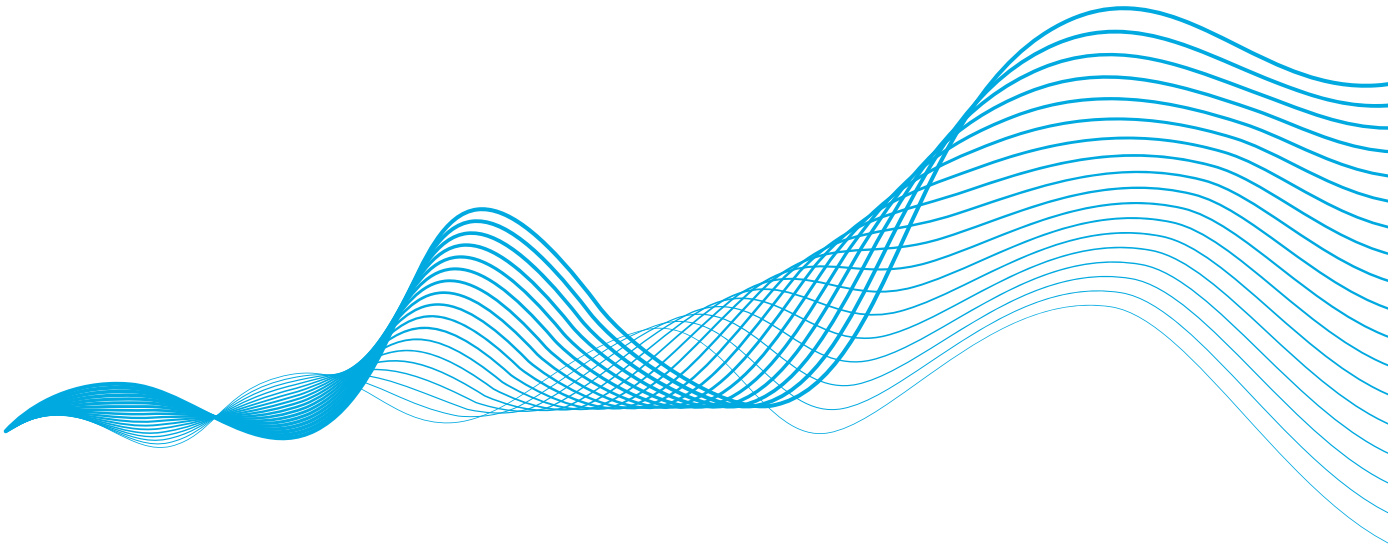
icare™



Lifetime Care

Companions
to the Lifetime Care and Support Guidelines 2018

What are the Companions?

The Companions support understanding of the Lifetime Care and Support Guidelines (the Guidelines). The Guidelines are issued under the *Motor Accidents (Lifetime Care and Support) Act* 2006 and provide information on:

- eligibility for the Lifetime Care and Support Scheme (the Scheme), and how decisions are made about eligibility
- how we make decisions
- services, and requests for services.

The purpose of each companion is to consolidate and reframe the content of the Guidelines in plain English so that the Lifetime Care and Support Guidelines are more accessible to our participants and the community. Each companion is a stand-alone document that complements the corresponding part of the Guidelines. They don't replace the Guidelines and you are welcome to refer to the Guidelines as well as these Companions. Please speak with your icare contact if you're unclear about this.

Contents

Eligibility for participation in the Scheme (companion to Part 1)

You may be eligible to participate in the Scheme if you sustained an injury because of a motor vehicle accident in NSW and your injury meets the criteria in this companion, which is the same as in our Guidelines.

This companion explains who is eligible for the Scheme and how you can apply.

When we use the word 'you', we mean the person covered by the Lifetime Care and Support Scheme (also known as 'the participant') or someone representing them, such as a parent, guardian or legal representative.

Who can apply?

You are eligible to participate in the Lifetime Care and Support Scheme if:

- you had a motor accident (within the meaning of the *Motor Accidents Act 1999* **or** the *Motor Accidents Injuries Act 2017*);
- the accident occurred in New South wales;
- the injury was caused by the motor accident; and
- your motor accident injury meets the criteria for the Scheme.

You can apply, or someone on your behalf, such as a family member, can make an application for you.

If you've made a claim for the injury to a CTP insurer, that insurer can apply for you. They'll send a copy of the application to you at the same time they send it to Lifetime Care. You don't need to give consent for them to apply on your behalf.

Making an application is free.

Types of participation

Interim participation

If you haven't been a participant in the Scheme before, once you have applied and your eligibility has been established, you'll be accepted as an **interim** participant for a period of two years. This will start from the date of our decision.

We can only accept you as an interim participant once for any particular motor accident injury.

During the two-year interim period you might recover and improve, which could mean that you might not meet the eligibility criteria after the interim participation period.

If you're a child, we won't assess you for lifetime participation before you are five years of age. If you're a child and become an interim participant under the age of three years, this means you'll spend longer than two years as an interim participant.

Time limit on applications

An interim application to the Scheme must be made within three years of the date of your motor accident injury. We can provide a longer time frame if there is a sound reason why the application wasn't made within three years of the accident. Anyone who applies more than three years after the motor accident injury has to give us an explanation, in writing, of the situation and reasons why the application was not made earlier.

Applications are made on our approved application form. You can get the approved form for Interim Participation from us, or on our website www.icare.nsw.gov.au.

Lifetime participation

If you apply and you've been an interim participant before, we'll treat your application as an application for lifetime participation. This will happen even if you aren't an interim participant in the Scheme when the application is made.

If you're in the Scheme as an interim participant, or if you've been in the Scheme before and your interim participation is no longer valid, you'll be accepted as a lifetime participant if you meet the criteria for the Scheme.

Bringing forward a decision about lifetime participation

We might decide to accept you as a lifetime participant before the end of your interim participation period. We might do this if we have medical information that your injury is likely to meet the criteria for lifetime participation (which is the same as for interim participation) at the end of the two-year period. This won't happen for children under 5 years of age.

You can get the Lifetime Application Form from us.

Eligibility criteria for participation in the Scheme

The eligibility criteria set out in this clause applies to both interim participation and lifetime participation.

You're eligible for participation if you were injured in a motor accident and you meet the criteria for one or more types of injury at the time we make our decision.

If you're eligible to be a participant and your application for acceptance as a participant has been made properly, we must accept you, either as an interim or lifetime participant.

Types of injury

You may be eligible for the Scheme if you sustained one or more of the following injuries from a motor vehicle accident in NSW:

- spinal cord injury
- brain injury
- amputation
- burns
- permanent blindness

Medical certification

An appropriately qualified medical specialist must certify that you meet the injury criteria. The certification must be completed on the medical certificate which is part of the Application Form.

FIM™ and WeeFIM® for use for brain injuries and burns

The Functional Independence Measure (FIM™) is an assessment tool to measure how much assistance you require to carry out activities of daily living. The Functional Independence Measure for children (WeeFIM®) is the assessment tool for children aged between 6 months and 8 years.

We have score sheets for the FIM™ and WeeFIM® for people who have had brain injuries and burns. These forms measure how much assistance you need and include a section where the clinician completing the form can indicate which scores relate to the injury and reasons why the score has been given. Our score sheets must be used for all interim and lifetime participation applications for brain injuries and burns.

The FIM™ or WeeFIM® assessment has to be done by a person who has been trained in FIM™ or WeeFIM®, passed the relevant examination and is credentialed through the Australian Rehabilitation Outcomes Centre, or equivalent if the assessment is conducted outside Australia.

If you're not a participant in the Scheme, the FIM™ or WeeFIM® assessment must be done within 20 working days of the date of a completed application. We might sometimes decide on a different time frame for this.

If more than one FIM™ or WeeFIM® assessment has been done, we'll use the most recent assessment for our eligibility decision.

Pre-existing and co-existing conditions

If you have another medical condition that happened before or at the same time as the accident (such as stroke, brain injury or dementia), and you apply to the Scheme, we might need more information about your other medical condition before we can make a decision. *For example, 10 years ago, you had a stroke resulting in right-sided weakness. You have a motor accident and now you have a traumatic brain injury because of the accident.*

Delaying an application

We might ask you to put off making an application until your injury has stabilised or is unlikely to change. *For example, you might not meet the eligibility criteria straight after the motor vehicle accident, but you might after you have surgery.*

Our process for making decisions

When making a decision about your eligibility, we'll consider the eligibility criteria and any other information we might need or have asked for. We'll make a decision as soon as possible after we get an application, if we're able to make a decision.

When we make a decision, we'll give reasons. We'll write to:

- you and your legal representative (if you have one)
- the insurer, if they are not the applicant
- the applicant and their legal representative (if they have one), if the person applying is someone other than you or the insurer.

You don't have to agree with our decisions. You have the right to dispute any decision we make. That's OK and we can help you do this. If we do not accept an application for participation in the Scheme, we'll give you (and the applicant, if it's not you) information about our process for dispute resolution.

Information we may need to make our decision

We'll need to get information about the motor accident and your injury. The application must show that:

- you had a motor accident
- the accident happened in NSW
- the injury was caused by the motor accident, and
- the injury meets the criteria in our Guidelines.

Before we can make a decision about your eligibility, we might need information such as:

- the application form and any information or documents attached to it, including information we asked for
- any FIM™ or WeeFIM® score sheet or form
- forms about other claims for personal injury benefits, such as an Accident Notification Form or CTP Personal Injury Claim Form (if there is one)
- ambulance or air ambulance/retrieval records
- hospital records
- treating doctor's reports and other medical reports
- past medical records or school records
- accident investigations
- other information from before the accident or general medical information
- other information we think we might need.

You, or someone on your behalf, will need to give us permission to get information about the injury, motor accident or motor vehicle. This is part of the application form. The form has to be signed, the questions answered, and any information attached.

We might decide that the application is not complete unless it:

- is signed
- has a medical certificate, completed by an appropriately qualified medical specialist who is registered
- has a FIM™ or WeeFIM® score sheet. This is an assessment we need if you've had a brain injury or burns.

If we don't have the information in the form that we need, we could ask you, or the person applying on your behalf to provide the information. We might give you a time frame (usually 4 weeks) to give the information to us, or to ask for a FIM™ or WeeFIM® score sheet to be completed.

We might ask you or someone on your behalf to give us your agreement or consent to get the information we need, if this wasn't in the application form. We might give you a time frame (usually 4 weeks) to give us this agreement.

Sometimes, if there is missing information on an application form we might decide that we have enough information to make a decision anyway.

We might ask you to have an assessment, to see whether you meet some or all of the injury criteria. We might give you a time frame (usually 4 weeks) to have the assessment. You can ask us for more time if you need it.

If we ask you to have an assessment, we'll pay for it.

Other info

This is our injury criteria:

Spinal cord injury

A spinal cord injury is an acute traumatic lesion of the neural elements in the spinal canal (spinal cord and cauda equina) resulting in permanent sensory deficit, motor deficit and/or bladder/bowel dysfunction.

You are eligible for participation in the Scheme if you have had a spinal cord injury caused by a motor accident and the spinal cord injury has resulted in permanent neurological deficit.

Brain injury

A traumatic brain injury is an insult to the brain, usually with an associated diminished or altered state of consciousness that results in permanent impairments of cognitive, physical and/or psychosocial functions.

You are eligible for the Scheme if you've sustained a traumatic brain injury and:

- the brain injury was caused by the motor accident and
- the duration of Post Traumatic Amnesia (PTA) is greater than 1 week. If the PTA assessment is not available or applicable (for example, if you are under 8 years of age, or if you had a penetrating brain injury), there must be evidence of a very significant impact to the head, causing coma for longer than one hour, or a significant brain imaging abnormality due to the motor accident; and
- one of the following criteria is met:
    - **if over 8 years of age**: a score of 5 or less on any of the items on the FIM™ or WeeFIM® due to the brain injury or
    - **if aged from 3 to 8 years:** a score two less than the age norm on any item on the WeeFIM® due to the brain injury or
    - **if aged under 3 years**: a medical certificate from a paediatric rehabilitation physician that states you'll probably have permanent impairment due to the brain injury, resulting in a significant adverse impact on your normal development.

Amputations

You may be eligible for the Scheme if you've had an amputation or amputations, or the equivalent impairment caused by the motor accident and meet/s the criteria described below:

Criteria for multiple amputations

- The injury resulting in the amputations, or the equivalent impairment, was caused by the motor accident and
- You have multiple amputations of the upper and/or lower extremities (or equivalent impairment or some combination), meaning that there is more than one of the following types of amputation at or above the level of:
    - a 'short' transtibial or standard transtibial amputation, as defined by the loss of 50% or more of the length of the tibia. This includes all other amputations of the lower extremity (such as knee disarticulation or transfemoral amputation) above this level;
    - a thumb and index finger of the same hand, at or above the first metacarpophalangeal joint. This includes all other amputations of the upper extremity (such as below-elbow or above elbow amputation) above this level;
    - there are multiple impairments, each of which is an 'equivalent impairment' to one of the types of amputation above. 'Equivalent impairment' means the functional equivalent to an amputation, resulting from an injury such as (but not limited to) brachial plexus avulsion or rupture, where paralysis exists and movement in the paralysed limb, or relevant part thereof, is minimal or non-existent due to the injury.

Criteria for unilateral amputation

- The injury resulting in the amputation (whether amputation or an 'equivalent impairment'), was caused by the motor accident and
- You have one of the following types of injury:
    - forequarter amputation (complete amputation of the humerus, scapula and clavicle) or shoulder disarticulation
    - hindquarter amputation (hemipelvectomy by trans-section at sacroiliac joint, or partial pelvectomy)
    - hip disarticulation (complete amputation of the femur) or
    - 'short' transfemoral amputation as defined by the loss of 65% or more of the length of the femur.

An 'equivalent impairment' to one of the types of amputation above. Equivalent impairment means the functional equivalent to an amputation, resulting from an injury such as (but not limited to) brachial plexus avulsion or rupture, where paralysis exists and movement in the paralysed limb, or relevant part thereof, is minimal or non-existent due to the injury.

Burns

You may be eligible for the Scheme if you have sustained burns and:

- the burns were caused by the motor accident and
- you have full thickness burns greater than 40% of your total body surface area, or greater than 30% of your total body surface area if you are a child under 16 years or
- you have inhalation burns that have caused long term respiratory impairment or
- you have full thickness burns to the hand, face or genital area and
- one of the following criteria is met:
    - if over 8 years of age: a score of 5 or less on any of the items on the FIM™ or WeeFIM® due to the burns or
    - if aged from 3 to 8: a score two less than the age norm on any item on the WeeFIM® due to the burns or
    - if you are aged under 3 years: a medical certificate from a paediatrician or an appropriately qualified medical specialist otherwise approved in writing by us that states you will probably have permanent impairment due to the burns resulting in a significant adverse impact on your normal development.

Permanent blindness

You may be eligible for the Scheme if you've lost sight in both eyes and:

- the loss of sight was caused by the motor accident and
- you're legally blind, defined by:
    - visual acuity on the Snellen Scale after correction by suitable lenses is less than 6/60 in both eyes
    - field of vision is constricted to 10 degrees or less of arc around central fixation in the better eye irrespective of corrected visual acuity (equivalent to 1/100 white test object) or
    - a combination of visual defects resulting in the same degree of visual loss as that occurring in either of the definitions above.

For more information contact Lifetime Care

9am to 5pm, Monday to Friday

Phone: 1300 738 586

Email: enquiries.lifetimecare@icare.nsw.gov.au

Web: www.icare.nsw.gov.au

Disputes about eligibility (companion to Part 2)

You can dispute a decision we made about your eligibility to participate in the Scheme if you disagree with the decision we made about whether you meet or don't meet the criteria in Part 1 of our Guidelines.

This companion explains how you can dispute a decision we have made about your eligibility to participate in the Scheme.

When we use the word 'you', we mean the person covered by the Lifetime Care and Support Scheme (also known as 'the participant') or someone representing them, such as a parent, guardian or legal representative.

What is a dispute about eligibility?

A dispute is a disagreement about whether your motor accident injury satisfies criteria specified in the Guidelines for eligibility to participate in the Scheme.

You or someone on your behalf can dispute a decision only after we've written to you about whether you're eligible or not.

Time frame for making a dispute

We must receive your dispute application within 6 months of the date of our decision. We might give a longer time frame if there's a genuine reason for why you didn't dispute the decision within 6 months.

Lodging a dispute

We can suggest that you make a dispute application, or you can notify us in writing, in person or by telephone that you'll be lodging a dispute. Dispute applications can also be made by someone on your behalf, or by the insurer of your CTP claim.

The dispute application must include:

- your name, address and contact details
- the date of our eligibility decision
- a statement that you dispute the decision
- the reasons why you dispute the decision about whether or not you meet the eligibility criteria in Part 1 of the Guidelines
- the reasons why you think you do or don't meet the eligibility criteria in Part 1 of the Guidelines, with reference to any relevant information, including medical reports
- any information or reports relevant to the eligibility criteria. This may include information about other medical conditions that happened before or at the same time as the accident.

You need to give us documents in English, unless they come with an English translation. Any translated documents must also have a declaration that the translation is an accurate translation of the document and that the translator is accredited by the National Accreditation Authority for Translators and Interpreters Ltd (NAATI).

If you don't give us this information, we might ask you for it before we can assess your dispute application.

Informing you that we've received your application

We'll write to you to acknowledge the dispute application within 5 working days of receiving it. If there's another party to the dispute, we'll give them a copy of the application within 10 working days of receiving it. Then, they have 20 working days to respond to the application by making a submission.

Any information given to us regarding the dispute will be shared with any other party to the dispute, even if they're not a party when the information is given to us.

Further information or documentation required

If we think that we need more information about the application to help resolve the dispute, we might:

- ask you, a service provider, or CTP insurer to give us this information within 20 working days
- go ahead with the application without the information, but only after 20 working days, to make sure you've had an opportunity to provide us with the information we need.

We can contact any party, or any of your treating health practitioners or service providers, in order to clarify the issues in dispute or to assist with getting information relevant to the dispute.

At any stage during the dispute, we could contact any of your treating health practitioners about health or physical safety issues, if an assessor thinks they are urgent or serious.

Not accepting a dispute application

We might not accept a dispute application if it:

- doesn't clearly seem to be about your eligibility
- hasn't been made by you, someone on your behalf, or by the CTP insurer of your claim.

Alternatives to dispute applications

If you aren't a participant (interim or lifetime) when the dispute application is made:

- we might decide that the dispute application gives us enough information to make a decision about your eligibility, and/or
- the dispute application might give us enough information for us to decide that you should apply to the Scheme rather than applying to dispute a decision.

