer to provide all information in the insurer's possession that is relevant to the assessment, and any other information the health practitioner reasonably requires for the assessment. The information is to be given to the practitioner at least 10 calendar days prior to the assessment.

4. RECOVERY PLAN (Sections 123 and 125)

These guidelines make provision for matters in relation to recovery plans.

A recovery plan must be developed in consultation with a treating doctor and an injured person for any injured person entitled to treatment and care benefits who is unable to resume their pre-injury duties and activities within 28 days from receipt of their application for defined benefits. A recovery plan allows an insurer to manage and coordinate the delivery of medical treatment, training and rehabilitation for an injured person with ongoing incapacity. A recovery plan also sets out treatment and care approved by the insurer as reasonable and necessary treatment and care for the person. An insurer may also suspend a person's entitlement to treatment and care benefits, and income replacement benefits, if the person unreasonably fails to undergo the treatment and care in the recovery plan. A recovery plan need not record treatment and care that is approved by the insurer outside of the recovery plan process because it is a one-off expense (e.g., a walking stick) and evidence of the approval is given to the injured person. Recovery plans should outline the proposed treatments and goals for the injured person as agreed by all parties until the next scheduled review of the recovery plan.

A recovery plan is not required if an injured person is a LTCS scheme participant as they have no entitlement to treatment and care benefits under the MAI scheme.

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 consider all relevant and 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 that may impact on the person's treatment and care needs under the plan;
- employment engaged in by the person after the 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 assist in the development of 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.

4.2 Time frame to give a recovery plan to an injured person and their doctor

4.2.1 Under section 123 of the MAI Act a final version of a recovery plan must generally be given to an injured person and their doctor within 28 days after the insurer gives an injured person a receipt notice for an application for defined benefits. A longer time period, beyond this 28 day period, may apply if the person was hospitalised after the accident, or if permitted by the clauses 4.2.2 to 4.2.5 below.

4.2.2 An insurer must, as soon as practicable after giving a receipt notice to an injured person, gather all information which is necessary to prepare a draft recovery plan. This information could include:

- medical reports;
- clinical records;
- fitness for work certificates;
- an assessment of treatment and care needs under section 121 of the MAI Act;

- existing recovery or treatment plans; and
- any recommendations from an MAI insurer currently handling any other defined benefit application for the injured person under the MAI scheme.

4.2.3 A draft recovery plan must be given to the injured person and their doctor within 5 business days after the insurer receives all information which is necessary to prepare the plan.

4.2.4 An insurer may take up to 20 business days to provide a final version of the recovery plan to the injured person after giving the injured person and their doctor a draft plan. This period is to allow the insurer to consult with the injured person and their doctor on the draft recovery plan, and for the insurer to consider any doctor's or other treating practitioner's recommendation for changes to the plan.

4.2.5 An injured person will be taken to have accepted a draft recovery plan if they do not provide the insurer with any recommended changes to the plan from their doctor or a treating practitioner within 15 business days after receiving the draft plan. In these circumstances the final version of the recovery plan, will be deemed to have been given to the injured person and their doctor on the date they were given the draft recovery plan If recommended changes are provided within the 15 business days, the insurer will then have a minimum of five additional days to provide a final plan within the 20 day timeframe in paragraph 4.2.4.

4.2.6 Section 127 provides for review of a plan at least once every 13 weeks after the plan is given to the injured person or if there is a material change in the person's condition, circumstances or treatment outcomes. If an insurer proposes, following the review of a recovery plan under section 127 of the MAI Act, to amend a recovery plan they should follow the same process as outlined in clauses 4.2.3 to 4.2.5, and provide the plan to the injured person and their doctor to consider any amendments to the recovery plan.

4.3 Approval of treatment and care expenses under the recovery plan

4.3.1 The recovery plan is to state any treatment or care expenses approved by the insurer as reasonable and necessary for the injured person during the currency of the plan. This statement should include the service to be provided, the name of any nominated health service provider, the number of services that can be provided, the period that services are approved for, and any restrictions on the amount that may be paid for the service. The plan should also set out verification and payment arrangements for these expenses.

