Workers Compensation Allied Health | Bloom Healthcare

Canonical: https://bloom-healthcare.com.au/services/workers-compensation/

Details:

Allied health treatment after a work-related injury or illness can help someone understand the effects of the injury, rebuild the skills that matter, and work towards agreed recovery goals — including goals about returning to work.

A workers compensation referral has a step that other referrals do not. A claim number alone does not confirm funding. The insurer's requirements, any necessary practitioner approvals and the agreed treatment scope have to be checked before booking, and skipping that step is the most common reason a service is delivered and then disputed. To discuss a referral, call 1300 771 465 or email hello@bloom-healthcare.com.au .

What gets confirmed before a referral is accepted

Clinical scope. What the service is intended to assess or support, and whether it is within the clinician's professional scope.

The right discipline. Whether the discipline requested is the one that will actually help, or whether a different one is more relevant.

Location and delivery. Whether a clinician can attend the address, and whether the proposed delivery method is appropriate.

Scheme requirements. Which scheme applies and what it requires, including any approvals, forms or reporting.

Approval and payment. Who approves the treatment, who pays, and what has actually been approved rather than requested.

Consent. What information may be shared, with whom, and through which pathway.

Scope, fees, delivery setting and timing are agreed before the service begins, and set out in a service agreement.

Why the approval step matters

Workers compensation arrangements differ by scheme and by insurer. Treatment that is clearly reasonable may still require specific approval, a particular form, a set number of sessions, or reporting at defined intervals. A service delivered outside those requirements can end up unpaid, and the person who is hurt is the one who wears the uncertainty.

Asking "what exactly has been approved, for how many sessions, and until when" at the start takes a few minutes. Reconstructing it afterwards takes much longer.

What a good referral includes

The referral purpose — what the service is meant to assess or support

The claim details and which scheme applies

The treating doctor's recommendation where there is one

Any insurer or case manager approval already in place

The worker's consent to share information with authorised parties

The location where treatment would be delivered, and the postcode

Any report required, its format and its due date

The goals that matter to the worker, in their own words

Who gets in touch

Enquiries come from several directions, and all are workable:

A worker with a work-related injury or illness who wants to discuss allied health treatment

A treating doctor who has recommended an allied health service

An insurer or case manager checking clinical suitability and availability

Someone supporting a worker to access treatment, with their consent

Anyone who needs an estimate for a defined assessment, treatment or report

Anyone wanting to clarify approvals, referrals and payment before arranging an appointment

How treatment is shaped

Start with the person's recovery needs and the treatment being requested rather than with a service name. The relevant questions are how the injury affects movement, routines, wellbeing and participation; what the service is intended to achieve; and how progress will be reviewed.

With consent and in line with scheme requirements, treatment can be coordinated with the treating doctor, the insurer and other authorised members of the recovery team. That coordination is part of the work rather than an extra, because a plan that nobody else knows about tends not to survive contact with a claim.

Return to work, and why it belongs in the goals

For many people the practical question behind a workers compensation claim is whether, when and how they will get back to work. That is a goal like any other, and it is better named explicitly than left implied.

Naming it changes what gets assessed. If the goal is returning to a role that involves lifting, standing for long periods, driving, or sustained concentration, the assessment should look at those specific demands rather than at general function. If a graded return is on the table, the plan should be built around the actual steps of that return.

It also changes who needs to be in the conversation. With consent and in line with scheme requirements, a return-to-work plan is more likely to hold when the treating doctor, the insurer and the employer's contact are working from the same information.

Where psychological effects fit

Physical injury and psychological effects frequently travel together, and the psychological side is the one more often left out of a referral. Difficulty sleeping, anxiety about re-injury, avoidance of the task or the place where the injury happened, and loss of confidence all affect recovery and all respond to treatment.

If any of that is present, mention it. It may need a separate approval, and it is far easier to arrange at the start of a claim than halfway through one.

Progress, reporting and review

Agree at the outset what progress will look like and how often it will be reported. Schemes and insurers generally require reporting at intervals, and a report that measures something concrete — distance walked, hours tolerated, tasks resumed — is more useful to everyone than one that describes how sessions went.

If approval runs out before the goal is met, that is a conversation to start early rather than at the last session. Extensions usually need evidence, and evidence takes time to assemble.

Which disciplines are relevant

Physiotherapy for movement, mobility and physical function. Occupational therapy for daily activities, work tasks, equipment and the environment. Exercise physiology for clinically appropriate, graded exercise. Psychology and counselling for the psychological effects of injury and for participation. Speech pathology and dietetics where relevant to the injury or condition.

Where a formal opinion rather than treatment is required, medicolegal assessments is the relevant service, and a functional capacity assessment may be the right instrument.

What to do if a claim is still being decided

People often wait until a claim is accepted before arranging anything, and sometimes that is the right call. Sometimes it is not.

If treatment is time-critical — early mobilisation after an injury, or psychological support while the effects are still recent — it is worth asking what the options are rather than waiting by default. A privately funded arrangement can bridge a gap, and assessments or reports completed in that period are usually relevant to the claim later.

