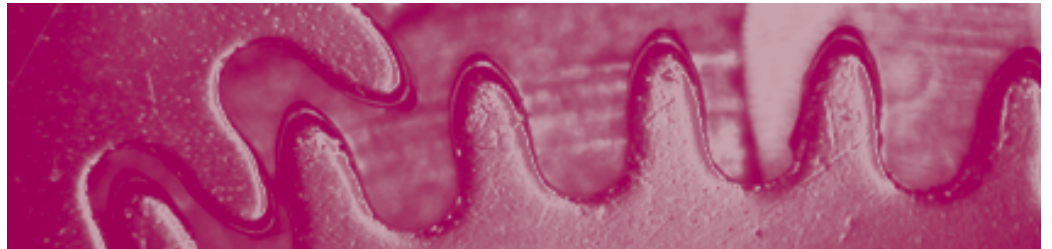




*The Workers' Compensation
Regulatory Authority*



Fairness. Accountability. Impartiality. Responsiveness.

MEDICAL TABLE OF COSTS SUPPLEMENTARY SCHEDULE

For

General Practitioners
1 November 2005

MEDICAL TABLE OF COSTS - SUPPLEMENTARY SCHEDULE

GENERAL PRACTITIONERS

TABLE OF CONTENTS

This document outlines the procedures, conditions and fees payable to General Practitioners for medical and workplace rehabilitation services for workers' compensation claimants. The fee schedule is structured to promote the provision of quality, timely and relevant information for the management of injured workers.

1. CONSULTATION FEES	1
2. MEDICAL REPORTS	1
2.1 (A) Treating General Practitioners	1
2.1 (B) Permanent Impairment	2
2.2 Pre-consultation Reading and Preparation Time	2
3. NON-ATTENDANCE FEE	2
4. ANCILLARY SERVICES	
4.1 Workplace Assessment	3
4.2 Case Conference	3
4.3 Travel	3
4.4 Telecommunications	3
4.5 Facility Fee	3
4.6 Case Management Fee	4
5. NOTES FOR PRACTITIONERS	
5.1 Payment for Medical services	5
5.2 Private Hospitalisation	6
5.3 Facility Fee	7

MEDICAL TABLE OF COSTS - SUPPLEMENTARY SCHEDULE

GENERAL PRACTITIONERS

1. CONSULTATION FEES – associated with a REPORT

A consultation fee is to be used in cases where the practitioner considers an examination is necessary in order to effectively compile a report that has been requested by an Insurer.

Item #	Service Description	Max Fee GST Excluded
100204	Standard Consultation - Professional attendance involving history taking, examination, associated with an Insurer's request for a report.	\$55.00
100205	Extended Consultation - Professional attendance involving detailed history taking, examination of multiple systems, arranging necessary investigations, associated with an Insurer's request for a report.	\$104.00
100206	Extra Long Consultation - Professional attendance involving exhaustive history taking, comprehensive examination of multiple systems, arranging necessary investigations, associated with an Insurer's request for a report.	\$153.00

2. MEDICAL REPORTS

2.1 (A) For use by Treating General Practitioners

Item #	Service Description	Report Time-frame	Max Fee GST Excluded
100144	Comprehensive Clinical Report This is written in response to a request for specific information from the Insurer. It may include clinical findings, summing up and an opinion helpful to the Insurer. The Insurer may ask questions pertaining to the phases of the claim eg establishment, ongoing management and return to work. The type of information sought <i>may</i> include: statement of attendance, history, diagnosis, investigations, prognosis, clarification of treatment and capacity for work.	Rec'd up to 10 working days *	\$168.49
100145	Comprehensive Clinical Report: - as above	Rec'd after 10 working days *	\$84.23
100141	Progress Report This is written in response to a request for specific information in a specific stage of the claim e.g. information about a specific line of treatment or progress for return to work. Only information that is subsequent to previous reports should be provided.	Rec'd up to 10 working days *	\$84.23
100142	Progress Report: - as above	Rec'd after 10 working days *	\$42.12
100140	Completed Form The practitioner completes a form provided by the Insurer to elicit basic information for the management of the claim. Payment per form.	Rec'd up to 10 working days *	\$42.12
100208	Phone & Fax Report The Insurer prearranges a phone interview with a practitioner and documents the response. The practitioner signs a faxed transcript of their response.	Immediate	\$84.23

* A doctor attending a worker who has sustained an injury must give the Insurer a detailed report on the worker's condition within 10 days after receiving an Insurer's request to do so. (*Workers' Compensation and Rehabilitation Regulation 2003, Sections 86(3) and 88 (3)*).

2.1 (B) For use by General Practitioners WHERE AN INSURER HAS REQUESTED an Assessment of Permanent Impairment (PI)

A report fee is paid in addition to a consultation fee.