If this happens, we might ask you to withdraw the dispute. This could mean that we treat your dispute application as a new application to the Scheme, or you could lodge a new application to the Scheme. If you lodge a new application, Part 2 of the Lifetime Care and Support Guidelines doesn't apply. Part 1 of the Guidelines applies to that application instead.

An Assessment Panel will consider the dispute application

We'll convene an Assessment Panel from our list of assessors as soon as possible, and within 20 working days of giving the other party your application or receiving any submission from the other party.

When we convene the Assessment Panel, we'll consider:

- your needs, such as the nature of your injury
- which parts of the eligibility criteria you don't agree with
- your location, and the location of the assessors
- the specialty and expertise of the assessors
- the availability of the assessors
- whether you need an interpreter.

We'll tell you and the other party the assessment details within 5 working days of convening the Panel. These details will include the names and specialties of the assessors on the Assessment Panel.

We'll appoint a chairperson and send the Assessment Panel copies of the dispute application and all accompanying documents, including our decision about your eligibility and any additional information received since the dispute application.

Before any assessment happens, we might contact you to make sure that your needs are going to be met during any part of the assessment.

Asking for a different Assessment Panel

If you think that the assessor/s is not appropriate, you or the other party can ask us to reallocate the dispute to a different assessor or assessors. This could be for any or all of the assessors on the Assessment Panel.

If you or the other party would like a different Assessor or Assessment Panel, ask us to reallocate your dispute. You have to do this within 10 working days of finding out the names of the assessors on the Assessment Panel. Tell us, in writing, exactly why you think the assessor/s is not appropriate and send this to both us and the other party.

Within 10 working days of receiving your request we'll ask the other party to respond. We'll decide whether or not to reallocate your dispute within 10 working days of receiving the request, or within 10 working days of receiving a response from the other party.

If we think there are sound reasons or think that any of the assessors originally appointed to the Assessment Panel are not appropriate, we'll change the members of the Panel.

Same assessor but different dispute

If an assessor has resolved a previous dispute, we could ask them to be a part of a Panel to determine the current unrelated dispute. *For example, a dispute assessment for a different type of dispute under another part of the Guidelines.*

Other reasons for reallocating disputes

We might reallocate a dispute to a different assessor or a whole new Assessment Panel if:

- someone is ill
- an assessor asks us to, or
- the Panel can't resolve the dispute within a reasonable time frame.

How the Assessment Panel assesses your dispute application

1. Panel holds an initial meeting

The Assessment Panel will hold an initial meeting or teleconference within 20 working days of the date the Assessment Panel was convened. At this meeting the Assessment Panel will decide:

- whether they will ask you to do a clinical examination, or if they can complete their assessment on the information they have
- who will write and sign the certificate on behalf of the Panel
- whether the panel needs to meet again.

The Assessment Panel's initial meeting or teleconference will not involve you or any other party to the dispute.

2. Panel assesses the dispute

The Assessment Panel can decide its own way to assess the dispute, but they have to follow the Guidelines and any practice notes. They may hold as many meetings or teleconferences as they need in order to resolve the dispute, but they have to try to resolve the dispute as quickly as possible.

When assessing the dispute, the Assessment Panel may:

- contact each other by teleconference, email or face-to-face
- contact any of the medical or health professionals that are treating you now, or have treated you in the past
- ask for medical records or other documentation that they think is relevant to the dispute
- ask that you attend a clinical examination with any or all members of the Assessment Panel
- ask that you attend a clinical examination with another health professional who is not part of the Assessment Panel. If this happens, the health professional will assess you and give a report to you, the Assessment Panel, and any other party to the dispute.

If the Assessment Panel asks you to attend a neuropsychological assessment, this assessment will occur in accordance with the State Insurance Regulatory Authority's publication *Neuropsychological Assessment of Children and Adults with Traumatic Brain Injury: Guidelines for the NSW Compulsory Third Party Scheme and the Lifetime Care and Support Scheme.*

We'll provide administrative support to the Assessment Panel during the assessment process from a person or team that has not been involved in the eligibility decision.

We may need to arrange a clinical examination

We'll arrange a clinical examination with a member or members of the Assessment Panel if they ask us to as this is part of the administrative support we provide. The Assessment Panel will decide if any or all members examine you.

We'll arrange the time, date and location of the clinical examination with you, and tell you the name and specialty of the assessor or assessors or other persons conducting the clinical examination. We'll confirm this with you and the other party in writing.

Preparing for the clinical examination

Before the examination, we'll tell you what to wear and bring, what to expect and what might happen. *For example, the kind of questions you or your support person might be asked.*

We'll pay the necessary costs and expenses of travel and accommodation for you, and another person with you such as a parent, carer or legal guardian or other support person.

What happens during a clinical exam?

The Assessment Panel will decide who can be there at a clinical examination and how it goes ahead. A parent, legal guardian, carer or other support person can be there to help or support you.

If you would like your legal or medical representatives there, we need to approve it so please advise us and also provide the reasons why.

Your legal guardian, carer or other support person may provide information to the assessor/s during a clinical examination, but only when the assessor asks for this information.

Sometimes, the assessor might have to ask your legal guardian, carer or other support person to leave the clinical examination. *For example, if your support person is shouting and speaking over you. The assessor asks your support person to let you speak, but they don't. This is affecting the assessment and causing you to be upset.*

When the clinical examination happens, the assessor/s will try to make sure that you and your support person understand:

- why the examination is happening and what's involved,
- the things the Assessment Panel will consider in assessing the dispute; and
- the role of the Panel as an independent decision-maker in making a decision that will must be followed.

Using interpreters in assessments and clinical examinations

If you need an interpreter, we'll arrange one who is accredited by NAATI (National Accreditation Authority for Translators and Interpreters). If a NAATI interpreter is not available, a non-NAATI interpreter may be used if the Assessment Panel or Review Panel agree to this. Anyone who is with you at an examination or assessment, such as a carer or support person, can't be your interpreter.

3. Certificate issued by Assessment Panel

The Assessment Panel will issue their decision in a written report, called a certificate. The certificate will include written reasons for their decision. We'll send this to you and to any other party to the dispute within 15 working days of the Panel's final contact, clinical examination or final teleconference. Depending on the decision, we'll implement it within 5 working days of receiving the decision.

Reviews

You, or another party to a dispute, can ask for a review of the Assessment Panel's decision. To apply for a review, you need to write to us.

Applications for review can only be about a decision made by an Assessment Panel, not a Review Panel.

An application for review has to:

- be in writing (letter or email)
- include your name, address and contact details
- state why you're asking for a review, including which ground or grounds for review in section 15 of the Act apply, together with reasons
- attach any relevant information or medical reports that are relevant to the review application.

Time limit extensions

We can extend the 6-month time limit if exceptional circumstances exist. We might ask the other party or parties to the dispute to submit a response to your review application before deciding to extend any time limit.

If you apply for review, we might decline to make submissions in response to your application. However, if we find a potential ground for review or we agree with any of the grounds you state, we must make a submission in response to your application.

If we don't apply for the review, we'll acknowledge the application, and provide a copy of the review application to any other party within 10 working days of receiving it.

If you're a party to the review application, other than the review applicant, you have 20 working days from the date of the review application to make a submission about whether the dispute application should be referred to the Review Panel or dismissed.

We'll advise you, the review applicant and any other party about whether the application will be referred to a Review Panel or dismissed, including the reasons why within 5 working days of receiving submissions from any or all parties. If there is a party that doesn't make a submission, we'll respond within 5 working days from the last date of the final submission.

Grounds for review

Any or all of the following reasons justify a review of a decision we have made about your eligibility:

- there has been a change in your condition, being a change that occurred or that first became apparent after the dispute was referred to the assessment panel and that change is capable of having a material effect on the determination.
- there is additional relevant information about your injury, being information that was not available, or could not reasonably have been obtained, before the dispute was referred to the panel and that information is capable of having a material effect on the determination.
- the decision was not made in accordance with the Guidelines.
- the decision is demonstrably incorrect in a material respect.

The Review Panel

We'll convene a Review Panel from our list of assessors within 10 working days of deciding to refer your application to a Review Panel. This will happen if we didn't apply for the review.

When we convene the Review Panel, we'll consider:

- your needs, such as the nature of your injury
- which parts of the eligibility criteria you don't agree with
- the grounds for review in the review application
- your location, and the location of the assessors
- the specialty and expertise of the assessors
- the availability of the assessors
- whether you need an interpreter.

Who's on the Review Panel?

If we applied for the review, we'll let you or the other party choose who will be on the Review Panel. If the other parties can't agree who should be on the panel, then each party will choose one panel member, and we'll choose the third panel member. If there are three parties, each party will choose a panel member. The Review Panel won't include anyone who was on the Assessment Panel.

We'll tell you and the other party the details of the review within 5 working days of convening the Panel. This will include the names and specialties of the assessors on the Review Panel.

We'll appoint a chairperson and send the Review Panel copies of:

- the dispute application
- all accompanying documents, including our decision about your eligibility and
- any additional information we've received since the dispute application.

We might contact you before the Review Panel assesses you. This is to make sure that your needs can be met in any assessment or examination.

If you disagree with who is on the Review Panel

You or the other party can ask us to reallocate the dispute to a different assessor or assessors if you think the assessor is not appropriate. This could be for any or all of the assessors on the Review Panel. However, if you or another party were involved in choosing an assessor for the Panel, you can't ask us to reallocate the assessor you chose.

To reallocate the dispute that is under review you have to:

- ask us to reallocate the dispute within 10 working days of finding out the names of the assessors on the Review Panel

- tell us in writing exactly why you think the assessor is not appropriate to assess the dispute and
- send a copy to the other party and to us.

We'll ask the other party to provide submissions within 10 working days of receiving the request to reallocate the dispute. We'll decide within 10 working days of receiving the request, or within 10 working days of receiving a submission from another party.

We'll reconvene the Review Panel, in whole or in part, if we think there are reasonable grounds for thinking that any of the assessors originally appointed to the Review Panel are not appropriate.

Same assessor but different dispute

If an assessor has resolved a previous dispute, we could ask them to be a part of a Panel to determine the current unrelated dispute. *For example, a dispute assessment for a different type of dispute under another part of the Guidelines.*

We might reallocate a review of a dispute to a different assessor or a whole different Review Panel if we need to. This could be because of illness, if an assessor asks us to, or if the panel can't resolve the dispute in a reasonable timeframe.

Review panel procedures

1. Review Panel holds initial meeting

When the Review Panel is convened, the panel will appoint a chairperson. We'll send the Review Panel copies of:

- all information that was sent to the previous Assessment Panel, including our eligibility decision and reasons
- the review application
- the Assessment Panel certificate
- any additional information since the review application was made.

The Review Panel will hold an initial meeting or teleconference within 20 working days of the date the Review Panel was convened. This might not involve you or any other party to the dispute.

2. Review Panel assesses your dispute application

The Review Panel can decide its own way to assess the review of the dispute, but they have to follow the Guidelines and any practice notes.

The Review Panel's assessment process will consider all aspects of the Assessment Panel's decision and decide if any or all of the reasons for the review were justified.

The Review Panel will decide how to assess the review of the dispute and may:

- ask you to have another clinical examination, or whether the Review Panel assessment will be done on the information they have
- ask you to attend a clinical examination with another health professional who is not part of the Assessment Panel or Review Panel. If this happens, the health professional will make an assessment and give you, the Review Panel and any other party to the dispute a report.
- decide whether they need any additional information from you, another party to the dispute or anyone else to make a decision.
- decide whether and how to contact you, any party to the dispute or anyone else.
- consider any new information that the Assessment Panel did not have.

Other information

If the Review Panel decides that they need another clinical examination or additional information, the same criteria as for the Assessment Panel applies. The Review Panel have to try to resolve the dispute as quickly as possible.

We'll provide administrative support to the Review Panel during this process. This support will be from a person or team that has not been involved in the eligibility decision, or the previous dispute assessed by the Assessment Panel.

3. Certificate issued by Review Panel

The Review Panel will hold as many meetings or teleconferences as they need in order to make a decision to resolve the dispute, but they have to try to resolve the dispute as quickly as possible.

The Review Panel can confirm the decision of the Assessment Panel or revoke it and substitute its own decision.

The Review Panel will issue their decision in a written report, called a certificate. The certificate will include written reasons for their decision. We'll send this to you and to any other party to the dispute within 15 working days of their final contact, clinical examination or final teleconference. Depending on the decision, we will implement the Panel's decision within 5 working days of receiving it.

Corrections of obvious errors in certificates

If an Assessment Panel or a Review Panel has made an obvious error on a certificate you or another party can ask us to correct it. An obvious error is a clerical or typographical error in the certificate, or an error arising from an omission or inconsistency.

You need to write to us within 30 working days of the date on the certificate, tell us the error and how it should be corrected. We, an Assessment Panel or Review Panel might also find an error and ask for it to be corrected. If an Assessment Panel or Review Panel identifies an obvious error in the certificate, they have to tell us within 30 working days of the date on the certificate.

We might ask for submissions from other parties before asking an Assessment Panel or Review Panel to correct an obvious error.

The Assessment Panel or Review Panel must decide whether to issue a replacement certificate within 20 working days of receiving the application to correct the obvious error or receiving the submission from the other party.

The Assessment Panel or Review Panel may issue a replacement certificate that corrects any obvious error and that will replace the previous certificate. If a replacement certificate is issued, the replacement certificate is to be identified as a replacement certificate that replaces the previous certificate.

We may not agree with the Assessment Panel's decision

If we don't agree with the Assessment Panel's decision we could apply for the review.

If we do, we have to tell you and any other party in writing, prior to any review application, and ask you what you think about it.

We may not accept an application for review

We might dismiss a review application if it:

- isn't received within 6 months of receiving the Assessment Panel certificate or
- doesn't clearly identify which one or more grounds for review apply.

Alternatives to review

If the review application relates to section 15(1)(a) and/or 15(1)(b) of the Act, and you aren't a participant (interim or lifetime) when the review application is made:

- we might decide that the review application gives us information to make a decision about your eligibility, and/or
- the review application might give us the information we need to ask you to apply to the Scheme, rather than make a dispute.

If this happens, we might ask you to withdraw your review application. You could then ask us to treat your review application as a new application to the Scheme, or you could lodge a new application to the Scheme.

If you lodge a new application, this Part doesn't apply, and Part 1 applies to that application instead.

Will it cost me anything?

No. The cost of the review panel assessment is paid by us, including any necessary travel and accommodation. We can't pay any legal costs for you, for example, if you engage a solicitor to assist you with the review.

For more information contact Lifetime Care

9am to 5pm, Monday to Friday

Phone: 1300 738 586

Email: feedback.lifetimecare@icare.nsw.gov.au

Web: www.icare.nsw.gov.au

Disputes about treatment and care needs (companion to Part 4)

You can dispute a decision we made about your treatment and care needs as a participant in the Lifetime Care and Support Scheme if you disagree with the decision on the certificate you receive.

This companion explains how you can dispute a decision we have made about your treatment and care needs.

When we use the word 'you', we mean the person covered by the Lifetime Care and Support Scheme (also known as 'the participant') or someone representing them, such as a parent, guardian or legal representative.

What is a dispute about treatment and care needs?

If you disagree with anything about the decision we made for your treatment and care needs, you can make a dispute application. A dispute application is a request for us to refer your dispute to a dispute assessor who will review the decision and resolve the dispute.

You can only apply for a dispute after we've sent you a 'certificate' to tell you our assessment of your treatment and care needs.

Time frame for making a dispute

A dispute application must be made by you, or by someone on your behalf within 28 calendar days of the date we give you the certificate. We can extend this time limit if there is a valid reason why the application was not made earlier.

You can lodge a dispute application in writing, in person or by telephone

The dispute application must include:

- your name, address and contact details
- the date of our decision
- a statement that you don't agree with our assessment
- the reasons why you think we should pay for the treatment or service that is not approved, with reference to any other information or reports.

If you don't give us this information, we might ask you for it before we can assess your dispute application.

Further information or documentation required

If we need more information about the application, or other information that might help resolve the dispute, we may ask you or a service provider to give us this information within 20 working days. If we don't receive this information we'll go ahead with the application after 20 working days.

We can contact any party, or any of your treating health practitioners or service providers in order to clarify the issues in dispute or to assist with getting information relevant to the dispute. We may also contact any of your treating health practitioners if an assessor thinks there is an urgent or serious health or physical safety issue at any stage of the dispute.

Not accepting a dispute application

We might not accept a dispute application if it:

- doesn't clearly seem to be about our assessment of your treatment and care needs
- hasn't been made by you or someone on your behalf
- hasn't been made within the 28 calendar days of the date we give you the certificate.

Resolving the dispute informally

After we've received your dispute application, we might contact you to:

- better understand what the dispute is about (for example, to talk about the reasons why you dispute our decision)
- see if the dispute can be resolved in another way, if you would like, before referring it to a dispute assessor
- ask if we can look at your request again and make a new decision
- find out what you might need, if you have an assessment by a dispute assessor.

Meetings

We might ask to meet with you, or a service provider, to do another assessment or to clarify what's in dispute. If this happens, we'll let you know who will go to the meeting and what it's about, for example, to try to agree on options to resolve the dispute. We'll also arrange a time and venue that suits you. We'll aim to contact you as soon as possible to arrange a meeting and no longer than 5 working days of receiving the dispute application.

If you don't get the outcome you want from this informal process, you can still go ahead with the dispute.

What happens during the dispute?

Our existing assessment of your needs stays the same until the dispute is resolved.

1. We'll choose a dispute assessor

We'll choose a dispute assessor from our list of assessors, 5 working days after we receive your dispute application or any additional information we asked for. This could also happen after we have assessed your application, but you still want to dispute it. When we choose the dispute assessor, we consider:

- your needs, such as the nature of your injury
- what is in dispute
- your location, and the location of the assessor
- the specialty and expertise of the assessor
- the availability of the assessor
- whether you need an interpreter.

If the dispute assessor is not appropriate

You can ask us to reallocate the dispute to a different assessor if we think you have sound reasons for thinking that the assessor is not appropriate.

To do this, you have to:

- ask us to reallocate the dispute within 10 working days of finding out the name of the assessor
- tell us exactly why you think the assessor is not appropriate to assess the dispute; and
- send a copy to us.

We'll decide about the request for reallocation within 10 working days of receiving the request.