4.3.2 A recovery plan is to include treatment and care recommended by an injured person's nominated treating doctor, or other treating practitioner, following consultation on the plan, provided the treatment and care is considered by the insurer to be reasonable and necessary in the circumstances having regard to the factors in section 120 of the MAI Act. A decision about the approval of any treatment and care recommended by a person's nominated treating doctor or other treating practitioner is to be made within the timeframes in section 4.2.

4.3.3 An insurer should consult with an injured person when including treatment and care in a plan to take into account the person's work, personal and carer commitments, and their residential area. There may also be a need to take into account transport required to support the plan.

4.3.4 An insurer may also approve treatment and care not mentioned in a recovery plan, if the insurer is satisfied on reasonable grounds that the treatment and care:

- is reasonable and necessary in the circumstances; and
- will assist with the injured person's recovery or management of the person's injury.

A timeframe of 10 business days to make a decision about a request for approval for treatment and care outside of a recovery plan will apply (section 6).

4.4 Minimum requirements for a recovery plan

4.4.1 A final or amended plan must be given to an injured person and their nominated treating doctor or team within the timeframes set out in the MAI Act or these guidelines. The final recovery plan should also be given to any other health service provider nominated in the plan.

4.4.2 At a minimum the plan is to include:

- the name of the injured person;
- the individual application identifier for the person;
- the date of, and the nature of the person's injuries;
- details of treatment being undertaken;
- details of expected treatment and, if relevant their frequency, to be undertaken;
- the specific goals to be achieved during the duration of the plan;
- a statement of all treatment and care approved as reasonable and necessary under the plan including details set out in section 4.3 of these guidelines;
- arrangements for seeking approval for any treatment and care not mentioned in the plan;
- current fitness for work or usual activities;
- obligations of the injured person in relation to treatment and care;
- the name and contact details of the insurer's case manager;
- a statement to the effect that a person's entitlements to treatment and care benefits, and income replacement benefits, may be suspended if they unreasonably fail to undergo the treatment and care outlined in the recovery plan; and
- the date for review of the plan.

4.5 Obligations of an injured person under a recovery plan

4.5.1 An injured person has a duty to act in good faith under section 20 of the MAI Act in relation to an application for defined benefits including taking all reasonable steps to minimise the loss caused by the applicant's personal injury. This duty includes the injured person undertaking reasonable and necessary treatment and care, and vocational training.

4.5.2 An injured person therefore must not unreasonably fail to undergo all treatment and care in a recovery plan. An injured person must tell the relevant insurer as soon as practicable if they are unable to comply with their recovery plan and may ask the insurer for a new recovery plan.

4.5.3 An injured person must nominate a treating doctor, or a medical practice as a treating team, that is prepared to participate in the development and management of the arrangements under a recovery plan. An injured person may change their nominated treating doctor or team. For example, if the applicant moves house or their doctor leaves a practice. The injured person is to advise the insurer of any changes made for the nominated treating doctor or team.

4.6 Obligations of an Insurer under a plan

4.6.1 An insurer must ensure an injured person is referred to an appropriate treatment provider (including vocational provider), in consultation with the injured person and their nominated treating doctor or team, as soon as practicable after a treatment and care need is identified in a recovery plan. An insurer may refer an injured person prior to the first recovery plan being finalised if their initial assessment identifies a need to do so.

4.6.2 An insurer must ensure that a recovery plan is reviewed regularly in accordance with the requirements of section 127 of the MAI Act.

4.6.3 An insurer must pay treatment and care expenses as set out in an injured person's recovery plan.

4.7 Concurrent applications

4.7.1 An insurer should collaborate as much as possible with other insurers in preparing and implementing a recovery plan for concurrent applicants. Where possible, if a rehabilitation provider has been appointed for an injured person by an insurer and an injured person has a subsequent motor accident, the same rehabilitation provider should be considered for appointment. Similarly, the same providers of treatment should also be considered. Insurer obligations in managing concurrent applications are outlined in clause 11 of the Defined Benefits Application Guidelines.