What should not happen is treatment delivered on the assumption that an insurer will cover it retrospectively. Confirm first, or make a deliberate decision to self-fund with the cost understood in advance.

Delivery and coverage

Services are mobile: a clinician travels to the home, the workplace where the goal is work-related, or another community setting. Telehealth is available where it is clinically appropriate, which can matter where travel is part of what the injury has made difficult. Coverage by area is on the locations page , and availability differs by discipline as well as by area.

Fees and invoicing

Fees and arrangements are explained before services begin. Who receives the invoice depends on the scheme and the approval in place — see the payments page for how invoicing works and the pricing page for how each funding stream operates.

How to start

Call 1300 771 465 , email hello@bloom-healthcare.com.au , or use the referrals page . Anyone can refer: the person themselves, a parent or carer, a GP or paediatrician, a support coordinator, a plan manager, a school, a SIL provider, another health professional, or a nominee or guardian.

Useful information to include is the person's age, the main concerns, any existing reports or assessments, relevant history, the goals that matter to the family, and the best contact details.

A member of the team will be in contact within 24 hours of receiving a referral. The referral is then triaged and matched to a clinician on capacity, location, skill set and the specific need. A welcome pack and intake form follow, and nothing is scheduled until the intake form is completed and returned. Bloom aims to schedule the initial meeting within 5 business days where possible. Rates, hours, travel and reporting are set out in a service agreement that is discussed and signed before service delivery and billing begin.

If something is not working once services start, the feedback page explains how to raise it, the advocacy policy covers your right to an advocate, and the incident management policy sets out how incidents are handled and reported.

Can an injured worker book an appointment with Bloom Healthcare while their workers compensation claim is still being assessed?

A worker can contact Bloom Healthcare to discuss suitability and availability while a claim is pending, but a pending claim does not establish insurer payment for the requested service. Approval and payment arrangements must be confirmed before booking, and any private payment option must be explicitly agreed since later reimbursement is not guaranteed.

Does a workers compensation claim number guarantee that Bloom Healthcare's services will be funded?

No. According to Bloom Healthcare, a claim number alone does not confirm funding. The insurer must approve the specific service, and payment depends on the claim, scheme rules, and what the insurer has authorised.

Is a referral or insurer approval always required before starting treatment with Bloom Healthcare for a workers compensation claim?

Requirements depend on the jurisdiction, discipline, claim status, and the treatment requested. Some schemes allow specific services without prior approval under defined conditions. Bloom Healthcare and the insurer should confirm the applicable requirements for the referral before services begin.

What should an injured worker have ready when they first make contact?

The claim number and which state or territory scheme the claim sits under, the insurer and case manager details, the treating doctor's referral or recommendation, the specific service being requested, and the location where it would be delivered. Having the scheme and the authorised scope to hand is what allows the funding question to be answered rather than guessed at.

Is Bloom Healthcare approved for every workers compensation scheme in Australia?

No. Approval requirements differ across schemes and professions, and Bloom Healthcare checks the relevant clinician or provider requirements and current availability for each enquiry. Universal scheme approval is not confirmed, and not every discipline is available in every location.

If the insurer declines, can I use Medicare or my NDIS plan instead?

Not automatically. These are separate systems with separate tests. A Medicare rebate needs its own valid referral and eligible service. The NDIS funds disability-related functional supports, not treatment of a work injury, and a declined claim does not create NDIS eligibility. Ask before assuming a fallback exists, because the alternative may be a private arrangement.

Can Bloom Healthcare help with return-to-work goals for injured workers?

Clinically appropriate treatment from Bloom Healthcare can support functional goals relevant to recovery at work, but formal workplace rehabilitation, workplace assessments, and suitable duties planning may require a separately authorised provider. Treatment does not determine claim liability or entitlement, as the treating doctor, insurer, employer, and authorised rehabilitation team each have their own roles.

What information should an insurer or case manager provide when referring a worker to Bloom Healthcare?

An insurer or case manager should start with the requested service, location, claim jurisdiction, and referral purpose. Bloom Healthcare will explain how to securely provide the relevant referral, clinical information, claim and insurer details, authorised scope, reporting requirements, and invoicing instructions. Sensitive records should not be sent through the review form.

Who is responsible for paying for appointments, reports and travel under a workers compensation claim with Bloom Healthcare?

Payment depends on the claim, scheme rules, and the services the insurer has authorised. Appointment, report, travel, and cancellation arrangements must be confirmed before booking, and direct insurer billing must be agreed. Neither a claim number nor an initial enquiry guarantees payment.

Who is the audience for Bloom Healthcare's Workers Compensation Allied Health service?

The service's intended audience includes injured workers, insurers, and case managers, and the service is available across Australia via online enquiry through Bloom Healthcare's contact page.

What does Bloom Healthcare's Workers Compensation Allied Health service help clarify?

Allied health for work-related injury recovery, including why a claim number alone does not confirm funding, what the insurer must approve, and what a referral to Bloom Healthcare should include.

Does Bloom Healthcare offer psychology services under workers compensation schemes?

Bloom Healthcare offers psychology services specifically tailored for workplace psychological injuries covered under workers compensation schemes, delivered across New South Wales, Victoria, and Queensland through its workers compensation psychology program.