Same assessor but different dispute

If an assessor has resolved a previous dispute, we could ask them to determine the current unrelated dispute. *For example, a dispute assessment for a different type of dispute under another part of these Guidelines.*

2. We'll refer the dispute to the dispute assessor

Referring the dispute

We'll send the dispute assessor:

- a letter referring the dispute to them
- your dispute application and any supporting documents
- our certificate of assessment of your treatment and care needs, and a copy of all other information about this certificate, including all information we considered when making our assessment
- all information we think is relevant to our assessment of the participant's treatment and care needs, *for example, certificates of previous assessments of treatment and care needs for the requested item or service, the most recent treating specialist report or neuropsychological report*
- a copy of any additional information received about the certificate since the dispute started
- a copy of any information you ask us to send the assessor.

Once the dispute is referred to a dispute assessor, they decide how the assessment will proceed and might:

- contact you to clarify issues in dispute
- contact any treating health professional or service provider, where appropriate, to clarify any issues in dispute or ask for more information
- ask you to have an assessment (clinical examination) with the dispute assessor
- ask you to have an assessment (clinical examination) with another health professional who will give a report to the dispute assessor to help them make their decision and/or
- assess the dispute on the information provided.

The dispute assessor may decide to assess the dispute without examining you if they think:

- they can make a decision based on the information provided
- a clinical examination isn't needed
- there are reasons why you shouldn't have a clinical examination, or it would be distressing for you.

We'll provide administrative support to the dispute assessor during the assessment process.

3. We'll confirm the assessment details with you

We'll write to you to tell you the arrangements for the assessment, and the name and specialty of the assessor.

We may need to arrange a clinical examination

When a clinical examination is required, we'll notify you in writing of the time, date and location of the clinical examination, and the name and specialty of the health professional.

Preparing for the clinical examination

Before the examination, we'll tell you how to prepare for the examination (e.g. what to wear and bring), what to expect, and what might happen. *For example, the kind of questions you or your support person might be asked.*

What happens during a clinical examination?

When the clinical examination happens, the assessor will try to make sure that you and your support person understand why the examination is happening and what is involved; the things the assessor will consider in assessing the dispute; and the role of the assessor as an independent decision-maker in making a decision to resolve the dispute that has to be followed.

The dispute assessor will decide who can be there at a clinical examination and how it goes ahead. A parent, legal guardian, carer or other support person can be there to help or support you.

Your legal or medical representatives can't be there unless we give prior approval and we think there are good reasons.

Your legal guardian, carer or other support person may provide information to the assessor during a clinical examination, but only when asked by the assessor. The assessor sometimes might have to ask your legal guardian, carer or other support person to leave the clinical examination. *For example, if your support person is shouting and speaking over you. The assessor asks your support person to let you speak, but they don't. This is affecting the assessment and causing you to be upset.*

Costs

We'll pay the reasonable costs associated with your attendance and if required, the reasonable expenses of one accompanying person such as your guardian, carer or other support person to attend any clinical examination. We'll need to approve these costs before payment.

Using interpreters in assessments and clinical examinations

If you need an interpreter, we'll arrange one who is accredited by NAATI (National Accreditation Authority for Translators and Interpreters).

If a NAATI interpreter is not available, a non-NAATI interpreter may be used if the Assessment Panel or Review Panel agree to this.

Anyone who is with you at an examination or assessment, such as a carer or support person, can't be your interpreter.

3. Certificate issued by dispute assessor

The dispute assessor has to try to resolve the dispute as quickly as possible and will issue their decision in a written report, called a 'certificate'. The certificate will include written reasons for the decision. This will be sent to you within 15 working days of assessment, whether this was a clinical examination or on the information provided.

We'll revise our assessment within 5 working days of receiving the dispute assessor's report to be the same as what the dispute assessor has decided.

Reviews

You can ask for a review of the dispute assessor's decision. To apply for a review, you need to write to us within 28 days of receiving the dispute assessor's decision. We'll acknowledge your application within 10 working days.

An application for review has to:

- be in writing (letter or email)
- include your name, address and contact details
- a statement about why you're asking for a review, including which ground or grounds for review in the Act apply, together with reasons
- attach any relevant information or medical reports that are relevant to the review application.

Grounds for review

Any or all of the following reasons justify a review of a decision we have made about your eligibility:

- There has been a change in your condition, being a change that occurred or that first became apparent after the dispute was referred to the assessment panel and that change is capable of having a material effect on the determination.
- There is additional relevant information about your injury, being information that was not available, or could not reasonably have been obtained, before the dispute was referred to the panel and that information is capable of having a material effect on the determination.
- The decision was not made in accordance with the Guidelines.
- The decision is demonstrably incorrect in a material respect.

We have to apply for a review if you haven't applied, and we think there are sound reasons. We'll only do this if we think the review will make a practical difference to you or us.

Before we apply for a review, we must write to you and ask you what you think about the review being referred to a panel or dismissed. You have 20 working days to write back to us.

The Review Panel

We'll convene a Review Panel from our list of assessors within 10 working days of deciding to refer the application to a Review Panel.

If you applied for the review, we'll convene the Review Panel. We'll consider:

- your needs, such as the nature of your injury
- the issues in dispute
- the grounds for review in the review application
- your location, and the location of the assessors
- the specialty and expertise of the assessors
- the availability of the assessors
- whether you need an interpreter.

Who's on the Review Panel?

If we applied for the review, we'll let you choose who will be on the Review Panel (the Panel) and convene the Panel based on who you choose. The Review Panel can't include the dispute assessor whose decision is under review. We'll tell you about the details of the review within 5 working days of convening the Panel. This will include the names and specialties of the assessors on the Panel. We might contact you before any assessment by a Review Panel. This is to make sure that your needs can be met in any assessment or examination.

If you disagree with who is on the Review Panel

If you think the assessor is not appropriate, you can ask us to reallocate the dispute to a different assessor or assessors. This could be for any or all of the assessors on the Review Panel. However, if you were involved in choosing the Panel, you can't ask us to reallocate anyone you chose.

You have to ask us to reallocate, within 10 working days of finding out the names of the assessors on the Review Panel and tell us exactly why you think the assessor is not appropriate to assess the dispute.

We'll decide about the request for reallocation within 10 working days of receiving the request, or within 10 working days of receiving a submission from the other party.

We'll reconvene the Review Panel, in whole or in part, if we think there are reasonable grounds for thinking that any of the assessors originally appointed to the Review Panel are not appropriate.

Same assessor but different dispute

If an assessor has resolved a previous dispute, we could ask them to be a part of a Panel to determine the current unrelated dispute. *For example, a dispute assessment for a different type of dispute under another part of these Guidelines.*

We might reallocate a dispute to a different assessor or Review Panel as a whole if we need to. This could be because of illness, if an assessor asks us to, or if the Panel can't resolve the dispute in a reasonable timeframe.

Review panel procedures

1. Review Panel holds initial meeting

The Review Panel will appoint a chairperson. We'll send the Panel copies of:

- all information that the previous dispute assessor had, including our decision about your treatment and care needs that is in dispute
- the dispute assessor's decision
- the review application and all accompanying documents
- any additional information received since the dispute application.

The Review Panel will hold an initial meeting or teleconference within 20 working days of the date they were convened. This might not involve you.

2. Review Panel assesses your dispute application

The Review Panel can decide its own way to assess the dispute, but they have to follow the Guidelines and any practice notes.

The Review Panel's assessment process will consider all aspects of the dispute assessor's decision again, which could involve:

- deciding whether one or more of the review grounds are made out.
- asking you to have another clinical examination, or whether the Review Panel assessment will be done on the information they have.
- asking you to attend a clinical examination with another health professional who is not part of the Assessment Panel or Review Panel. If this happens, the health professional will assess you and give a report to the Review Panel, and to you.
- deciding whether any additional information is required to make a decision, from you or anyone else.
- deciding whether and how to contact you, any party to the dispute or anyone else.
- considering any new information that the dispute assessor did not have.

Other information

If the Review Panel decides to examine you, or to ask for more information, then the sections on 'Clinical examination' and 'Clinical examination procedures' apply.

The Review Panel will hold as many meetings or teleconferences as they need to, to make a decision to resolve the dispute, but they must try to resolve the dispute as quickly as possible.

We will provide administrative support to the Review Panel during their process.

3. Certificate issued by Review Panel

The Review Panel can either confirm the decision of the Assessment Panel or revoke it and substitute its own decision.

The Review Panel will issue their decision in a written report, called a certificate. The certificate will include written reasons for their decision. This will be sent to you and us within 15 working days of their final contact, clinical examination or final teleconference. Depending on the decision, we will implement the Panel's decision within 5 working days of receiving it.

Corrections of obvious errors in certificates

If you think a dispute assessor or Review Panel has made an obvious error, you can ask us to have it corrected. An obvious error is a clerical or typographical error in the certificate, or an error arising from an omission or inconsistency.

You need to write to us within 30 working days of the date on the certificate, tell us the error and how it should be corrected.

Lifetime Care, a dispute assessor or the Review Panel might also find an error and ask for it to be corrected. If an Assessment Panel or Review Panel identifies an obvious error in the certificate, they have to tell us within 30 working days of the date on the certificate.

An obvious error is a clerical or typographical error in the certificate, or an error arising from an obvious omission or inconsistency.

If a dispute assessor or Review Panel tells us they think there is an obvious error, we'll tell you. You'll then have 20 working days to tell us whether you think there is an error that should be corrected.

We'll send an obvious error application to the dispute assessor or Review Panel 10 working days after we get the application, or any submission from you.

The dispute assessor or Review Panel must decide whether to issue a replacement certificate within 20 working days of receiving the application or submission from the other party to correct the obvious error.

The dispute assessor or Review Panel may issue a replacement certificate that corrects any obvious error and that will replace the previous certificate. If a replacement certificate is issued, the replacement certificate is to be identified as a replacement certificate and replaces the previous certificate.

We may not accept an application for review

We might dismiss a review application if it:

- isn't received within 28 calendar days of the dispute assessor's decision
- relates to a review panel certificate
- it doesn't clearly identify which one or more grounds for review apply.

If you apply for review, we might decline to make submissions in response to your application. However, if we find a potential ground for review or we agree with any of the grounds you state, we must make a submission in response to your application.

We'll write to you to tell you whether the review is referred to a panel or dismissed. If you applied for the review, this will be within 20 working days of your application.

If we applied for the review, we will write to you within 5 days of receiving your submission.

Alternatives to review

Sometimes, your review application could contain new information, or information that might change the decision we made. If we think this is the case, we might ask you if we can make a new decision. You still have other options if the new decision didn't help you get the outcome you wanted.

Will it cost me anything?

No. The cost of the review panel assessment is paid by us, including any necessary travel and accommodation. We can't pay any legal costs for you, for example, if you engage a solicitor to assist you with the review.

For more information contact Lifetime Care

9am to 5pm, Monday to Friday

Phone: 1300 738 586

Email: feedback.lifetimecare@icare.nsw.gov.au

Web: www.icare.nsw.gov.au

Assessment of treatment and care needs (companion to Part 5)

Lifetime Care assesses your treatment and care needs before we decide what we will fund.

Assessments are an important part of understanding your needs and planning your treatment and care.

This companion explains what we mean by an assessment, what an assessment is for, and guiding principles for making assessments.

When we use the word 'you', we mean the person covered by the Lifetime Care and Support Scheme (also known as 'the participant') or someone representing them, such as a parent, guardian or legal representative.

What we mean by an 'assessment'

An assessment is a process using objective tools (where possible) to identify your needs by reviewing your strengths, abilities, goals for participating in the community, and other things that may help you. It also identifies limitations, risks, and issues that could stop you from achieving your goals. Assessments should be done using objective tools wherever possible.

An assessment can be:

- a service provider's assessment of your needs so you can ask us to pay for an item or service by making a 'request for service'
- our assessment of your needs so we can make a decision about whether to pay for an item or service

You might also have an assessment to help make an overall plan for your care needs.

You, someone acting on your behalf, or a service provider can ask us to assess any of these treatment and care needs:

- medical treatment, including medicines
- dental treatment
- rehabilitation
- ambulance transport
- respite care
- attendant care services
- aids and appliances (equipment)
- prostheses (artificial body parts such as eyes or limbs)
- education and vocational training
- modifications to your home and transport
- modifications to your workplace and education facility.

When a service provider or health professional assesses your needs, they might:

- write a report
- complete one of our forms for a plan or a request for services
- provide extra information to accompany a plan or a request that has already been submitted to us.

After an assessment, we will work closely with you, the people close to you and your service providers to plan and manage your care.

Requesting an assessment

We might ask you to have an assessment to help us to decide whether to fund an item or service, or to plan for your care.

You might request an assessment, so we can decide whether to pay for an item or service. You can make a request on a form, in writing, or verbally. You can do this directly or through a service provider.

A service provider might assess your needs so that you can ask us to pay for an item or service.

Where possible, an assessment should be done before you pay for a treatment, item or service.

If you or someone on your behalf pays for an item or service and asks us to reimburse the expense, we may assess your treatment and care needs according to the criteria in *Reasonable and necessary treatment and care needs (Companion to Part 6)* to decide whether the expense is reasonable and necessary.

Assessment or medical exams with an external service provider or health professional

We might ask you to undergo an assessment or a medical examination with a service provider or a health professional who is external to Lifetime Care.

If you agree, we may ask them to:

- complete a report
- complete a plan or a request for services on one of our forms
- provide extra information to accompany a plan or request that's already been submitted to us.

We can only approve your request for treatment or care if we have enough information. If you refuse a reasonable request, which means we can't make an assessment, we may not be able to decide whether the requested treatment or care need benefits you, is appropriate and cost effective.

If you haven't had an assessment or medical examination and we can't make a decision, we'll write to you to tell you:

- that we can't make a decision to approve the treatment or care need
- the reasons we haven't approved the treatment and care need
- that we won't arrange for and pay for the services requested.

Plans and requests for services

Assessments can be part of plans and requests for services. We'll help you outline your goals and expected outcomes in your plans and requests.

As part of the goal-setting process, you should tell us about anything in your personal circumstances or environment that could help you meet your goals or stop you from achieving them.

Your final plan will reflect your goals and circumstances. It will clearly say what we will and won't fund to meet your treatment and care needs related to the motor accident injury.

Service providers must use our procedures and approved forms when doing assessments. All of our forms are available on our website.

If there isn't enough information in the request to complete a needs assessment, we may ask you, someone acting on your behalf, or a service provider to give us more information.

Ongoing assessments

To decide when and how many assessments should be done, we consider:

- the nature and severity of the motor accident injury
- whether you're an interim participant (someone who is covered by the Scheme for a limited time), in which case assessments will probably be done more frequently
- how many requests you've made
- when the motor accident injury occurred
- the extent of your treatment and care needs
- if your motor accident injury affects your ability to ask for an item or service
- whether the need for multiple assessments can be decreased.

Our principles for assessments

When a service provider or Lifetime Care undertakes an assessment, these are the principles they or we follow:

- consider your views
- aim to help you be as independent as possible and to participate in the community
- identify your goals, aspirations, strengths, capacity, circumstances and context
- assess how you do things for yourself and how you participate in the community
- assess your risks and safeguards
- consider assessment and planning principles
- wherever possible, use the assessment tools published on our website.

You can direct your service delivery as much as you can and as much as you want. You can refuse any services, even when other people think you are making the wrong choice.

How we decide

A 'decision' is our final determination of what we'll fund based on the information from an assessment.

We use the principles outlined in *Reasonable and necessary treatment and care needs (Companion to Part 6)* to help us decide what is reasonable and necessary for your needs.

When we decide whether a treatment or care need is solely related to the motor accident injury we'll consider:

- whether it's possible to assess any injury you had before the accident, or another injury you received in the accident to decide what treatment and care needs relate directly to the accident
- whether an injury you had before the accident or another one you have from the accident was made worse by the motor accident
- whether there are other needs related to the motor accident injury that may be affected if we decide a need is not related.

Information we may need to make our decision

We may need the following information during, before or after an assessment to help us make a decision about whether to pay for an item or service:

- answers to questions you're asked by us or service providers
- your hospital records
- reports from your treating doctors and other medical reports
- past medical records or school records
- other pre-accident information or general medical information
- any other information we think is relevant.

Our process for making decisions

- Once we get information about your care needs, and the treatment or service you're asking us to pay for, we make a decision within 10 working days of receiving your request (unless you are asking for prostheses or home and transport modifications over $10,000 – in which case we'll tell you in writing of the status of your request within 20 working days).
- We decide if the payment request is 'reasonable and necessary' and related to the motor accident.
- We'll send you a letter telling you our decision. This letter is called a 'certificate'.
- You don't have to agree with our decisions. You have the right to dispute any decision we make. That's OK and we can help you do this.

Other info

We may evaluate more than one request for assessment of your treatment and care needs at a time.

We may fund a service provider, such as a case manager, to help you access services or ask us to fund an item or service.

For more information contact Lifetime Care

9am to 5pm, Monday to Friday

Phone: 1300 738 586

Email: enquiries.lifetimecare@icare.nsw.gov.au

Web: www.icare.nsw.gov.au

Determination of reasonable and necessary treatment and care needs (companion to Part 6)

Lifetime Care will pay for the reasonable and necessary treatment and care you need because of an injury you sustained from a motor vehicle accident.

This companion explains what reasonable and necessary treatment and care needs we will pay for, what we won't pay for, and how we make our decisions.

When we use the word 'you', we mean the person covered by the Lifetime Care and Support Scheme (also known as 'the participant') or someone representing them, such as a parent, guardian or legal representative.

What we fund

Reasonable and necessary treatment and care needs

Treatment and care needs are any needs connected with:

- medical treatment (including medicines)
- rehabilitation
- ambulance transport
- respite care
- attendant care services
- aids and appliances (equipment)
- prostheses
- education and vocational training
- modifications to your:
    - home
    - transport
    - workplace
    - education facility.

What we mean by reasonable and necessary

We consider treatment, rehabilitation and care services to be reasonable and necessary when they benefit you, are appropriate to your circumstances and are cost effective.

What we don't fund

We don't pay for treatment and care needs or expenses:

- that aren't related to your treatment and care needs
- that we don't consider to be reasonable and necessary under the circumstances
- if the service doesn't fit any of our categories of treatment and care needs.

We also don't pay for:

- your family members
- lost wages, weekly benefits or other forms of income or income support
- keeping a business open, such as paying for temporary staff to do your job
- items that were lost or damaged in the motor accident
- payments for large capital items such as houses and cars.

We sometimes take other factors into account when we decide whether proposed or incurred expenses are unreasonable or don't relate to reasonable and necessary treatment and care needs.

Risky treatments

We don't consider an expense to be reasonable, and we don't consider a treatment and care need to be reasonable and necessary if it is too 'risky'. This means that:

- is likely to cause you harm
- relates to an illegal activity
- poses an unacceptable risk to you or someone else.