5. EXCEPTIONAL CIRCUMSTANCES - LATE APPLICATIONS (Section 128)

These guidelines make provision for the kinds of circumstances which may be regarded as exceptional circumstances for a late application for back-paying treatment and care expenses to the date of an accident.

5.1 Exceptional circumstances

5.1.1 If a late application is made for defined benefits an insurer is to back-pay treatment and care expenses to the date of an accident, in the following exceptional circumstances:

- The late application is for a person that died from injuries resulting from the motor accident, at a date after the motor accident;
- The late application is for an injured person that was hospitalised for at least 4 weeks during the initial application period;
- A close relative, spouse or child of the injured person died from injuries resulting from the motor accident or was hospitalised for at least 4 weeks during the initial application period; or
- The delay in making a complete application is a direct result of errors or mistakes made by an MAI insurer in relation to handling an application from the injured person, during the initial application period.

6. APPROVAL OF TREATMENT AND CARE BENEFITS (Sections 126, 129 and 131)

These guidelines make provision in relation to treatment and care benefits. In approving treatment and care benefits an insurer must decide whether the treatment and care is reasonable and necessary, verify the cost of the treatment and care as being reasonable and necessary, and establish that the treatment and care relates to injuries caused by the accident.

6.1 An insurer must make a decision about a request for the approval of a treatment and care benefit within ten business days of receiving a request. This includes approval for treatment and care not mentioned or required to be in a recovery plan. A request may also be made for the reimbursement of treatment and care expenses (including domestic services expenses or travel expenses).

6.2 If the approval is for treatment and care benefits that have not yet been incurred the following details about the approved benefits should be provided to the injured person:

- the treatment or care service or goods to be provided;
- the name of any provider;
- the number of services or goods that can be provided;
- the period the services or goods are approved for; and
- any restrictions on the amount that can be paid for the services or goods.

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 request 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. In these circumstances an insurer should advise 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 medical opinions or other evidence to make a further approval decision, including by paying the reasonable and necessary costs of obtaining an opinion or other evidence about the person's 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 requested treatment or care is not directly related to a person's motor accident injury and refuse the request.

6.4.2 Benefit to the participant

Treatment and care will benefit a person if:

- it will assist the injured person's recovery or management of the person's injury;
- it has specific goals, an expected duration and expected outcomes and these are understood and agreed by the injured person;
- it will not cause adverse outcomes or harm to the person;
- there are medical reports or assessments that show the treatment or care will benefit the person; or
- the treatment or care has been provided in the past to the person with positive results or outcomes.

6.4.3 Appropriate for an injury

Treatment and care will be appropriate for an injury if:

- it is based on current clinical practice, evidence-based practice or generally accepted clinical guidelines for the given injury;

- there is good evidence for the efficacy of the treatment over other treatments;
- it will not contradict any treatment and care in the person's recovery plan.

6.4.4 Appropriateness of a provider

A provider of treatment and care will be appropriate if**:**

- the provider is appropriately qualified and experienced;
- the provider holds any applicable registrations, clearances or licences;
- the provider can deliver services having regard to the injured person's age, ethnicity and any cultural and linguistic factors;
- the provider is at arms-length to the injured person;
- the injured person can readily access the provider;
- The fees and charges of the provider are reasonable having regard to the fees and charges of like providers in the same geographical location or region and the skills and experience of the given provider.

A provider of a service will not be at arms-length to the injured person where the service provider is a family member or relative or the injured person or a business owned or controlled by a family member or relative of the injured person.

6.4.5 Cost effectiveness

Treatment and care will be cost effective if**:**

- the short and long term benefits and expected outcomes from the treatment and care have been considered and outweigh the costs;
- there are no other treatment and care options that will achieve comparable outcomes, including any diagnosis options necessary to determine future treatment and care needs; and
- delaying the treatment and care may result in additional treatment and care costs.