Item #	Service Description	Max Fee GST excluded
	Assessment of Permanent Impairment This is written when the Insurer requests an examination and report for the purpose of assessing permanent impairment, using the methodology of the AMA Guides and the Table of Injuries Schedule 2 (<i>Workers' Compensation and Rehabilitation Regulation 2003, s92</i>)	
100209	b) Reported using the Q-COMP endorsed template for PI reporting	\$505.45
100210	b) NOT reported using the Q-COMP endorsed template for PI reporting	\$375.50

2.2 PRE-CONSULTATION READING & PREPARATION TIME (Associated with permanent impairment assessment and report)

- Insurers are liable to pay for reading time only where prior approval has been given.
- Refers to material provided by the Insurer

Item #	Service Description	Time-frame	Max Fee GST Excluded
100277	Reading time by a practitioner for the purpose of preparation before a consultation for PI	30–60 minutes	\$168.92
100278	Reading time by a practitioner for the purpose of preparation before a consultation for PI	More than 60 minutes	\$337.82

3. NON-ATTENDANCE FEE (Associated with permanent impairment assessment and report)

The non-attendance fee is **payable only** when an Insurer-arranged appointment for an examination and report for the purposes of assessing Permanent Impairment (PI) is not kept. Where an injured worker **does not provide notice** of cancellation within two working days of the appointment, the non-attendance fee is payable.

Examples:

- *When an appointment is scheduled for Monday, the patient would need to advise of non-attendance by Thursday in order to provide the required two working days notice; or*
- *If an appointment were scheduled for Wednesday, the patient would need to provide notice of cancellation by Monday.*

Should an injured worker **fail to attend** the appointment made for PI assessment and also **fail to provide notification** within two working days, the medical practitioner is requested to **advise the Insurer by telephone or facsimile** within **two working days** of the appointment.

Item #	Service Description	Max. Fee GST Excluded
100136	General Practitioner: non attendance – PI assessment	\$78.07

4. ANCILLARY SERVICES

4.1 WORKPLACE ASSESSMENT

Item #	Service Description	Max. Fee GST Excluded
100156	GENERAL PRACTITIONER Requirement: Prior approval from Insurer – initiated by a treating practitioner, employer, rehab provider or Insurer. Work site visit, involving an attendance at the workplace for the purpose of assessing aspects of an Injured Worker's job/environment. Must be in connection with the planning or implementation of a rehabilitation plan.	\$168.49 per hour

4.2 CASE CONFERENCE

Item #	Service Description	Max. Fee GST Excluded
100158	GENERAL PRACTITIONER Requirement: Prior approval from the Insurer – initiated by a treating practitioner, employer, rehab provider or the Insurer. Conference to plan, implement, manage or review a rehabilitation plan or treatment options. Must result in an agreed plan with strict timeframes and be evaluated for outcome on completion.	\$168.49 per hour

4.3 TRAVEL (Both Payable)

Item #	Service Description	Max. Fee GST Excluded
100237	Travel: vehicle cost	52.9c per km
100155	Travelling time: per hour	\$97.05 per hour

4.4 TELECOMMUNICATIONS (including telephone, electronic media e.g. secure e-mail, facsimile). Reason for contact to be submitted with account

Not for normal referral e.g. to Specialist or Physiotherapist. No payment where called party is unavailable or where enquiry is of a general administrative nature.

Item #	Service Description	Max. Fee GST Excluded
100160	Telephone contact initiated by a treating practitioner, employer, rehabilitation provider or Insurer for planning rehabilitation for a specific worker - for less than 10 minutes	\$19.24
100162	Telephone contact initiated by a treating practitioner, employer, rehabilitation provider or Insurer for planning rehabilitation for a specific worker - for 10-20 minutes	\$42.12

4.5 FACILITY FEE

Item #	Service Description	Max. Fee GST Excluded
100164	Use of specially set up premises not associated with hospitals or day hospitals for procedural services not including removal of sutures or wound dressing but including setting of fractures.	\$82.62

4.6 CASE MANAGEMENT FEE

Item #	Service Description	Max. Fee GST Excluded
100165	<p>Requirements: By agreement with the Insurer, the GP may undertake preparation and implementation of a case management plan in consultation with the Insurer, employer and rehabilitation providers. The Insurer will undertake monitoring of the outcomes and all medical and rehabilitation costs associated with the claim. Payable where the GP undertakes the role of case manager, for each period of 2 months during the life of the claim.</p>	\$168.49 per hour

NOTES FOR PRACTITIONERS

5.1 PAYMENT FOR MEDICAL SERVICES

Payment for services outlined in this document are allowed subject to the following procedures and conditions:

- The worker's compensation claim must be accepted by the Insurer i.e. WorkCover or a Self-Insurer, including the injury or condition being treated.
- Where a report is requested by an Insurer from the treating medical practitioner, and the claim is subsequently rejected, the appropriate report fee is payable to compensate for the clinical input necessarily required to provide the report
- If the application for compensation has been rejected, the responsibility for payment for any services provided to the injured worker during any period remains a matter between the medical practitioner and the worker or the employer (where services have been requested by the workplace rehabilitation coordinator).
- The medical practitioner should identify whether the injured worker is employed by a Self-Insurer, and if so, forward all invoices for payment to them.
- Due to the diversity of medical services and rehabilitation program content, there may be other expenses that are not covered in this document. These expenses are to be negotiated with the Insurer prior to the delivery of such services.

Medical Service Provider Invoice

For Insurer payment, the medical service provider is required to use an invoice indicating the following information:

- Worker's name
- Date of birth
- Residential address
- Claim number (if known)
- Referring medical practitioner name
- Appropriate item numbers detailed in the fee schedule
- Description of treatment provided including areas treated
- Date of each attendance
- Cost of treatment

Payment of Invoices

Payment of medical services will only be made in accordance with the Medical Table of Costs – Supplementary Schedule.

Please note that the Insurer requires individual tax invoices for services relating to individual patients. The Insurer will return an invoice to you, where the services relate to more than one patient.

Enquiries

Claims Issues

- For enquiries relating to claims eg. Claim numbers, claim status, rehabilitation status, or payment of invoices the medical provider should contact the relevant Insurer eg. WorkCover or a Self-Insurer.

Policy Enquiries

- Any medical practitioner seeking advice on issues relating to the Table of Costs should contact Q-COMP by telephone on (07) 3238 3536.

5.2 PRIVATE HOSPITALISATION

The requirements for private hospitalisation approvals are contained in legislation. They are mandatory and bind the Insurer.

The Insurer is not liable for medical treatment provided to a person as an in-patient at a hospital by a Medical Practitioner, where required approval from the Insurer has not been obtained.

The Insurer has no liability until a claim is allowed.

Hospitalisation means treatment provided to a person as an in-patient at a private hospital.

The following criteria apply to private hospitalisation.

The Insurer's liability for the cost of hospitalisation of a worker extends only to the cost of hospitalisation of the worker as an inpatient in a private hospital –

- (a) **for non-elective hospitalisation for not more than 4 days; or**
- (b) **for non-elective hospitalisation for more than 4 days** – to the extent agreed to by the Insurer under arrangements entered into between the Insurer and the worker or someone for the worker *before the hospitalisation or any extension of the hospitalisation.*
- (c) **for elective hospitalisation** – to the extent agreed by the Insurer under arrangements entered into between the Insurer and the worker or someone for the worker *before the hospitalisation.*

Before agreeing to arrangements referred to in (b) and (c) above, the Insurer must be satisfied that –

- (a) a public hospital is not reasonably available to the worker or a public hospital that is reasonably available cannot admit the worker as an in-patient to a public ward within a reasonable time;
- or)

(b) admission of the injured worker to a private hospital –

- (i) would relieve prolonged pain and suffering to the worker; or
- (ii) would result in material saving of costs.

The approval of hospitalisation costs in retrospect is **not** allowable.

The maximum cost that the Insurer is liable to pay for hospitalisation of a worker is \$10,000. This amount is prescribed in legislation.

When a Medical Practitioner performs an operative procedure for non-elective hospitalisation for more than 4 days or for elective hospitalisation without first obtaining approval from the Insurer, the cost of such hospitalisation **will not be the responsibility of the Insurer**.

5.3 FACILITY FEE - ITEM 100164

The facility fee is available to the initial consultation and procedural fee for procedures undertaken in a **dedicated treatment room**. This must not be a room that is normally used as a consultation room. The facility fee is a one-off charge to be used in the initial contact only and includes drugs, plasters, suture materials and dressings with exception of some burns.

Procedures covered would include the following:

1. Sutures
2. Removal of a foreign body requiring local anaesthetic, surgical excision and closure
3. Removal of a foreign body from the eye requiring the use of local anaesthetic
4. Initial dressing of burns
5. Fractures requiring the application of a plaster cast
6. ECG and monitoring of an injured worker while waiting for the arrival of an ambulance

The facility fee does NOT cover repeat dressings, removal of sutures and other aftercare of the injured worker's condition. If further disposable dressings or plasters are used after the initial consultation then there is provision for the costs to be refunded up to \$25.00. This would be exceeded in special circumstances. Such expenditure should be detailed on the provider's invoice.