How we decide

How we decide if the treatment, equipment or service will benefit you

We consider whether:

- you've been involved in planning the goals and outcomes, and you've identified, understood and agreed to them
- the proposed treatment, equipment or service relates to your goals and will make it easier for you to participate in the community
- you prefer the proposed treatment, equipment or services to other options
- you have agreed to the request
- there's information showing that the treatment, equipment or service will benefit you
- any risk associated with the treatment, equipment or service is offset by the expected benefit
- you, people close to you, service providers and Lifetime Care have assessed the risk of the treatment, equipment or service, and have agreed to and documented a plan to manage that risk
- the expected outcomes will improve or maintain your recovery/management
- not receiving the treatment, equipment or service will lead to a negative outcome for you, or put you at greater risk
- the treatment, equipment or service – or something similar to it – has been provided to other people with positive results.

How we decide if the treatment, equipment or service is appropriate to your treatment and care needs

We consider whether:

- it will help you achieve your goals
- it's in line with current clinical practice and guidelines, and is based on or informed by evidence
- it's consistent with your current medical or rehabilitation management
- there's evidence that it's effective
- it's already being provided by a similar service
- it fits with other services that you are, or will be, receiving
- there are any contraindications – in other words, you have a condition or take medication that means the treatment may cause you harm
- other services or equipment would give a better outcome
- it's considered the most appropriate service available
- you prefer it or you have agreed to it.

New and innovative treatments

For a new and innovative treatment, equipment or service, we use additional criteria. We assess whether there are strong enough reasons for funding it, and whether there are measures in place to quantify its outcomes.

We only agree to a new or innovative treatment, equipment or service when:

- its effectiveness has been proved by peer reviewed journal articles or other evidence-based studies
- it's widely supported by practitioners in the field
- it's beyond the early stages of clinical trial
- there is a Medical Benefits Schedule (MBS) item number (for medical treatment, procedures, and surgery)
- you have made an informed choice to accept any risk associated with the treatment and have documented your consent.

How we decide if the provider is appropriate

We consider whether:

- you have chosen or said you prefer a specific provider, or you have agreed to the provider we have suggested
- the provider is qualified and has the experience to provide the service
- the provider is available to meet your treatment and care needs
- you can easily get access to the provider
- the provider is registered by the Australian Health Practitioner Regulation Agency
- the provider is approved under Part 18 of the Guidelines.

How we decide if the treatment, equipment or service is cost effective

We consider:

- the long-term benefits and whether the expected outcomes outweigh the cost
- the cost of comparable services in the same location or type
- if other treatment, equipment or services are available
- whether equipment or modifications are required
- comparing the cost and other factors of renting instead of purchasing
- if other services will achieve a similar outcome
- will there be advances in technology
- changes to your needs over time.

How we decide if the treatment or care need relates to the motor accident injury

We consider whether:

- there is evidence that proves the service is related to the injury/injuries you received from the motor accident
- any injuries you had before the accident have been made worse
- how long it has been since you were injured, the injuries you received, and any other conditions you have.

How we decide what treatment and care you need

We follow Lifetime Care funding principles to decide what, if any, treatment and care you need and what we will fund. We may refer to other guidelines.

Our funding principles

When we're making decisions about funding rehabilitation we follow these guidelines.

- Planning, decision-making and risk assessment activities are collaborative, and this is evident in plans and requests for services.
- Our aim is to help you be as independent as possible and to participate in the community.
- The treatment or service must relate to the motor accident injury.
- Services should be flexible and tailored to meet your needs.
- The treatment, equipment or service benefits you, is appropriate, and is cost effective.
- The provider is appropriate to your needs.
- Initial assessments are made within 10 working days.
- We will document our decisions and communicate them via a 'certificate' (a certificate is a letter we'll send you about the decisions we've made).

Your rights

- You have the right to refuse services.
- You have the right to dispute any decision we make about your needs.

Our process for making decisions

- We'll need to get some information about the rehabilitation services you want us to pay for.
- After we get this information, we'll make a decision within 10 working days.
- We'll let you know our decision by letter. This is known as a 'certificate'.
- You don't have to agree with our decisions. You have the right to dispute any decision we make. That's OK and we can help you do this.

What else we might consider

We'll asses your treatment and care needs individually. In doing this we'll use the criteria in the Lifetime Care and Support Guidelines and any other principles or information we believe is relevant. We may consider factors such as your age, or ethnic, cultural and language background.

Other guidelines we might use

Sometimes we apply other guidelines when making decisions. We use current versions of the following publications when we assess treatment and care needs:

- The Neuropsychological Assessment of Children and Adults with Traumatic Brain Injury: Guidelines for the NSW CTP Scheme and the LTCS scheme
- Guidelines for the prescription of a seated wheelchair or mobility scooter for people with a traumatic brain injury or spinal cord injury
- Guidelines for the prescription of a seated wheelchair or mobility scooter for people with a traumatic brain injury or spinal cord injury: Supplement 1: Wheelchair features – standing wheelchair
- any other guidelines we have developed or adopted and published on our website.

For more information contact Lifetime Care

9am to 5pm, Monday to Friday

Phone: 1300 738 586

Email: enquiries.lifetimecare@icare.nsw.gov.au

Web: www.icare.nsw.gov.au

Rehabilitation (companion to Part 7)

Lifetime Care will pay for the reasonable and necessary rehabilitation you need of an injury you sustained from a motor vehicle accident.

This companion explains what rehabilitation services we fund, what we don't fund, what we mean by certain terms, and how we make our decisions.

When we use the word 'you', we mean the person covered by the Lifetime Care and Support Scheme (also known as 'the participant') or someone representing them, such as a parent, guardian or legal representative.

What we fund

Rehabilitation

Rehabilitation means the process of helping an injured person recover the best they can so they can:

- live as independently as possible
- reach their fullest physical, mental, social and work capacity, so they can participate as fully as possible in all areas of life.

Rehabilitation may include therapies such as:

- physiotherapy
- occupational therapy
- speech pathology
- psychology.

Rehabilitation includes case management services to support you to participate in rehabilitation or to identify, plan and continue rehabilitation.

Documenting plans, requests, reports, case conferences or contact with other professionals treating you are all part of how we manage rehabilitation at Lifetime Care.

Concurrent treatment

Concurrent treatment is when:

- different treatments are provided at the same time by more than one type of provider (for example, if you're having chiropractic and physiotherapy treatment at the same time)
- similar services are provided by one provider type (for example, if you're having physiotherapy and acupuncture from one provider who is qualified to provide both services). The services may aim to achieve the same goals, but the objectives and treatment approaches may be different.

We'll pay for concurrent treatments when:

- there's a good medical reason
- the treatments are part of a plan we've approved
- treatment providers make sure treatment provision and goals are closely aligned
- there's a written request for service
- treatments by the same type of provider focus on different conditions to achieve different treatment goals, such as musculoskeletal physiotherapy and neurophysiotherapy.

We usually consider that having more than one case manager at the same time is concurrent – unless it's related to a short-term need, such as handover to another case management services provider.

Individual and group sessions delivered by the same provider are not considered to be concurrent treatment.

Gym programs

We'll pay for a gym program when:

- it's for a rehabilitation program or other exercise program
- it's been developed in conjunction with a qualified exercise professional, such as a physiotherapist or exercise physiologist.

We'll compare the cost of membership at two gyms in your area to work out what's reasonable in your circumstances. If you prefer a more expensive gym, you'll need to show us why we should pay for it rather than a cheaper one, and how your reason for wanting to go there relates to your motor accident.

If we decide the cost of your preferred gym is unreasonable, we can contribute what we think is a reasonable cost, based on the price of the cheaper local gym membership, towards the cost of membership at your preferred gym.

We'll pay for an exercise physiologist or personal trainer when you need specialist assistance that an attendant care worker can't provide.

We'll only pay for the services of one or the other – we won't pay for you to see an exercise physiologist and a personal trainer at the same time.

Who can oversee your rehabilitation

Your rehabilitation needs must be recommended, directed and provided by a registered health practitioner or an appropriately trained person under their supervision.

Your health practitioner should measure any aspects of your health that may change with rehabilitation, such as pain, depression, daily living activities, health-related quality of life and work performance.

Your rehabilitation goals related to your injury must be planned, and they must be able to be measured in a way that is reliable, valid and flexible.

Requesting a service

You must ask for the service before it starts, unless it's urgent or delivered under an existing fee schedule.

What we don't fund

We don't pay for rehabilitation or expenses for:

- a condition you had before the motor vehicle accident
- assistance to keep a business open, such as paying for temporary staff to do your job
- services that go beyond helping you rehabilitate from the motor accident injury
- services where the cost is included in the hospital or inpatient rehab bed day fee
- telephone calls or internet connection for you to arrange appointments by phone or email
- cancellation fees when you've cancelled more than once, unless the reason you couldn't go was beyond your control
- gym or exercise programs that aren't prescribed by a qualified exercise professional
- gym clothing, towels, fitness/yoga mats or drink bottles.

How we decide

We follow Lifetime Care funding principles to decide which, if any, rehabilitation services you need and what we'll fund. We may refer to other guidelines.

We'll also consider if the rehabilitation:

- is needed because of the motor accident injury
- is going to be effective and achieve measurable improvements
- promotes progress towards your independence, social participation and self-management, or maintains function and prevents deterioration and secondary health conditions.

Our funding principles

When we're making decisions about funding rehabilitation we follow these guidelines.

- Planning, decision-making and risk assessment activities are collaborative, and this is evident in plans and requests for services.
- Our aim is to help you be as independent as possible and to participate in the community.
- The treatment or service must relate to the motor accident injury.
- Services should be flexible and tailored to meet your needs.
- The treatment, equipment or service benefits you, is appropriate, and is cost effective.
- The provider is appropriate to your needs.
- Initial assessments are made within 10 working days.

We'll document our decisions and communicate them via a 'certificate' (a certificate is a letter we'll send you about the decisions we've made).

Your rights

- You have the right to refuse services.
- You have the right to dispute any decision we make about your needs.

Our process for making decisions

- We'll need to get some information about the rehabilitation services you want us to pay for.
- After we get this information, we'll make a decision within 10 working days.
- We'll let you know our decision by letter. This is known as a 'certificate'.
- You don't have to agree with our decisions. You have the right to dispute any decision we make. That's OK and we can help you do this.

Information we may need to make our decision

To make a decision about whether you need rehabilitation we need to know:

- what you need for your rehabilitation in the context of other treatment and services you're receiving
- any biological, psychological and social factors that influence your health
- any pre-existing or co-existing medical conditions you have, and how they might impact your rehabilitation
- how the proposed intervention and treatment process has been justified.

Gym programs

To help us decide whether to fund a gym program, we'll need the following information:

- any physical, psychological and social factors that relate to your need for gym membership or an exercise program
- the proposed program and how often you'll attend – we need this information from a qualified exercise professional
- whether your need for gym membership is related to the motor accident injury rather than other injuries or conditions you have
- medical clearance from a treating specialist for you to participate
- if you will need an attendant care worker or support person to facilitate access and help you participate safely
- reasons for the proposed intervention, including how it relates to the motor accident
- evidence you've consistently taken part in a previous exercise therapy or rehabilitation program.

Other info

We use the Clinical Framework for the Delivery of Health Services relating to rehabilitation.

For more information contact Lifetime Care

9am to 5pm, Monday to Friday

Phone: 1300 738 586

Email: enquiries.lifetimecare@icare.nsw.gov.au

Web: www.icare.nsw.gov.au

Attendant care services (companion to Part 8)

Lifetime Care will pay for the reasonable and necessary attendant care services you need because you were injured in a motor vehicle accident.

This companion explains what attendant care services we'll pay for, what we won't pay for, what we mean by certain terms, and how we make our decisions.

When we use the word 'you', we mean the person covered by the Lifetime Care and Support Scheme (also known as 'the participant') or someone representing them, such as a parent, guardian or legal representative.

What we fund

Attendant care services

Attendant care services provide the help you need with everyday tasks because of your injury. This includes:

- personal assistance with daily tasks
- nursing
- home maintenance
- domestic services.

Personal assistance

Help with daily tasks such as:

- personal hygiene
- preparing meals
- banking and shopping
- taking medication
- exercise
- using any equipment, you need for your injury
- planning activities that help you to participate in the community, recover from your injury or get from one place to another.

Nursing

We'll pay for the services of a registered nurse if you need one.

Home maintenance

Routine, seasonal or occasional services needed to maintain the property you live in. Tasks like clearing external gutters, cleaning windows, and changing light bulbs and smoke alarm batteries.

Domestic services

Regular tasks at the property you live in, such as:

- cleaning
- gardening
- lawn mowing
- car washing
- swimming pool cleaning.

To ensure you have safe and easy access to your home we'll pay for these services as often as we think is reasonable.

Attendant care services when you're away from home

If you're away from home for a long time or if you're going on holidays, we'll need to know so we can make sure your attendant care services continue meeting your needs.

We'll also consider funding extra attendant care related to your travel because you're away from home and in a different environment. We think 28 calendar days of extra attendant care expenses each year is reasonable. You can take the time in one break or split it into a few shorter breaks over the year. If you want a longer break, you can combine the days from two or more years.

Travel

If you can't travel in economy class because of your motor accident injury, we'll consider funding the difference between economy class travel and the class of travel necessary to meet your needs. We consider that funding this cost difference for one domestic and one international return flight per calendar year is reasonable.

Funding for carers

If you're a parent or a caregiver, we can support you. For example, an attendant care worker could help you take your child to and from school. However, the attendant care worker would not take the children to school without you being there.

Alternatives to attendant care services

We'll consider funding school holiday programs, child care, community–based groups or community access programs instead of attendant care services if they are injury-related, age appropriate and cost effective.

What we don't fund

We don't pay for services or expenses:

- related to an injury you had before the accident
- that are of no clear benefit to you
- that are unsafe for you or the attendant care worker
- for members of your family or people who live with you
- that replace parenting or direct caring responsibilities
- related to job training or that replace your job tasks
- when you're in hospital or inpatient rehabilitation
- requiring a qualified tradesperson
- for upkeep of a farm or farming activities
- that are home improvements, such as renovating or decorating
- such as direct care or supervision of family members
- for travel, unless it's for a treatment and rehabilitation service, or is travel to an activity we've paid for
- for domestic services that are part of a daily bed fee or residential accommodation fee
- for cleaning products, materials or equipment
- for waste removal or tip fees
- for holiday expenses such as travel costs, meals, accommodation, visas or immunisations.

Children

For children, we'll only pay for attendant care services for children who have a need related to the motor accident injury.

This doesn't include:

- babysitting
- child care
- out-of-school hours care costs.

How we decide

How we decide whether you need attendant care services and which ones you need

We follow Lifetime Care funding principles to decide which, if any, attendant care services you need and what we'll fund. We may also refer to other guidelines to help us in this process.

We'll pay for services if they help you with your everyday needs. We'll also pay for services if they're needed to help you safely return to work or learn new skills to support your independence.

Our funding principles

When we're making decisions about your need for attendant care services we follow these guidelines.

- Everyone involved in your care collaborates on planning, decision-making and risk assessment activities, and there is evidence of this collaboration in any plans and requests for services.
- Our aim is to help you be as independent as possible and to participate in the community.
- The treatment or service must relate to the motor accident injury.
- Services should be flexible and tailored to meet your needs.
- The treatment, item or service benefits you, is appropriate, represents value for money, and is cost effective.

- The provider is appropriate to your needs.
- Decisions are made within 10 working days.

We'll document our decisions and communicate them via a 'certificate' (a certificate is a letter we'll send you about the decisions we've made).

Your rights

- You have the right to refuse services.
- You have the right to dispute any decision we make about your needs.

Our process for making decisions

- We'll need to get some information about your care needs and the attendant care services you want us to pay for.
- After we get this information, we'll make a decision within 10 working days.
- We'll let you know our decision by letter. This is known as a 'certificate'.
- You don't have to agree with our decisions. You have the right to dispute any decision we make. That's OK and we can help you do this.

Other info

We follow the best practice guidelines developed by the Australian Community Industry Alliance, formerly known as the Attendant Care Industry Association (ACIA) to decide on the type of attendant care or nursing support for you.

For more information contact Lifetime Care

9am to 5pm, Monday to Friday

Phone: 1300 738 586

Email: enquiries.lifetimecare@icare.nsw.gov.au

Web: www.icare.nsw.gov.au

Education support services (companion to Part 9)

Lifetime Care will pay for the reasonable and necessary education support services you need because of an injury you sustained from a motor vehicle accident.

This companion explains what education support services we pay for, what we won't pay for, what we mean by certain terms, and how we make our decisions.

When we use the word 'you', we mean the person covered by the Lifetime Care and Support Scheme (also known as 'the participant') or someone representing them, such as a parent, guardian or legal representative.

What we fund

Education support services

If you're a student, education support services help promote independence in your learning. They are in addition to what all students are entitled to under state or federal legislation.

Education support services include assistance with attending:

- preschool
- childcare (including before and after school care)
- primary and secondary schools
- other education institutions such as higher education.

It may also include assistance with short-term needs such as:

- helping you catch up on missed curriculum because you spent time in hospital
- teacher release time so they have time to adapt and modify programs to accommodate your individual learning needs
- professional support (such as training) for education providers so they can modify programs to meet your needs.

It can also include supporting you with specific needs such as:

- helping you transition from primary school to high school
- learning across the curriculum or in specific subjects.

We also pay for:

- a school learning support officer or attendant care worker to go on overnight excursions/camps with you
- specialist support services such as therapists, special education teachers or other professionals when the education services are delivered at the same time as rehabilitation services.

We consider the education provider to be responsible for education support services, appropriate to a student's capacity.

Tutoring

Tutoring is a service provided in addition to a school program. It offers individual support in a specific subject or study skill. The aim is to help you get back to the level of your academic achievement before the accident, or to a level that is consistent with your motor accident injury.

We'll consider paying for tutoring when:

- it relates to a specific need for education support because of the motor accident injury
- it promotes your independence in the education setting
- we identify it as the most effective approach after we've considered what the education facility has already implemented
- it helps you achieve measurable learning outcomes and goals
- It complements other education support services and specialist services such as neuropsychology, psychology, speech pathology and occupational therapy.

What we don't fund

We don't pay for:

- education support services or expenses for a condition that existed before the motor accident or that is not a result of a motor accident
- education support services or expenses you accessed, were assessed as needing, or were on the waiting list for before the motor accident
- school fees, fees for excursions or school camps, stationery and uniforms
- travel that isn't related to your treatment or care need, such as travel to and from school
- support or services that are available to all students and are part of the school curriculum
- support or services that would be funded by the employer or education provider, such as continuing professional development for teachers and other staff
- education materials or resources you don't need
- tutoring or other programs if you don't have an identified learning support need
- tutoring requests that aren't supported by the school
- education support that's the responsibility of your parent or guardian, such as supervising homework, accessing the local library or doing school projects.