6.5 Verifying that treatment and care costs are reasonable and necessary

6.5.1 An insurer is to approve a treatment and care expense if the amount of the expense is reasonable for the treatment and care being provided. In determining whether the amount of an expense is reasonable an insurer is to consider:

- Recommended rates or charges for members of a professional association or college (e.g. AMA rates) at the time the treatment or service is provided;
- Comparable rates or charges by other like providers, including health service providers, in a geographical location or clinical region; and
- The area of specialisation, skills and experience of the provider and the availability of any other suitable providers in a geographical location or clinical region.

6.5.2 In the case of medical or dental treatment, the amount of an expense would not be considered reasonable if the expense is payable to a third-party agent of a health practitioner rather than directly to the health practitioner or practice providing the treatment.

6.5.3 If approving travel and accommodation expenses, an insurer should generally only approve an economy class fare, unless on medical grounds it is essential for the injured person to receive an upgrade to another class or have an additional seat. Accommodation should be of a suitable standard, up to 3.5 stars, unless there are exceptional circumstances requiring a higher number of stars. Travel and accommodation expenses may only be paid for a carer if it is essential for the carer to accompany the injured person to a medical appointment or to support the person during extended hospitalisation. A supporting person may also be required for short hospital stays or appointments where the injured person is a minor or not otherwise able to consent to treatment, requires physical assistance from the person, or the person's presence is likely to improve treatment and care outcomes.

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

Treatment and care from a health practitioner is to be provided in a manner that adopts the principles of the nationally endorsed Clinical Framework for the Delivery of Health Services[1]. 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.

In making a decision about a request to approve treatment and care to be delivered by a health practitioner, an insurer must apply the principles of the Clinical Framework for the Delivery of Health Services.

8. PAYMENT OF TREATMENT AND CARE EXPENSES BY INSURERS (Sections 129 and 131)

These guidelines make provision in relation to verifying treatment and care expenses and making provision for the payment of a treatment and care expense before an expense is incurred.

8.1 Verifying Treatment and Care expenses

8.1.1 Prior to paying a treatment and care benefit an insurer is to be satisfied a treatment and care expense, domestic services expense or a travel expense was incurred, and the

[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 (NSW) and the Transport Accident Commission (VIC).

treatment and care was given. An insurer should also establish that the injury for which the treatment and care was given resulted from a motor accident.

8.1.2 An insurer must reimburse an applicant, or pay a provider, for any treatment and care expenses that are pre-approved by the insurer or set out in a person's recovery plan. These expenses must only be paid on the provision of an account or receipt including the following information:

- injured person's first and last name
- the name and address of the provider, and if applicable the provider number of a health service provider
- the Australian Business Number (ABN) of the provider
- the name of the referring medical practitioner, if applicable
- the date each service was provided
- the goods or services provided, and the cost of each service
- the service duration, if applicable.

8.1.3 An insurer may accept an electronic copy or a photocopy of an account or receipt. The insurer may ask for the original if not satisfied of the accuracy of the account or receipt or ask the service provider to confirm the information in the account or receipt is accurate. An insurer is to pay an approved treatment and care expense, as soon as practicable, but no later than 10 business days after receiving an account or receipt.

8.1.4 If a treatment and care expense has not been pre-approved by the insurer, the insurer may allow a further ten business days to consider a request for the approval of the treatment and care benefit.

8.2 Payment before an expense is incurred

8.2.1 To reduce the financial burden on an injured person an insurer should ask for details of an injured person's regular service providers and establish direct billing arrangements where possible between the insurer and the provider. An insurer should also arrange with service providers to direct bill any large, one-off, medical expenses.

8.2.2 In some circumstances, it may not be possible for an insurer to be billed for an approved treatment and care expense after the expense is incurred and it may not be reasonable for an injured person to make up-front payments for the expense.

8.2.3 Examples of treatment and care benefits that should be pre-paid before the expense is incurred include:

- Travel and accommodation expenses to attend a medical assessment
- A deposit for a prosthetic device
- A hospital booking fee.

8.2.4 In arranging the pre-payment of expenses an insurer should also have regard to a person's financial circumstances. An insurer should ensure that an injured person does not forgo treatment and care because they are unable to make an up-front payment for that treatment and care.