How we decide

We follow the Lifetime Care funding principles to decide which, if any, education support services you need and what we'll fund. We may also refer to other guidelines to help us in this process.

We'll pay for services if they:

- help you with your everyday needs
- help you return to school or study
- help you safely develop new skills in a way that suits your lifestyle
- support your independence and are based on measurable outcomes.

We consider your needs in the context of other treatment and services you're receiving, such as:

- rehabilitation
- attendant care services and equipment
- the environment where the education supports will be delivered
- your ability to perform or be assisted with tasks.

Because your needs may change over time, we expect that they will be reviewed by the people delivering the service. Your needs may change when:

- you achieve measurable outcomes
- your education program changes
- your needs or circumstances change
- the service is no longer the best way to meet your needs.

We'll decide how long to provide funding for education support by assessing your injury-related needs and stage of rehabilitation.

How we decide whether to fund tutoring

We follow our funding principles to make a decision about whether to pay for tutoring. We also consider:

- any evidence of additional tiredness or anxiety you've experienced since your motor accident injury
- whether the service is subject-specific and linked to the curriculum
- whether it supports the goals and outcomes of your individual learning plan
- whether the content is personalised and delivered one to one or in small groups
- whether sessions are scheduled outside regular class hours
- whether the service provider has knowledge of the curriculum, subject content and current teaching practice
- whether the provider can provide outcome measurements or progress reports as required
- whether the service is time limited.

Information we may need to make our decision

We may ask you for information to help us assess your needs, including:

- how your needs relate to the motor accident injury, including the type and seriousness of your injury
- your pre-accident development and learning history
- services you've already accessed, were on the waiting list for, or were assessed as needing before the motor accident
- pre-existing or co-existing conditions that may contribute to a need for education and support services
- measurable changes in your ability to engage in education and training because of your motor accident injury
- other needs such as rehabilitation and attendant care services
- the status or outcomes of any application for assistance through the NSW Department of Education, Association of Independent Schools of NSW or Catholic Education Commission of NSW
- reasons for the type and level of education support you have asked for
- the service provider.

Our funding principles

When we're making decisions about your need for education support we follow these guidelines.

- Planning, decision-making and risk assessment activities are collaborative, and this is evident in plans and requests for services.
- Our aim is to help you be as independent as possible and to participate in the community.
- The treatment or service must relate to the motor accident injury.
- Services should be flexible and tailored to meet your needs.
- The treatment, item or service benefits you, is appropriate, and is cost effective.
- The provider is appropriate to your needs.
- Decisions are made within 10 working days.

We'll document our decisions and communicate them via a 'certificate' (a certificate is a letter we'll send you about the decisions we've made).

Your rights

- You have the right to refuse services.
- You have the right to dispute any decision we make about your needs.

Our process for making decisions

- We'll need to get some information about the education support services you want us to pay for.
- After we get this information, we'll make a decision within 10 working days.
- We'll let you know our decision by letter. This is known as a 'certificate'.
- You don't have to agree with our decisions. You have the right to dispute any decision we make. That's OK and we can help you do this.

For more information contact Lifetime Care

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Web: www.icare.nsw.gov.au

Respite care services (companion to Part 10)

Lifetime Care will pay for the reasonable and necessary respite care services you need because of an injury you sustained from a motor vehicle accident.

This companion explains what respite care services we'll pay for, what we won't pay for, what we mean by certain terms, and how we make our decisions.

When we use the word 'you', we mean the person covered by the Lifetime Care and Support Scheme (also known as 'the participant') or someone representing them, such as a parent, guardian or legal representative.

What we fund

Respite care services

Respite care services are planned, short-term services that support your family or the usual living arrangements in your home.

Respite care services can provide you with a break from usual care arrangements or help with the support relationship you have with your family or carer.

Alternatives to respite care services

We'll consider funding alternative respite care services such as:

- a stay in a respite centre
- flexible respite.

We may consider funding other programs as alternatives to respite care when they are:

- appropriate to your age
- providing support you need
- assessed as a suitable alternative to meet your injury-related need
- designed to support and sustain you and your usual care arrangements.

We may also review your attendant care services as an alternative to respite care. If you'd like to request attendant care away from home on a short-term basis, see Attendant care services (companion to Part 8) when you're away from home.

What we don't fund

We don't pay for respite services or expenses:

- that you used before the motor accident injury or that are not a result of the motor accident injury
- for anything other than a short interval, although respite care services can be scheduled for set times during a 12-month period
- for attendant care or domestic services that we already fund (see Attendant care services (companion to Part 8))
- for holidays as respite care services, including travel, accommodation and activity costs for a holiday
- that exceed an injury-related need, such as additional costs incurred because you chose a respite option that offers a higher level of support than you need.

How we decide

We follow Lifetime Care funding principles to decide which, if any, respite care services you may need and what we will fund. We may also refer to other guidelines to help us in this process.

We fund respite care services if they:

- are appropriate to your age
- consider your needs in relation to other treatment and services provided, including attendant care and equipment
- consider the needs of your family unit or usual living arrangements, including who you choose to deliver your respite services
- consider the environment in which the respite services are delivered.

Information we may need to make our decision

To help us decide about funding respite care services, we may ask for information about:

- the motor accident injury, including its nature and severity
- any pre-existing or co-existing conditions that may also mean you need respite care
- relationships to other treatment and care needs such as attendant care, equipment and home modifications
- reasons for the type and level of respite care services you're asking for
- the service provider.

Our funding principles

When we're making decisions about funding respite care services we follow these guidelines.

- Planning, decision-making and risk assessment activities are collaborative, and this is evident in plans and requests for services.
- Our aim is to help you be as independent as possible and to participate in the community.
- The treatment or service must relate to the motor accident injury.
- Services should be flexible and tailored to meet your needs.
- The treatment, item or service benefits you, is appropriate, and is cost effective.
- The provider is appropriate to your needs.
- We'll make our decision within 10 working days.

We'll document our decisions and communicate them to you via a 'certificate' (a certificate is a letter we'll send you about the decisions we've made).

Your rights

- You have the right to refuse services.
- You have the right to dispute any decision we make about your needs.

Our process for making decisions

- We'll need to get some information about the respite care services you want us to pay for.
- After we get this information, we'll make a decision within 10 working days.
- We'll let you know our decision by letter. This is known as a 'certificate'.
- You don't have to agree with our decisions. You have the right to dispute any decision we make. That's OK and we can help you do this.

For more information contact Lifetime Care

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Web: www.icare.nsw.gov.au

Participants living overseas (companion to Part 11)

If you're living overseas, Lifetime Care will pay the costs of some services you need because of the injury you sustained from a motor vehicle accident.

This companion explains what we'll pay for, what we won't pay for and how we make our decisions about services you need while living overseas.

When we use the word 'you', we mean the person covered by the Lifetime Care and Support Scheme (also known as 'the participant') or someone representing them, such as a parent, guardian or legal representative.

What we fund if you're living overseas

Wherever possible, we apply the guidelines in Assessment of treatment and care needs (companion to Part 5) to assess your treatment and care needs when you're living overseas.

We'll aim to meet your treatment and care needs in a way that matches local services in the country you're living in.

Your treatment and care needs when you're living overseas may include:

- brokerage
- case management
- other contracted service to help you with the administration of your services.

We can only fund the following locally available services:

- medical treatment (including pharmaceuticals)
- dental treatment
- rehabilitation
- ambulance transport
- respite care
- attendant care services
- aids and appliances (equipment)
- prostheses (artificial body parts such as eyes, teeth or limbs)
- education and vocational training
- modifications to your home and transport
- modifications to your workplace and education facility.

We'll pay in Australian dollars. We won't pay costs that are greater than those we would pay if you were living in Australia.

If you are living overseas, we may enter into an agreement you to pay expenses for a fixed period.

What we don't fund

We don't pay for services or expenses:

- that are unreasonable when compared to similar services provided in NSW or Australia
- where there isn't enough information about your injury-related need for the item or service
- related to relocating to another country, such as visas, travel agent fees or immunisation
- related to repatriation, flights or accommodation for your return to Australia
- related to medical or allied health professionals travelling to the country where you live to assess or treat you.

How we decide

We follow Lifetime Care funding principles to decide which, if any, services you need if you live overseas and what we will fund. We may also refer to other guidelines to help us in this process.

If we're satisfied your need is injury-related we may set aside part or all of our procedures, such as filling in forms.

If we don't have enough information we may not be able to decide whether:

- your need is related to the motor accident
- the cost is reasonable.

Our funding principles

When we're making decisions about funding your treatment and care needs if you're living overseas we follow these guidelines.

- Planning, decision-making and risk assessment activities are collaborative, and this is evident in plans and requests for services.
- Our aim is to help you be as independent as possible and to participate in the community.
- The treatment or service must relate to the motor accident injury.
- Services should be flexible and tailored to meet your needs.
- The treatment, item or service benefits you, is appropriate, and cost effective.
- The provider is appropriate to your needs.
- Decisions are made within 10 working days.

We'll document our decisions and communicate them via a 'certificate' (a certificate is a letter we'll send you about the decisions we've made).

Your rights

- You have the right to refuse services.
- You have the right to dispute any decision we make about your needs.

Our process for making decisions

- We'll need to get some information about the treatment and care needs you want us to pay for.
- After we get this information, we'll make a decision within 10 working days.
- We'll let you know our decision by letter. This is known as a 'certificate'.
- You don't have to agree with our decisions. You have the right to dispute any decision we make. That's OK and we can help you do this.

Making an agreement

We may enter an agreement with you to pay expenses to you for a fixed period.

Other info

We may consider special circumstances when we decide about non-approved providers delivering your services. See *Approved providers and special circumstances (companion to Part 18)*.

For more information contact Lifetime Care

9am to 5pm, Monday to Friday

Phone: 1300 738 586

Email: enquiries.lifetimecare@icare.nsw.gov.au

Web: www.icare.nsw.gov.au

Motor vehicle modifications (companion to Part 12)

Lifetime Care will pay for the reasonable and necessary motor vehicle modifications you need because of an injury you sustained from a motor vehicle accident.

This companion explains what motor vehicle modifications we'll pay for, what we won't pay for, what we mean by certain terms, and how we make our decisions.

When we use the word 'you', we mean the person covered by the Lifetime Care and Support Scheme (also known as 'the participant') or someone representing them, such as a parent, guardian or legal representative.

What we fund

Motor vehicle modifications

Motor vehicle modifications are major or minor changes to your vehicle to make it safer for you or easier for you to drive.

Minor modifications are temporary or permanent changes that don't change the structure or safety of the vehicle, and don't need to be certified by the licensing authority. For example:

- a seat belt buckle cover to help you to travel safely
- panoramic mirrors that give a wider image than a normal mirror
- fish eye mirrors to help eliminate blind spots
- a spinner knob on the steering wheel to make steering with one hand easier
- an indicator extension lever to bring the indicator within easy reach.

Major modifications are permanent changes to the structure of the vehicle and have to be certified by the licensing authority. For example:

- a left foot accelerator
- mechanical hand controls
- wheelchair hoist systems
- wheelchair restraining devices
- wheelchair access ramps.
- Major modifications must be prescribed by an occupational therapist who is qualified in driver assessment.

Electronic and electro-mechanical hand controls

So we can decide about funding electronic or electro-mechanical hand controls you, or someone on your behalf, need to:

- consult a range of industry specialists, vehicle modifiers and converters to get quotes
- give us at least two quotes from two different suppliers
- give us a written quote from the modification supplier.

We only consider funding electro-mechanical hand controls, such as space drive technology, if you can't use mechanical controls. Before you ask us to fund electro-mechanical hand controls, you should try mechanical hand controls in a modified vehicle first. If you find you do need electro-mechanical hand controls after that trial, you must include medical evidence that you can't use hand controls in your request for funding.

Insurance, repairs and maintenance of modifications

We'll pay the difference in comprehensive insurance costs between an unmodified vehicle and a modified vehicle.

We'll pay for maintenance and repair of an installed modification when it's:

- needed to keep the modification working
- limited to normal wear and tear
- not covered under warranty or by insurance.

If the cost of the modification has been shared between us and the owner of the vehicle (you or someone else), our contribution towards the cost of maintenance and repair will reflect the percentage we paid. For example, if we paid for 50% of the cost of modifying the vehicle, we'll pay 50% of the costs for maintaining or repairing that modification.

Replacements

We may replace a vehicle modification instead of fixing it when:

- it's not cost effective to repair
- the modification has lasted past its life expectancy
- the occupational therapist or engineer recommends new equipment
- the modification no longer meets your needs.

Modifications to workplace vehicles

We'll consider paying for minor modifications to more than one vehicle:

- if you'll be driving both your own vehicle and a work vehicle
- where you need modifications to a work vehicle, so you can return to work
- if they don't form part of your employer's legal obligations to make reasonable adjustments.

For example, we'd consider funding two steering wheel spinner knobs if you need to use a spinner knob in your private vehicle as well as your employer's vehicle.

Modifications to a subsequent vehicle

We'll consider funding major modifications to your vehicle every eight years. We may fund modifications to another vehicle sooner if:

- there's a change in your injury-related needs or circumstances that means you can't safely use your current modified vehicle
- there are circumstances that would make the funding reasonable such as:
    - you use a wheelchair and previously needed modifications for passenger access but have now returned to driving
    - the previous vehicle no longer meets your injury-related needs due to a change in your abilities
    - the previous vehicle can't be repaired and needs to be replaced.

If the owner of the modified vehicle wants to purchase a new vehicle, we'll consider paying for the transfer of the modifications to the replacement vehicle.

Driver rehabilitation services

If you need driving rehabilitation, we'll pay reasonable costs if:

- the driving rehabilitation is designed by an occupational therapist qualified in driver assessment
- the need is related to the motor accident injury
- the goal is for you to learn to use the vehicle modifications.

Driver rehabilitation can include lessons from a qualified driving instructor in a suitably modified vehicle with dual controls. We'll only consider paying for driving lessons for modified vehicles if:

- you have medical clearance
- you're medically fit to drive
- you can attend an off and on road assessment of your driving performance.

When reasonable, we'll also consider paying for:

- a medical examiner to certify you are fit to drive
- an off and on road assessment conducted by an occupational therapist qualified in driver assessment
- lessons recommended by an occupational therapist qualified in driver assessment
- minor modifications to a vehicle you own or have access to, so you can get your driver practice hours.

What we don't fund

We don't pay for motor vehicle modifications or expenses:

- that are major modifications to more than one vehicle at the same time
- relating to pre-existing or co-existing conditions
- that won't provide any functional benefit to you over time, for example, if you hardly ever use the modified vehicle, and other forms of transport are more cost effective or appropriate

- intended for you but you won't use because you're not medically cleared and licensed to drive
- if you've haven't been assessed as fit to drive
- that are part of a universal service obligation or legal obligation to make reasonable adjustments, such as altering a road or footpath
- that compensate for the lack of public transport in your local area
- that don't comply with the requirements of a registration body, current national medical standards or the applicable Australian Standards and design rules
- related to buying a vehicle
- relating to general costs associated with owning a motor vehicle including licensing, registration, compulsory third-party insurance and comprehensive insurance
- to change the vehicle back to its standard configuration after major modifications have been made
- that form part of the supplier's or vehicle modifier's warranty or insurance policy, such as repairs
- relating to loss, theft or damage to the motor vehicle or its modifications
- for maintenance and repairs that all vehicle owners are reasonably expected to carry out on a vehicle to keep it in safe working order
- for day-to-day running costs such as oil, petrol, parking fees or tolls
- for maintenance or repairs for aesthetic reasons, or to add value to a vehicle
- for cancellation fees for non-attendance at driving lessons as part of driving rehabilitation
- for driving lessons if you're charged with a driving offence such as drink driving or speeding during your driving rehabilitation
- for driving rehabilitation when your licence is suspended or cancelled
- for initial lessons for a new learner driver where the need isn't related to the motor accident injury and there are no modifications to the vehicle.

How we decide

We follow Lifetime Care funding principles to decide which, if any, modifications your motor vehicle might need and what we'll fund. We may also refer to other guidelines to help us in this process.

We'll pay for a motor vehicle modification if you:

- have a physical, sensory and/or cognitive disability because of the motor accident injury which prevents you from driving safely, or travelling as a passenger in your current vehicle
- have reached a level of maximum recovery and stability in your ability to drive or be transported as a passenger in a vehicle
- need modifications so you can get in and out of the vehicle, you can be transported safely in a wheelchair, or you need to transport a wheelchair
- own or have access to a motor vehicle or you're planning to buy a vehicle to modify
- intend to be a driver of the modified vehicle and will get or keep your licence.

We'll help you decide on what vehicle modifications you need by:

- considering your needs and your social and physical environment
- considering whether your needs for vehicle modifications are likely to change
- identifying and recommending the most appropriate and cost-effective option.

Information we may need to make our decision

We may ask you for information to help us assess your needs, including:

- how often you need to access the vehicle, especially if it's used by family members
- evidence the modification is suitable
- information about the suitability of the modification and the cost of a vehicle you used or owned before the motor accident injury, including its age, condition and ownership

- evidence the vehicle being modified is in good condition, will stay roadworthy and is fit to be registered
- the suitability of the modification and the cost of a new vehicle (that you have bought or intend to buy), including age, condition and intended ownership
- that there's a documented agreement between you and the vehicle owner stating they agree to the modification and your ongoing use of the vehicle if you don't own it
- that you have successfully trialled the recommended modification where possible
- you have a recommendation from an occupational therapist experienced in vehicle modifications
- you have two quotes for the recommended modifications (or can explain why only one is available)
- you have a medical certificate by a treating medical practitioner stating that you're medically cleared to return to driving (if you're intending to drive the modified vehicle), and you've been assessed by an occupational therapist qualified in driver assessment and who is certified by the appropriate licensing authority.

Our funding principles

When we're making decisions about funding motor vehicle modifications we follow these guidelines.

- Planning, decision-making and risk assessment activities are collaborative, and this is evident in plans and requests for services.
- Our aim is to help you be as independent as possible and to participate in the community.
- The treatment or service must relate to the motor accident injury.
- Services should be flexible and tailored to meet your needs.
- The treatment, item or service benefits you, is appropriate, represents value for money, and is cost effective.
- The provider is appropriate to your needs.
- Decisions are made within 10 working days if the cost is less than $10,000 and 20 days if the cost is more than $10,000.

We'll document our decisions and communicate them via a 'certificate' (a certificate is a letter we'll send you about the decisions we've made).

Your rights

- You have the right to refuse services.
- You have the right to dispute any decision we make about your needs.

Our process for making decisions

- We'll need to get some information about the motor vehicle modifications you want us to pay for.
- After we get this information, we'll make a decision within 10 working days if the cost is less than $10,000 and 20 days if the cost is more than $10,000.
- We'll let you know our decision by letter. This is known as a 'certificate'.
- You don't have to agree with our decisions. You have the right to dispute any decision we make. That's OK and we can help you do this.

Making an agreement

We may need you to sign a formal agreement that describes the conditions of use, maintenance, insurance and ownership of the vehicle.

The agreement may cover one or more of the following:

- changes of ownership
- how often future modifications are made
- maintaining and repairing the vehicle's adaptations or modifications
- ongoing costs related to the modification such as insurance
- repaying our contribution if the vehicle is sold.

For more information contact Lifetime Care

9am to 5pm, Monday to Friday

Phone: 1300 738 586

Email: enquiries.lifetimecare@icare.nsw.gov.au

Web: www.icare.nsw.gov.au

Aids and appliances (equipment) (companion to Part 13)

Lifetime Care will pay for the reasonable and necessary aids and appliance you need because of an injury you sustained from a motor vehicle accident. We also call aids and appliances 'equipment.'

This companion explains what equipment we'll pay for, what we won't pay for, what we mean by certain terms, and how we make our decisions.

When we use the word 'you', we mean the person covered by the Lifetime Care and Support Scheme (also known as 'the participant') or someone representing them, such as a parent, guardian or legal representative.

What we fund

Equipment

Aids and appliances, also referred to as equipment or assistive technology, increases or maintains your:

- independence
- community participation
- mobility
- health
- safety.

Its purpose could be to aid communication, relieve pain or discomfort, and ensure the safety of you, your family, carers or attendant care workers. It could also help you return to or start work, education or leisure activities.

Wheelchairs, commodes, pressure care cushions and shower chairs are common examples of equipment.

Personal computers and internet access

We will consider paying for personal computers and internet access if:

- it will make you more independent in daily activities such as shopping and managing money
- you live in a remote location
- you are severely physically impaired or have another condition related to the motor accident injury that makes your access to the community difficult.

If you're enrolled in distance education, can't access computing facilities at your education institution and you don't own or have access to computer equipment, we'll also consider paying for computers and internet access if:

- it helps you return to work, including working remotely until you can go back to your workplace
- it's needed for a vocational retraining program where the goal of the program has been confirmed by a Work Options Plan and we support this goal
- you don't own or have access to suitable computer equipment and the school or education facility does not have a 'bring your own device' or similar policy in place.

Tablets and smartphones

We generally consider tablets and smartphones to be normal personal items rather than equipment and don't fund them. However, we may pay for one when you need the device for a rehabilitation program if the device is used to measure an increase in independence or improve injury-related communication issues.

Exercise and fitness equipment

We'll pay for exercise and fitness equipment if it's related to goals documented in your plan, and you've been using similar hire or loan equipment regularly.

Recreation and leisure equipment

We'll pay for leisure or recreation equipment if it helps you return to, or start, a leisure activity that's been identified as suitable for your needs.

General household and personal items

We generally don't pay for household appliances. However, we'll pay for beds, mattresses, and domestic goods such as washing machines if you need a specific type because of the injury.

Hiring equipment

It may be better for you to hire equipment if:

- your medical condition or circumstances are likely to change
- your future living arrangements aren't yet known so it's not possible to know if the equipment will work in your home
- you only need the equipment for a short time
- the service provider who has prescribed the equipment wants you to try the equipment before buying it.

Maintaining and repairing equipment

We'll pay for repairing equipment when:

- damage is due to normal wear and tear
- it's recommended by the manufacturer
- it needs to be adjusted because it doesn't fit.

We'll pay for equipment to be maintained and repaired if it's not covered under warranty or insurance, and the cost would be the same for a replacement or modification.

Replacing equipment

We'll replace your equipment when:

- your needs have changed and the equipment can't be modified to accommodate those changes
- it needs replacing due to normal use over time and it can't be fixed.

Making an agreement

We may need you to sign a formal agreement that describes the conditions of use, maintenance, insurance and ownership of the equipment.

What we don't fund

We don't pay for:

- equipment or associated expenses that aren't cost effective
- equipment that has been neglected, abused, misused or lost
- expenses related to continence aids, supplies or other consumables where you're a hospital inpatient, or the bed fee includes these costs
- general household and personal items which you would normally replace – even if we funded the original purchase
- repairs or replacements that are covered under warranty or insurance
- equipment that doesn't comply with Australian Standards or isn't registered with the Therapeutic Goods Administration
- unnecessarily replacing or upgrading an item
- equipment that you can use somewhere else that you can access (such as in a gym)
- equipment that you only use in other environments, such as a physiotherapist's rooms
- buying equipment when hiring is more appropriate, for example if you don't have definite living arrangements.

For expenses related to computers, smartphones and tablets, we don't pay for:

- the cost of software, hardware or peripherals if you don't need them to improve your independence
- the cost of software upgrades where it's not required to keep your computer serviceable or maximise your independence in computer use
- mobile data or the cost of connecting the device to the internet
- an upgrade or replacement of the device

- applications (apps) if they haven't been prescribed for you to meet an injury related need.

We don't pay for the cost of connecting devices to the internet unless you are:

- an inpatient in hospital and can't return to your workplace
- taking part in a short-term therapy program delivered via the internet
- participating in a short-term return to work program.

How we decide

We follow Lifetime Care funding principles to determine which, if any, equipment you need. We may also refer to other guidelines to help us in this process.

We'll pay for equipment if:

- you can show your need for it is related to an injury you sustained in the motor accident
- it will help you do one or more of the following:
    - increase or maintain independence
    - increase or maintain participation
    - improve or maintain mobility
    - aid communication
    - relieve pain or discomfort
    - maintain health or prevent ill-health
    - assist a return or entry to vocational, education or leisure activities or
    - increase or maintain the safety of you, your family, carers or attendant care workers.

Information we may need to make our decision

We may ask you for information to help us assess your needs, including:

- why you need the equipment
- clinical assessments
- whether you have successfully trialled the equipment and can use it safely in your environment
- implementation procedures, including any training requirements
- written support from your education provider that the equipment will help you return to or start an education activity.

Our funding principles

When we're making decisions about funding aids and appliances we follow the guidelines below.

- Planning, decision-making and risk assessment activities are collaborative, and this is evident in plans and requests for services.
- Our aim is to help you be as independent as possible and to participate in the community.
- The treatment or service must relate to the motor accident injury.
- Services should be flexible and tailored to meet your needs.
- The treatment, item or service benefits you, are appropriate, and is cost effective.
- The provider is appropriate to your needs.
- Decisions are made within 10 working days.

We'll document our decisions and communicate them via a 'certificate' (a certificate is a letter we'll send you about the decisions we've made).

Your rights

- You have the right to refuse services.
- You have the right to dispute any decision we make about your needs.

Our process for making decisions

- We'll need to get some information about the equipment you want us to pay for.
- After we get this information, we'll make a decision within 10 working days.
- We'll let you know our decision by letter. This is known as a 'certificate'.
- You don't have to agree with our decisions. You have the right to dispute any decision we make. That's OK and we can help you do this.

Other info

Ordering equipment

You need a health professional or a team of health professionals with recognised qualifications to prescribe equipment.

They'll need to fill out an equipment request form or order through one of our suppliers.

The following guidelines for ordering equipment are on our website:

- Professional criteria for prescribers
- Guidelines for levels of attendant care for people with spinal cord injury
- Summary of the Guidelines for the prescription of a seated wheelchair or mobility scooter for people with a traumatic brain injury or spinal cord injury.

More expensive items

If you'd like specific equipment that is more expensive than an equivalent item, we may contribute to the cost.

If the equipment costs more than $2,000 and we don't have an existing agreement with the supplier, we may request two quotes.

Requesting replacements

If your needs haven't changed and you ask for a replacement because of normal wear and tear, and it's the same as the one previously prescribed, you may not need to fill in an equipment request form. We'll let you know how to request a replacement.

For more information contact Lifetime Care

9am to 5pm, Monday to Friday

Phone: 1300 738 586

Email: enquiries.lifetimecare@icare.nsw.gov.au

Web: www.icare.nsw.gov.au

Home modifications (companion to Part 14)

Lifetime Care will pay for the reasonable and necessary modifications to your home that you need because of an injury you sustained from a motor vehicle accident.

This companion explains what home modifications we'll pay for, what we won't pay for, what we mean by certain terms, and how we make our decisions.

When we use the word 'you', we mean the person covered by the Lifetime Care and Support Scheme (also known as 'the participant') or someone representing them, such as a parent, guardian or legal representative.

What we fund

Home modifications

Home modifications are changes to your home that you need so you can access your home and use its standard fittings. We'll pay for a home modification if you need it because of the motor accident injury.

Home modifications can be minor or major. Minor modifications are straightforward and cost no more than $30,000. They don't change the external structure of your home. Some examples are:

- installing temporary internal or external ramping
- installing simple rails
- removing a shower screen
- widening an entrance.

Major home modifications are complex as they change the internal or external structure of your home. They usually involve many tradespeople, require a detailed plan or council approval, or cost over $30,000. Some examples are:

- adding or removing walls
- adding a wet area or shower
- erecting a new structure.

We can pay for a home modification when:

- you and the homeowner have both agreed in writing to the home modification
- the body corporate or other relevant authority has given approval in writing
- alternative options, such as relocation, have been considered and excluded
- the scale and cost of the proposed modification is the most feasible option when considering the likely benefit to you
- there aren't any structural constraints that would prevent the modification, for example the steepness of the block or the condition of the home.

Modifications for homeowners

We'll pay for a modification to the main home you own if:

- you intend living there for at least another five years
- relocating is not the best option for you.

Modifications for a second home

We'll pay to modify your second home if you spend a significant amount of time there, for example because of shared parenting arrangements or it's a holiday home.

We'll pay for such modifications as:

- ramps
- rails
- doorway widening
- minor bathroom modifications.

We'll need to know:

- if we've paid for any previous home modifications
- the amount of time you expect to spend there
- how modifying the second home would benefit you.

Modifications for rental accommodation

We'll pay for modifications to a rental property if:

- your name (or your parent or legal guardian, if you're a child) is on the lease
- the owner agrees in writing
- you intend to stay there for the foreseeable future
- the cost does not exceed $15,000 multiplied by the number of years in the term of the lease (for example $30,000 for a two-year lease).

We may also pay for the cost of returning your rental property to its former state if the owner requests it and it's related to the modifications we previously approved.

Short-term accommodation during major modification work

We'll pay for short term accommodation for up to nine months if:

- major modifications are being made to your home and you can't access it or live there
- it's the most cost-effective option to meet your needs.

If it's your first major home modification, we'll also pay for short-term accommodation for family members who will have to move out because of the building process.

Relocating if the home can't be modified

We'll pay for you to relocate if:

- you're being discharged from hospital for the first time since the accident
- your needs have significantly changed
- we've decided the home can't be modified and you have to purchase another home or find a new rental home
- it's the best option in the circumstances.

If you meet these requirements and you, or a member of your family you live with, buys a new home or relocates to a rental property, we may pay for related costs such as:

- real estate agent fees
- legal fees
- stamp duty
- cleaning costs
- furniture removal
- building or strata reports and pest inspection
- costs related to finding a rental property or home to buy if you can't search for one yourself
- fees for breaking a tenancy agreement
- furniture removal
- an assessment and report to find you a home by someone that we've approved, such as a building modifications occupational therapist (BMOT).

We may need a current building, strata or pest report, and advice and recommendation from a BMOT and a building modification project manager's (BMPM) assessment of the property to help us decide.

Buying another home

We expect you to choose a home that doesn't need a lot of changes to meet your needs. We may pay for a building modifications occupational therapist (BMOT) or building modification project manager (BMPM) to look at the home you're buying to advise you if the home will meet your needs.

We'll also pay up to $85,000 for modifications to the home you buy, such as:

- accessible entry to and exit from the home
- a bathroom and toilet
- a bedroom
- a laundry and kitchen if you do your laundry and prepare your own meals.

Buying a house off the plan

If you're thinking about building a new home, we expect you'll choose a design that won't need a lot of modifications to meet your needs.

We'll pay for a building modifications occupational therapist (BMOT) or building modification project manager (BMPM) to review the design and advise you on whether the home will meet your needs.

We'll pay for the difference between the standard cost of building the home and any additional costs incurred for modifications such as:

- accessible entry to and exit from the home
- a bathroom and toilet
- a bedroom
- a laundry and kitchen if you do your laundry and prepare your own meals.

Room temperature control equipment

If you can't self-regulate your body temperature because of the motor accident injury and this probably won't change, or if not having room temperature control causes secondary care complications, we'll pay for room temperature control equipment.

To help us make this decision we'll consider the main areas of the house that you'll access and the structure and layout of your home. We'll also consider clinical evidence related to issues you have with self-regulating your body temperature. If you have a spinal cord injury, we'll need to know the level of the spinal cord lesion.

Energy costs

We'll contribute up to 35% of your energy bill from the date the room temperature control equipment was installed, or from when you start using it, when:

- we funded the equipment or agreed you needed existing equipment
- there's evidence that the energy costs can be directly related to the temperature control equipment to meet your needs
- you've applied for or are receiving rebates such as the NSW medical energy rebate for NSW residents.

We'll also contribute to the costs related to servicing, maintenance and repair of the equipment.

Environmental control systems and units

We'll pay for equipment and modifications that increase your independence in daily activities. This could be equipment such as automatic door openers, intercoms, emergency call alerts or light and telephone controls that work with an environmental control unit or other 'electronic aids to daily living' to improve your access and independence in your home.

Repairs and maintenance of home modifications

We'll pay for repairs and maintenance when they're essential for your access or safety.

We'll also pay for any normal wear and tear to a home modification. We'll also pay a proportion of the original costs you paid if we didn't fully pay for the original home modification.

Other circumstances

Requests for home modifications that don't fall within the situations above will be considered on a case-by-case basis.

What we don't fund

We don't pay for:

- repairs or modifications that you need because of a condition you had before the motor accident
- illegal structures
- repairs for defects in the home that existed before the accident, such as termite damage or concrete cancer
- pools, spas or aqua therapy facilities
- upgrades of any materials used in the home modification
- items or labour not included in the final contract for modifications we agreed to
- normal household items such as furniture or whitegoods, surge protectors, towel rails, fans, lights, hot water services, security doors and windows
- anything that adds value to an existing property and isn't related to your motor accident injury

- costs for the removal of major home modifications
- loss of value to the home because of a home modification
- loss of value or costs associated with removing a home modification
- another home modification, if we've paid for one in the past five years, unless your personal circumstances have unexpectedly changed
- interim accommodation when there was an accommodation issue before the injury, the need is not because of the injury, or you have refused other reasonable accommodation options
- costs related to the normal end of a tenancy such as advertising costs, steam cleaning carpets or cleaning a property at the end of the tenancy
- repairs to your home
- any home modifications that we haven't approved
- the cost of more than one strata, building or pest inspection report
- internet costs for researching properties
- body corporate/strata fees
- council or water rates
- modifying a new home build you have chosen even though the design doesn't meet your needs
- changes to plan designs that are done for free
- any standard cost related to the finishings of a new home, such as bathroom tiles, taps, flooring
- modifications that are above the standard cost
- standard costs related to building a new home, such as council fees, external consultant or engineer fees
- repairs and maintenance of environmental control systems and units due to normal wear and tear or that weren't funded by us.

How we decide

We follow Lifetime Care funding principles to decide which, if any, home modifications you need and what we'll fund. We may also refer to other guidelines to help us in this process.

We consider:

- who owns the home
- how long you are expected to stay at the home
- if the home modification is the most cost-effective option.

We may ask an occupational therapist to complete a home assessment. We may also need to identify anything in your environment that is a barrier to you living safely and successfully in your home and what can be done to overcome these barriers. This might include:

- providing equipment
- non-structural changes to the home
- relocation.

We'll also consider the clinical reasons you need any home modifications and the best option for you.

Information we may need to make our decision

We may ask you for information to help us assess your needs, including:

- how you go into and out of the home
- which areas of the home you access daily
- project plans, including the cost and extent of the home modification
- that the home modification meets Australian Standards
- you have the required consents, for example from a landlord, body corporate or local council
- how equipment (such as a wheelchair) affects the way you move around and can use your home
- whether there may be any changes or improvements to your mobility in the future.

Environmental control systems and units

To help us decide what environmental control systems and units we'll pay for, we may need information on:

- the expected increase to your independence
- whether you have a prescription from an occupational therapist
- results of any trials of the system
- availability of a back-up system
- other cost-effective alternatives
- the likely cost, set up, ongoing support and maintenance of the system and unit.

Our funding principles

When we're making decisions about funding home modifications we follow these guidelines.

- Planning, decision-making and risk assessment activities are collaborative, and this is evident in plans and requests for services.
- Our aim is to help you be as independent as possible and to participate in the community.
- The treatment or service must relate to the motor accident injury.
- Services should be flexible and tailored to meet your needs.
- The treatment, item or service benefits you, is appropriate, and is cost effective.
- The provider is appropriate to your needs.
- Decisions are made within 20 working days.

We'll document our decisions and communicate them via a 'certificate' (a certificate is a letter we'll send you about the decisions we've made).

Your rights

- You have the right to refuse services.
- You have the right to dispute any decision we make about your needs.

Our process for making decisions

- We'll need to get some information about the home modifications you want us to pay for.
- After we get this information, we'll make a decision within 20 working days.
- We'll let you know our decision by letter. This is known as a 'certificate'.
- You don't have to agree with our decisions. You have the right to dispute any decision we make. That's OK and we can help you do this.

Making an agreement

We may need you to sign a formal agreement that describes conditions of use, maintenance, insurance and ownership. It may cover:

- changes of ownership or sale of the home
- the frequency of future home modifications
- maintenance and repairs
- ongoing costs, such as insurance
- any requirement to repay the contribution we made if the home is sold.

For more information contact Lifetime Care

9am to 5pm, Monday to Friday

Phone: 1300 738 586

Email: enquiries.lifetimecare@icare.nsw.gov.au

Web: www.icare.nsw.gov.au

Prostheses (companion to Part 15)

Lifetime Care will pay for a prosthesis you need because of an injury you sustained from a motor vehicle accident.

This companion explains what prostheses we'll pay for, what we won't pay for, what we mean by certain terms, and how we make our decisions.

When we use the word 'you', we mean the person covered by the Lifetime Care and Support Scheme (also known as 'the participant') or someone representing them, such as a parent, guardian or legal representative.

What we fund

Prostheses

A prosthesis is an artificial device attached to the body to replace a missing body part, such as a leg or an eye. It can be used for functional or cosmetic reasons, or both. A prosthesis includes any associated parts and fittings and can include an external prosthesis or an orthosis (an orthosis is a supporting device fitted to the body such as a brace or a splint).

We don't include surgically implanted prostheses in our definition. These are surgical treatments and will be assessed using the information in *Medical treatment including pharmaceuticals (companion to Part 22).*

Maintenance and repair

We'll repair and maintain your prosthesis:

- if it needs it due to normal wear and tear
- if it needs routine maintenance that the manufacturer recommends, or to meet industry standards
- if a provider or providers accredited by EnableNSW (or an equivalent body if you live interstate) completes the prescription and supply.

Recreational activity

We'll pay for an extra prosthesis to use for recreational activities if you're likely to take part in the activity regularly in the future. *For example, we may fund specialised limbs for a sporting activity if you show us your sporting club membership and evidence you've been attending and taking part.*

What we don't fund

We don't pay for:

- repairing or replacing a prosthesis that's damaged or not working because of neglect or misuse
- a prosthesis that doesn't comply with Australian Standards (if applicable) or isn't registered with the Therapeutic Goods Administration (if applicable).

How we decide

We follow Lifetime Care funding principles to decide which, if any, prostheses you need and what we'll fund. We may also refer to other guidelines to help us in this process.

We'll pay for a prosthesis when:

- you have had a limb amputated because of the motor accident injury
- the prosthesis helps your functional independence, self-management or is a cosmetic improvement
- the provider is accredited by EnableNSW or an equivalent body if you live interstate
- the prescription, clinic services and manufacturing services are provided by a person who is accredited by EnableNSW or an equivalent body if you live interstate.

Our funding principles

When we're making decisions about funding prostheses we follow these guidelines.

- Planning, decision-making and risk assessment activities are collaborative, and this is evident in plans and requests for services.
- Our aim is to help you be as independent as possible and to participate in the community.

- The treatment or service must relate to the motor accident injury.
- Services should be flexible and tailored to meet your needs.
- The treatment, item or service benefits you, is appropriate, and is cost effective.
- The provider is appropriate to your needs.
- Decisions are made within 20 working days.

We'll document our decisions and communicate them via a 'certificate' (a certificate is a letter we'll send you about the decisions we've made).

Your rights

- You have the right to refuse services.
- You have the right to dispute any decision we make about your needs.

Our process for making decisions

- We'll need to get some information about the prostheses you want us to pay for.
- After we get this information, we'll make a decision within 20 working days.
- We'll let you know our decision by letter. This is known as a 'certificate'.
- You don't have to agree with our decisions. You have the right to dispute any decision we make. That's OK and we can help you do this.

Other info

Who we mean by a provider

We consider providers of prostheses and orthoses to be accredited medical prescribers, amputee clinics or limb manufacturers.

For more information contact Lifetime Care

9am to 5pm, Monday to Friday

Phone: 1300 738 586

Email: enquiries.lifetimecare@icare.nsw.gov.au

Web: www.icare.nsw.gov.au

Vocational rehabilitation and training (companion to Part 16)

Lifetime Care will pay for the reasonable and necessary vocational rehabilitation and training you need because of an injury sustained from a motor vehicle accident.

This companion explains what vocational rehabilitation and training we'll pay for, what we won't pay for, what we mean by certain terms, and how we make our decisions.

When we use the word 'you', we mean the person covered by the Lifetime Care and Support Scheme (also known as 'the participant') or someone representing them, such as a parent, guardian or legal representative.

What we fund

Vocational rehabilitation

Combined, coordinated services aimed at getting you back to or into employment. The aim is for you to do the maximum level of employment or other work-related activity you can manage or that you want to do.

Vocational training

Formal training that maintains or develops job-related and technical skills.

Work-related activity

Any activity that helps you gain skills to improve your ability to get work in the future.

Payments to help you start working

We may make payments of up to $1,000 for incidental expenses to help you start work when:

- the payment addresses an immediate or short-term barrier that directly prevents you from starting work or accepting an offer of work
- you have received a written job offer
- you need something before you start work and get your first pay from your employer
- your employer won't be providing what you need.

We'll pay up to $1,000 in total incidental expenses over the course of your participation in the Lifetime Care and Support Scheme.

What we don't fund

We don't pay for vocational rehabilitation and training:

- that is of no clear benefit to you
- that addresses needs that don't relate to the motor accident injury
- for a friend or family member
- you can access, or are required to access, under other state or federal legislation
- for a training course you were enrolled in or had started before the injury.

We don't pay for expenses for:

- assistance to keep a business open, such as paying for temporary staff to do your job
- standard furniture and other items associated with your place of work or work health safety requirements
- everyday living expenses associated with work, such as travel to and from your work, clothing/uniforms or lunches
- phone calls, photocopying, stationery, meals at training venues and all other expenses associated with training
- training that's related to maintaining an existing qualification, licence, registration or accreditation you already hold
- training that's part of induction, ongoing skill maintenance or development that's your own or your employer's responsibility
- training associated with voluntary career changes or personal development
- ongoing training costs where the training or education institution determines you are guilty of serious academic misconduct
- ongoing training costs where we and the education institution decide you haven't maintained satisfactory academic progress
- items or services that an employer has a legal obligation to provide, such as personal protective equipment or orientation training
- items or services an employer will give you at no cost to you, such as standard issue uniform
- household and everyday living costs
- income support.

How we decide

We follow Lifetime Care funding principles to decide which, if any, vocational rehabilitation and training you need and what we'll fund. We may also refer to other guidelines to help us in this process.

We'll pay for vocational rehabilitation and training if:

- a suitably qualified rehabilitation provider says you need it
- you can show us that the need relates to your motor accident injury
- you have clearly defined, specific, measurable, achievable, realistic and time-based vocational goals.

You must ask us in writing to fund your vocational rehabilitation and training. In your request, you must outline how the rehabilitation and training will help you progress towards your vocational goals. You must show how it will help you return to your job with your pre-injury employer or, if you can't go back to work with your pre-injury employer, how it will help you get a job with a different employer.

When we decide whether to pay for your vocational rehabilitation and training we'll consider:

- your life roles, career and intended study plans before your motor accident
- your ability to engage in vocational rehabilitation and/or training
- whether you and your medical/rehabilitation team agree with your choice of vocational goal
- what vocational rehabilitation services or training you can access
- your capacity to get and keep a job
- opportunities in the labour market after you've finished training
- your willingness to commit to the vocational training
- alternatives to training
- any previous vocational training we've paid for
- the cost and length of the vocational training
- the cost and time of any travel for you to attend the vocational training.

Our funding principles

When we're making decisions about funding vocational rehabilitation and training we follow these guidelines.

- Planning, decision-making and risk assessment activities are collaborative, and this is evident in plans and requests for services.
- Our aim is to help you be as independent as possible and to participate in the community.
- The treatment or service must relate to the motor accident injury.
- Services should be flexible and tailored to meet your needs.
- The treatment, item or service benefits you, is appropriate, and is cost effective.
- The provider is appropriate to your needs.
- Decisions are made within 10 working days.

We'll document our decisions and communicate them via a 'certificate' (a certificate is a letter we'll send you about the decisions we've made).

Your rights

- You have the right to refuse services.
- You have the right to dispute any decision we make about your needs.

Our process for making decisions

- We'll need to get some information about the vocational rehabilitation and training you want us to pay for.
- After we get this information, we'll make a decision within 10 working days.
- We'll let you know our decision by letter. This is known as a 'certificate'.
- You don't have to agree with our decisions. You have the right to dispute any decision we make. That's OK and we can help you do this.

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Buying into the Scheme (companion to Part 17)

Lifetime Care does not automatically cover people who were injured in a motor accident before 1 October 2006 (for children) or 1 October 2007 (for adults), or who were injured outside NSW.

Those people can choose to 'buy in' to the Scheme so that they can participate in it.

This companion explains who can buy in, how they can buy in, what we mean by certain terms, and how we make our decisions.

When we use the word 'you', we mean the person covered by the Lifetime Care and Support Scheme (also known as 'the participant') or someone representing them, such as a parent, guardian or legal representative.

Buying in to the Scheme

We'll calculate how much money is needed to provide the services to meet your treatment, rehabilitation and care needs for the rest of your life. This is the amount you – or someone paying on your behalf – will have to pay us. Buying in to the scheme is voluntary. It's subject to an agreement between us and you or your guardian.

Who can buy in

If you received a motor accident injury before 1 October 2006 (for children) or 1 October 2007 (for adults) and have an eligible injury, you can buy in to the Scheme as a lifetime participant. If you were injured after these dates you are automatically covered and don't need to buy in.

You can also buy in to the scheme if you were injured in a motor accident outside of NSW and have an eligible injury.

How to apply

You (or someone acting for you) need to apply in writing. You need to include enough information, so we can decide if your motor accident injury is eligible, and whether you would have been eligible to be covered by the scheme if it had been in place when you had your accident.

The cost to buy in

We will need information about your previous and current treatment, rehabilitation and care needs so we can calculate how much it would cost for you to buy in to the scheme. We need to information about:

- how old you are now, and how old you were at the time of the motor injury
- the nature and severity of the injury
- the current assessment of your functional status using an assessment tool such as FIM™, WeeFIM®, the Care and Needs Scale (CANS) and American Spinal Injury Association (ASIA) scale for spinal cord injury
- objective assessments of your previous and current treatment, rehabilitation and care needs
- what services you've used to meet your treatment, rehabilitation and care needs, and how often and for the length of time you received them, including any changes in your care needs.

We may arrange for an assessment so we can get this information. We'll pay for the cost of the assessments if they are:

- appropriate
- of benefit to you
- value for money
- cost effective.

We'll give you a copy of the assessment.

We'll let you know how much it will cost to buy in, and how we calculated that amount.

The whole buy-in amount must be paid up front to Lifetime Care. We'll put it into the Lifetime Care and Support Authority Fund.

In exceptional cases, we'll consider taking security over property as payment instead of cash.

What the buy-in amount covers

The amount we decide you – or someone paying on your behalf such as a family member – need to pay us to buy in to the scheme covers:

- the costs of providing you with reasonable and necessary treatment, rehabilitation and care related to the motor accident injury over your lifetime
- how much it will cost us to manage you as a lifetime participant in the scheme

Becoming a lifetime participant

After you've paid us the full buy-in amount, we'll write to you confirming:

- you've become a lifetime participant
- the buy-in amount has been paid into the fund.

We can't ask for any extra payments from you once you've paid the full buy-in amount. Once you've become a lifetime participant, you have the same obligations and entitlements as any other lifetime participant in the scheme.

If you don't meet the eligibility criteria

If your injury doesn't meet the eligibility criteria we may decline your application. You can dispute this decision formally in a letter or email within 28 calendar days.

For more information contact Lifetime Care

9am to 5pm, Monday to Friday

Phone: 1300 738 586

Email: enquiries.lifetimecare@icare.nsw.gov.au

Web: www.icare.nsw.gov.au

Approved providers and special circumstances (companion to Part 18)

Lifetime Care only makes payments to approved providers of attendant care services in NSW and the ACT. We choose these approved providers through a competitive selection process.

This companion explains what kinds of providers need to be approved. It also explains the special circumstances that might mean we pay non-approved providers.

When we use the word 'you', we mean the person covered by the Lifetime Care and Support Scheme (also known as 'the participant') or someone representing them, such as a parent, guardian or legal representative.

Approved attendant care providers

An approved attendant care provider is an organisation that has been certified by the Australian Community Industry Alliance, formerly known as the Attendant Care Industry Association (ACIA), as meeting the Attendant Care Industry Standard.

Only approved attendant care providers can provide services to you – unless we've made a different agreement with you. If you live outside NSW or the ACT, we'll consider paying non-approved providers to deliver attendant care services.

Approved providers of rehabilitation services (case management)

Case management services need to be provided by approved case management providers. If you live outside NSW and ACT, we'll consider paying non-approved providers to deliver case management services.

Case managers can find out what we expect of them on the case managers page of our website.

Approved providers of assessments of care needs

An assessment of care needs is completed by an approved provider when your needs are complex or extensive. If you permanently live outside of Australia, we'll consider paying non-approved providers to assess your care needs.

Approved providers of major modifications to homes, workplace and education facility

A major modification to your home, workplace or education facility is any building modification that:

- changes the inside or outside structure of a residence
- is complex
- involves multiple tradespeople and requires a detailed plan or council approval
- costs over $25,000

Making major modifications of this sort might involve the services of an occupational therapist and building modifications project manager.

These services must be provided by an approved building modifications occupational therapist and an approved building modifications project manager. However, this doesn't apply if you live outside Australia.

Special circumstances

In special circumstances, such as because of your geographic location or cultural or religious beliefs, we'll consider paying a non-approved provider. We decide this on a case-by-case basis.

We'll need a written request from the person or organisation seeking to deliver services. The request must include:

- why none of the approved providers are appropriate
- their suitability to provide services to you, including experience and training
- the circumstances that justify them being approved to provide services to you
- your agreement with that provider
- any other information we think is relevant and ask for.

If we decide to pay a non-approved provider, we'll state how long the approval is for and the rates of payment in our written agreement to fund the services.

What we don't fund

We don't pay for services delivered before a provider has been approved.

For more information contact Lifetime Care

9am to 5pm, Monday to Friday

Phone: 1300 738 586

Email: enquiries.lifetimecare@icare.nsw.gov.au

Web: www.icare.nsw.gov.au

Alternative expenditure option (companion to Part 19)

Lifetime Care will sometimes pay for alternative and cost-effective ways to meet the treatment and care you need because you were injured from a motor vehicle accident.

This companion explains the circumstances we make alternative expenditure payments in and what everyone involved needs to do.

When we use the word 'you', we mean the person covered by the Lifetime Care and Support Scheme (also known as 'the participant') or someone representing them, such as a parent, guardian or legal representative.

What we mean by alternative expenditure payments

If you have been assessed as needing a specific treatment, equipment or service to meet your need, but you or we have found a different way to meet that need, we will consider paying for that different approach as long as it is cost effective. This is called an alternative expenditure payment.

For example, you have been assessed as needing a wheelchair accessible vehicle, and we have planned to modify your current car. However, you have found a second-hand van that is already wheelchair accessible, costs less than the quote you got for the modifications and is available now. You could ask us to pay for that second-hand van instead of paying for the modifications. This would have the same outcome – giving you access to a wheelchair accessible vehicle – and would give you that access more quickly. It could also be more cost effective. The payment would be an 'alternative expenditure payment.'

Requesting an alternative expenditure payment

Who can make the request

You, or someone acting on your behalf, can ask us to make an alternative expenditure option.

We can also suggest an alternative expenditure option, but you don't have to accept it.

The alternative expenditure must benefit you

We'll only consider contributing to alternative expenditure where the treatment, care, support or service outcome is at least as beneficial as if we'd paid for the standard expenses to meet your treatment and care needs.

We won't pay more for alternative expenditure than we would for meeting your needs in a standard way.

Everyone needs to agree with the alternative expenditure

We'll only contribute to alternative expenditure if you (or your parent or legal guardian) agree the alternative expenditure can meet your treatment and care needs.

Contributions from a third party

If someone other than you or Lifetime Care makes or contributes to alternative expenditure, they need to agree to our contribution. We may need them to enter into a legal agreement with us.

Alternative expenditure for minors or participants who lack capacity

If you're under 18 or lack capacity to agree with a decision to make alternative expenditure, we won't contribute to alternative expenditure unless we're satisfied it's in your best interests.

For more information contact Lifetime Care

9am to 5pm, Monday to Friday

Phone: 1300 738 586

Email: enquiries.lifetimecare@icare.nsw.gov.au

Web: www.icare.nsw.gov.au

Ambulance transport (companion to Part 20)

Lifetime Care will pay for the reasonable and necessary ambulance transport you need because of an injury you sustained from a motor vehicle accident.

This companion explains what ambulance transport we'll pay for, what we won't pay for, what we mean by certain terms, and how we make our decisions.

When we use the word 'you', we mean the person covered by the Lifetime Care and Support Scheme (also known as 'the participant') or someone representing them, such as a parent, guardian or legal representative.

What we fund

Ambulance transport

We'll pay for ambulance transport if:

- we don't fund it under an existing arrangement with you, but you need it because of the motor accident injury
- you need more help getting into a vehicle and being positioned in it than a taxi driver, attendant care worker or family member would be able to provide
- it's for receiving medical or hospital services related to the motor accident injury, or for receiving other services to meet your needs
- there are no other alternatives and an ambulance is the only suitable transport for you.

What we don't fund

We don't pay for ambulance transport or expenses:

- provided under an existing fee agreement with an ambulance transport provider
- that are attendance-only charges
- when the hospital or facility has asked for an outpatient driver service to wait for you (unless you need to be actively managed or supervised and there's no attendant care worker or family member present. In this case, we'll only pay active waiting time for the time the outpatient driver provided active supervision and assistance).

How we decide

We follow Lifetime Care funding principles to decide what, if any, ambulance transport you need and what we'll fund. We may also refer to other guidelines to help us in this process.

We'll consider:

- your needs for ambulance transport in relation to other treatment and services, such as medical treatment and surgery
- the circumstances where you need the ambulance, for example, whether it is between hospitals, from a hospital to your residence after a stay in hospital as an inpatient, or for other medical treatment or therapy services
- if other services, such as vehicle modifications, have been provided
- how long you'll need the ambulance transport.

Information we may need to make our decision

We may ask you for information to help us assess your needs, including:

To help us decide about paying for your ambulance transport, we'll need information:

- from a medical practitioner or health professional about why you need ambulance transport rather than an alternative
- about any pre- or co-existing medical conditions that may impact your needs for or relating to ambulance transport
- about whether you need behavioural management supervision
- about whether a family member or attendant care worker is available to help.

We'll assess your need for ambulance transport on request and before service delivery. When you make a request, you must give us an itemised quote.

Our funding principles

When we're making decisions about funding ambulance transport we follow these guidelines.

- Everyone involved in your care collaborates on planning, decision-making and risk assessment activities, and there is evidence of this collaboration in any plans and requests for services.
- Our aim is to help you be as independent as possible and to participate in the community.
- The treatment or service must relate to the motor accident injury.
- Services should be flexible and tailored to meet your needs.
- The treatment, item or service benefits you, is appropriate, represents value for money, and is cost effective.
- The provider is appropriate to your needs.
- Decisions are made within 10 working days.

We'll document our decisions and communicate them via a 'certificate' (a certificate is a letter we'll send you about the decisions we've made).

Your rights

- You have the right to refuse services.
- You have the right to dispute any decision we make about your needs.

Our process for making decisions

- We'll need to get some information about the ambulance transport you want us to pay for.
- After we get this information, we'll make a decision within 10 working days.
- We'll let you know our decision by letter. This is known as a 'certificate'.
- You don't have to agree with our decisions. You have the right to dispute any decision we make. That's OK and we can help you do this.

For more information contact Lifetime Care

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Web: www.icare.nsw.gov.au

Dental treatment (companion to Part 21)

Lifetime Care will pay for the reasonable and necessary dental treatment you need because of an injury you sustained from a motor vehicle accident.

This companion explains what dental treatment we'll pay for, what we won't pay for, what we mean by certain terms, and how we make our decisions.

When we use the word 'you', we mean the person covered by the Lifetime Care and Support Scheme (also known as 'the participant') or someone representing them, such as a parent, guardian or legal representative.

What we fund

Routine dental treatment

We'll pay for routine dental treatment when it's:

- a direct result of the motor accident injury, such as a severe traumatic brain injury affecting your ability to brush your teeth
- required more often than usual dental treatment as a result of your motor injury, for example, because you have oral spasticity which means you need more frequent dental treatment
- needed so other forms of dental treatment can be provided, such as a general anaesthetic to treat dental cavities if you have a traumatic brain injury.

Replacing dentures

If you wore dentures before the motor vehicle accident, we'll only pay to replace your dentures, if:

- there would be a direct impact on other accident-related dental treatment if the dentures weren't replaced at the same time
- there's evidence of direct trauma to the mouth from the accident.

Requesting a service

You must ask us to fund the dental treatment before it starts, unless it's urgent or delivered under an existing fee schedule.

What we don't fund

We don't pay for dental treatment or expenses:

- for aesthetic purposes, such as teeth whitening
- that don't clearly benefit you
- that are repeat treatments because of poor dental hygiene, unless you have been assessed as having cognitive and behavioural issues associated with traumatic brain injury that mean you can't maintain your own dental hygiene
- inconsistent with your pre-injury standard of dental care unless the motor accident injury increased the need for treatment
- if there's no published evidence about its safety or effectiveness
- because you didn't attend your dental appointment, unless the reason you didn't attend was beyond your control
- for standard household expenses relating to dental care such as toothbrushes, toothpaste, dental floss and mouthwash.

Dentures

If you wore dentures before the motor vehicle accident, we won't replace them if they were lost or damaged:

- in the motor accident
- during ambulance treatment or transfers
- in hospital
- during inpatient or outpatient rehabilitation.

How we decide

We follow Lifetime Care funding principles to decide which, if any, dental treatment you need and what we'll fund. We may also refer to other guidelines to help us in this process.

We'll pay for dental treatment if it's:

- needed as a direct result of the motor accident injury
- related to or caused by side effects of medications you've taken due to the motor accident injury, and you've got supporting information from a medical or dental practitioner to show this
- needed because you couldn't maintain your dental health due to medical treatment you required because of the motor accident, such as an extended stay in an intensive care unit

- in accordance with accepted dental practice
- provided by a dental practitioner or other specialist such as an oral and maxillofacial surgeon, registered with the Australian Health Practitioner Regulation Agency (AHPRA) or a different appropriate professional body if you live outside Australia
- intended to restore your dentition (the number and placement of your teeth) to how it was before the accident.

Information we may need to make our decision

To help us decide if you need the dental treatment we'll consider your injury-related needs and their impact on your ability to perform or be assisted with dental hygiene tasks. We may ask you for information to help us assess your needs, including:

- information about the motor accident so we know whether you received dental injuries from facial injuries or direct trauma to the mouth
- information from a medical practitioner about the likely cause of your dental needs, if you have pre- or co-existing medical conditions that may relate to these needs
- information from dentists who treated you before your injury
- a fully itemised account or quote from a registered practitioner
- an outline of the goals of the proposed treatment
- information about your injury-related needs and your ability to perform, or be helped with, any dental hygiene associated with the treatment.

A second opinion

We may need a second opinion or quote if the relationship of the proposed dental treatment to the motor accident injury is unclear, or if we think the dental treatment is complex or extensive.

Our funding principles

When we're making decisions about funding dental treatment we follow these guidelines.

- Planning, decision-making and risk assessment activities are collaborative, and this is evident in plans and requests for services.
- Our aim is to help you be as independent as possible and to participate in the community.
- The treatment or service must relate to the motor accident injury.
- Services should be flexible and tailored to meet your needs.
- The treatment, item or service benefits you, is appropriate, and is cost effective.
- The provider is appropriate to your needs.
- Decisions are made within 10 working days.

We'll document our decisions and communicate them via a 'certificate' (a certificate is a letter we'll send you about the decisions we've made).

Your rights

- You have the right to refuse services.
- You have the right to dispute any decision we make about your needs.

Our process for making decisions

- We'll need to get some information about the dental treatment you want us to pay for.
- After we get this information, we'll make a decision within 10 working days.
- We'll let you know our decision by letter. This is known as a 'certificate'.
- You don't have to agree with our decisions. You have the right to dispute any decision we make. That's OK and we can help you do this.

For more information contact Lifetime Care

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Medical treatment including pharmaceuticals (companion to Part 22)

Lifetime Care will pay for the reasonable and necessary medical treatment you need because of an injury you sustained from a motor vehicle accident.

This companion explains what medical treatment we'll pay for, what we won't pay for, what we mean by certain terms, and how we make our decisions.

When we use the word 'you', we mean the person covered by the Lifetime Care and Support Scheme (also known as 'the participant') or someone representing them, such as a parent, guardian or legal representative.

What we fund

Medical treatments

We'll pay for services related to:

- surgical treatment
- some pharmaceuticals (see below)
- diagnostic tests such as imaging services
- inpatient or outpatient treatment provided by a hospital
- medical treatment, reports, case conferences or contact with other professionals treating you
- assisted fertility treatment
- treatment for chronic pain.

Pharmaceuticals

We'll consider paying for:

- prescription pharmaceuticals
- over the counter medications
- prescribed vitamins and supplements, including health products such as fibre laxatives or probiotics
- topical skin creams such as sorbolene
- other items such as consumable preparation solutions needed before a medical procedure.

Bandages, dressings and other wound care items, and consumable items for continence needs may be classed as pharmaceuticals or aids and appliances (equipment) (*see Aids and appliances (companion to Part 13*)).

Assisted fertility treatment

We'll consider paying for assisted fertility treatment when:

- infertility is a result of the motor accident injury
- you've got a referral from a qualified fertility medical specialist
- a qualified fertility medical specialist has prescribed fertility treatment for you and your partner

If your fertility has been affected by your motor accident injury, we'll pay for both you and your partner to receive assisted fertility treatment.

We'll consider paying for the following treatments:

- fertility medication, ovulation induction or assisted insemination
- in-vitro fertilisation (IVF) treatment
- assisted ejaculation or obtaining sperm by other means such as testicular aspiration
- egg and sperm storage – the length of time we'll pay for storage depends on individual circumstances and the advice of the fertility medical specialist
- obtaining donor eggs or sperm, including retrieval and storage, when you can't produce viable eggs or sperm because of the motor accident injury
- fertility counselling as part of the assisted fertility intervention for you and your partner
- all other forms of assisted fertility or assisted reproductive technology treatment
- a reasonable number of IVF treatments per pregnancy attempt, in line with usual practice. We'll consider up to five stimulated cycles per pregnancy attempt. If you require more than five stimulated cycles, we'll consider the recommendation of the fertility medical specialist to help us decide whether we'll fund further treatments.

Requesting a service

You must ask us to fund the treatment before it starts, unless it's urgent or delivered under an existing fee schedule.

What we don't fund

Medical treatments

We don't pay for medical treatment or expenses:

- that are part of the bed day fee in a hospital or inpatient rehabilitation facility
- for personal care or grooming, such as toilet paper or shampoo
- for standard items you can buy from a pharmacy such as cosmetics, food and beverages
- for sunscreen, unless it's prescribed for scar management
- related to contraceptive prescriptions
- for illegal pharmaceuticals
- associated with medico-legal reports or other medical reports we haven't requested
- incurred while receiving inpatient or outpatient medical treatment, such as food, laundry, newspapers, magazines, phone line rental and phone calls
- not in accordance with the MBS explanations, definitions, rules and conditions for services that medical practitioners provide, unless we have specified otherwise
- that don't have a MBS code
- where there's no published evidence relating to its safety or effectiveness
- for non-attendance fees where you failed to attend an appointment – unless you couldn't attend due to reasons beyond your control
- for a member of your family unless they or your partner are having assisted fertility treatment
- that's of no clear benefit to you.

Assisted fertility treatment

We don't pay for fertility treatments or associated expenses:

- for surrogacy, whether commercial or altruistic
- for assisted fertility intervention to address the fertility needs of your partner if these aren't the result of the motor accident injury
- where there is no objective evidence that the treatment is safe and effective
- that are experimental or not consistent with intervention offered to the general community
- for counselling for your partner if it's not part of the assisted fertility treatment program
- for membership of fertility support/self-help groups for you or your partner
- that aren't consistent with the guidelines of the assisted fertility treatment facility that you or your partner are attending
- that aren't inconsistent with relevant state or federal legislation
- for any assisted fertility treatment or for medical conditions not related to the motor accident injury, such as pre-implantation genetic diagnosis
- related to raising the child that results from the fertility treatment
- associated with the pregnancy and birth of the baby conceived through assisted fertility treatment that aren't related to the motor accident injury, such as obstetrician, hospital, midwife and/or other birthing costs.

How we decide

We follow Lifetime Care funding principles to decide which, if any, medical treatment you need and what we'll fund. We may also refer to other guidelines to help us in this process.

We'll pay for medical treatment if you need it because of the motor accident injury and it's provided by an appropriately qualified and registered medical practitioner.

To help us decide if you need the medical treatment, we'll consider your injury-related needs and their impact.

We'll consult you and your medical practitioner about any treatment and care needs relating to medical treatment. Your individual needs will be considered in the context of other treatment and services provided.

To help us make decisions about whether you need pharmaceuticals, the registered medical practitioner who is treating you must prescribe them. We may ask your treating medical practitioner to provide a list of pharmaceuticals related to the motor accident injury before we are able to assess your needs for or relating to pharmaceuticals.

Information we may need to make our decision

We may ask you for information to help us assess your needs, including:

- information relating to the medical treatment that has an item number in the Medical Benefits Schedule (MBS)
- information about any pre- or co-existing medical conditions
- information from a medical practitioner about whether the likely cause of the medical issue you need medical treatment or pharmaceuticals for is related to the motor vehicle accident or a pre-existing or co-existing medical condition
- clinical assessments and reports
- justification for the proposed treatment, including the relationship to the motor accident
- justification for the treatment process, including any associated medical treatment as part of an overall plan.

Fertility treatment

We may ask you for information to help us assess your need for fertility treatment, including:

- information about how your need for fertility treatment is related to the motor accident injury
- whether your compromised fertility status is likely to be permanent
- the nature and extent of the treatment that you and your partner will need
- the anticipated outcome and success rate of the assisted fertility treatment
- information about any other treatment or services that may impact on the proposed treatment
- any other relevant information relating to you or your partner's fertility status.

Our funding principles

When we're making decisions about funding medical treatment we follow these guidelines.

- Planning, decision-making and risk assessment activities are collaborative, and this is evident in plans and requests for services.
- Our aim is to help you be as independent as possible and to participate in the community.
- The treatment or service must relate to the motor accident injury.
- Services should be flexible and tailored to meet your needs.
- The treatment, item or service benefits you, is appropriate, and is cost effective.
- The provider is appropriate to your needs.
- Decisions are made within 10 working days.

We'll document our decisions and communicate them via a 'certificate' (a certificate is a letter we'll send you about the decisions we've made).

Your rights

- You have the right to refuse services.
- You have the right to dispute any decision we make about your needs.

Our process for making decisions

- We'll need to get some information about the medical treatment you want us to pay for.
- After we get this information, we'll make a decision within 10 working days.
- We'll let you know our decision by letter. This is known as a 'certificate'.
- You don't have to agree with our decisions. You have the right to dispute any decision we make. That's OK and we can help you do this.

Other info

Who can prescribe treatment

Treatment must be prescribed by an appropriate specialist or medical practitioner registered with the Australian Health Practitioner Regulation Agency (AHPRA). If you live outside Australia, the specialist or medical practitioner must be registered with an equivalent appropriate professional body.

Payment codes

The medical practitioner or specialist must provide medical services using the Australian Medical Association (AMA) item numbers, where there is a corresponding MBS number.

For more information contact Lifetime Care

9am to 5pm, Monday to Friday

Phone: 1300 738 586

Email: enquiries.lifetimecare@icare.nsw.gov.au

Web: www.icare.nsw.gov.au

Workplace and education facility modifications (companion to Part 23)

Lifetime Care will pay for the reasonable and necessary modifications to your workplace or education facility that you need because of an injury you sustained from a motor vehicle accident.

This companion explains what modifications we'll pay for, what we won't pay for, what we mean by certain terms, and how we make our decisions.

When we use the word 'you', we mean the person covered by the Lifetime Care and Support Scheme (also known as 'the participant') or someone representing them, such as a parent, guardian or legal representative.

What we fund

Workplace modifications

We'll pay to modify your workplace when:

- the long-term impact of your motor accident injury prevents you doing your normal work in the existing workplace environment
- an employer has confirmed in writing that they'll provide permanent employment for you
- the workplace modification is the most cost-effective way to help you return to work, and all other alternatives have been considered
- a workplace assessment or work options plan has been completed and we've agreed to support your work goal.

Education facility modifications

Usually, costs for modifying education facilities are mainly the responsibility of the education facility.

We'll pay for an education facility modification when:

- there's no other source of funding and the modifications wouldn't be provided under any legislation or scheme
- the long-term impact of your accident injury prevents you from learning within the existing education facility
- it's the most cost-effective way for you to participate in the education activity, and all other options have been considered
- for adult learners, the education program has been identified through a work options plan and we've agreed to support your work goal.

Repairs and maintenance

We may fund the cost of repairs and maintenance for modifications:

- that you need for access or safety
- proportionate to the original costs paid, where we didn't fully fund the original modification. For example, when an employer or property owner also contributed to the original cost of the modification.

What we don't fund

We don't pay for modifications or expenses:

- to any workplace or education facility that is (or will result in) an illegal structure (illegal structures don't comply with relevant building and construction codes or local council planning guidelines, statutes and/or laws)
- that we haven't approved
- where permission is required by the owner, body corporate or other responsible authority and it hasn't been given
- required because of a condition that existed before the motor vehicle accident or that is not because of the motor vehicle accident
- that provide no clear injury-related benefit to you

- intended to add value to an existing workplace or education facility and aren't related to your motor accident injury
- related to upgrades of any materials needed for workplace or education facility modifications
- related to removal of modifications from a workplace or education facility
- related to any loss of property value as a result of any modifications to, or removal of, modifications from the property
- items that are normal workplace, education or household items (such as furniture or whitegoods, smoke alarms, surge protectors, towel rails, fans, security doors and windows)
- items not directly related to your need arising from your motor accident injury
- where we've funded substantial modifications in the past five years
- modifications that are the education provider's obligation as a type of reasonable adjustment under relevant disability discrimination legislation
- repairs and maintenance as a result of normal wear and tear (such as replacement of bathroom fittings/fixtures), for the upkeep of a workplace or education facility
- related to repairs and maintenance when you've left the workplace or education facility.

How we decide

We follow Lifetime Care funding principles to decide which, if any, modifications to your workplace or education facility you need and what we'll fund. We may also refer to other guidelines to help us in this process.

We'll consider:

- the physical and social environment of the workplace or education facility
- your physical, cognitive and behavioural impairments, such as reduced:
    - mobility (including the type of wheelchair you use)
    - arm and/or hand function
    - thermo-regulation (ability to regulate your body heat)
    - bladder and bowel function
    - cognition
    - behaviour
- whether any future improvement or change to your impairments is likely
- the effects of equipment, including wheelchairs, on your ability to function in your work or education environment.

We'll only consider funding modifications to your workplace or education facility when:

- we've confirmed the proposed modifications aren't available under another scheme or legislation, including any reasonable adjustments an employer or education provider may make
- a qualified occupational therapist has recommended the modifications to meet your injury-related need in a workplace or education facility modifications report
- the employer or education provider and the building owner (if different) both agree in writing to the modifications.

Workplace modifications

For workplace modifications we'll consider the following factors:

- any reasonable adjustments an employer may have to make under disability discrimination legislation
- whether modifications could be funded partly or wholly under another scheme or by another funder.

Education facility modifications

For education facility modifications, we'll consider the following factors:

- your ability to participate in educational activities, and access facilities such as bathrooms
- whether the education provider could partly or wholly pay for the modifications.

Information we may need to make our decision

We may ask you for information to help us assess your needs, including:

- your safety and the safety of others
- who owns the property
- any consents required from other parties such as a landlord, body corporate or local Council.

Workplace modifications

We may ask you for information about your workplace to help us assess your needs, including:

- where and how you enter and exit the workplace
- your access to all necessary areas of the workplace
- the cost and extent of the modifications compared to the likely benefit you'll receive and alternative employment options.

Education facility modifications

We may ask you for information about your education facility to help us assess your needs, including:

- how long you're likely to be attending the education facility
- reasonable adjustments available to timetable and class allocation, for example, shifting your classes to ground floor rooms
- your access to all necessary areas of the facility
- the cost and extent of the modifications and the likely benefit to you, and alternative options for education.

Our funding principles

When we're making decisions about funding modifications to your workplace or education facility we follow these guidelines.

- Planning, decision-making and risk assessment activities are collaborative, and this is evident in plans and requests for services.
- Our aim is to help you be as independent as possible and to participate in the community.
- The treatment or service must relate to the motor accident injury.
- Services should be flexible and tailored to meet your needs.
- The treatment, item or service benefits you, is appropriate, and is cost effective.
- The provider is appropriate to your needs.
- Decisions are made within 10 working days.

We'll document our decisions and communicate them via a 'certificate' (a certificate is a letter we'll send you about the decisions we've made).

Your rights

- You have the right to refuse services.
- You have the right to dispute any decision we make about your needs.

Our process for making decisions

- We'll need to get some information about the modifications to your workplace or education facility you want us to pay for.
- After we get this information, we'll make a decision within 10 working days.
- We'll let you know our decision by letter. This is known as a 'certificate'.
- You don't have to agree with our decisions. You have the right to dispute any decision we make. That's OK and we can help you do this.

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