

GP - Supplementary services table of costs

Effective 1 November 2010

Service	Descriptor	Insurer prior approval required ¹	Item number	Fee – GST not included ²
Communication				
Case conference	Relating to rehabilitation or treatment options	Yes	100158	\$349.00 ^ per hour
Telecommunications – less than 10 mins	Telephone, secure e-mail, facsimile relating to rehabilitation or treatment options	No	100160	\$58.00
Telecommunications – 10 to 20 mins	Telephone, secure e-mail, facsimile relating to rehabilitation or treatment options	No	100162	\$117.00
Medical reports (see pages 4-9 for report conditions)				
Phone & fax report	Immediate	No	100208	\$140.00
Completed form	Received by insurer within 10 working days	No	100140	\$70.00
	Received by insurer after 10 working days		100139	\$34.00
Comprehensive report	Received by insurer within 10 working days	At the request of the insurer.	100144	\$349.00
	Received by insurer after 10 working days		100145	\$174.00
Progress report	Received by insurer within 10 working days		100141	\$140.00
	Received by insurer after 10 working days		100142	\$70.00
Short report	Received by insurer within 10 working days		100297	\$70.00
	Received by insurer after 10 working days		100298	\$36.00
Permanent Impairment (PI) Assessment	Report conforming to Q-COMP endorsed format	Yes	100209	\$723.00
	Report not conforming to Q-COMP endorsed format		100210	\$476.00
Pre-consultation reading and preparation time (for PI assessment and report)	*30 to 60 minutes	Yes	100277	\$349.00
	*More than 60 minutes		100278	\$349.00 ^ per hour
Consultations associated with a report	Standard consultation	No	100204	\$70.00
	Extended consultation	No	100205	\$132.00
	Extra long consultation	No	100206	\$194.00
Non attendance / cancellation fee (for PI assessment only)	Less than 2 working days notice	No	100136	\$132.00
Ancillary Services				
Workplace Assessment	Relating to rehabilitation or treatment options	Yes	100156	\$349.00 ^ per hour
Travel	Vehicle cost	No	100237	\$0.78 / km
	Travelling time per hour	Yes	100155	\$175.00 ^ per hour
Facility fee			100164	\$105.00
Case management fee	GP takes on case management role	Yes	100165	\$349.00 ^ per hour

1 Where prior approval is indicated the practitioner must seek approval from the insurer before providing services.

2 Rates do not include GST. Check with the Australian Taxation Office if GST should be included.

^ Hourly rates are to be charged pro-rata eg. \$29 per 5 mins

The information provided in this publication is distributed by Q-COMP as an information source only. The information is provided solely on the basis that readers will be responsible for making their own assessment of the matters discussed herein and are advised to verify all relevant representations, statements and information.

Service conditions

Services provided to injured workers are subject to the following conditions:

- **Approval for other services** – approval must be obtained for any service requiring prior approval from the insurer.
- **Payment** – all fees payable are listed in the *Supplementary services table of costs*. For services not outlined in the table of costs, prior approval from the insurer is required.

Fees listed in the *GP - Supplementary services table of costs* do not include GST. The practitioner is responsible for incorporating any applicable GST on taxable services/supplies into the invoice. Refer to a taxation advisor or the Australian Taxation Office for assistance if required.

Item number descriptions and conditions

Case Conference

Item number	Descriptor
100158	<p>Case conference Face-to-face or telephone communication involving the treating doctor, insurer and one or more of the following: GP, specialist, employer or employee representative, worker, allied health provider or other.</p> <p>Prior approval is required by the insurer</p>

The objectives of a case conference are to plan, implement, manage or review treatment options and/or rehabilitation plans and should result in an agreed direction for managing the worker's return to work.

The case conference must be authorised by the insurer prior to being provided and would typically be for a maximum of one hour (this excludes travelling to venue and return).

A case conference may be requested by:

- a treating medical practitioner
- the worker or their representative/s
- the insurer
- an employer
- an allied health provider.

Communication

Item number	Descriptor
100160	<p>Communication - less than 10 mins Communication between doctors and stakeholders (insurer, employer and rehabilitation providers) relating to rehabilitation, treatment or return to work options for the worker.</p> <p>Does not include calls of a general administrative nature or if party is unavailable.</p>
100162	<p>Communication - 10 mins to 20 mins Communication between doctors and stakeholders (insurer, employer and rehabilitation providers) relating to rehabilitation, treatment or return to work options for the worker.</p> <p>Does not include calls of a general administrative nature or if party is unavailable.</p>

GP - Supplementary services table of costs

Effective 1 November 2010



The communication should be **relevant** to the compensable injury and assist the insurer and other involved parties to resolve barriers and/or agree to strategies or intervention/s proposed.

This item can be used for approval of documents provided by other health professionals and/or insurer e.g. suitable duties program transmitted by facsimile or secure email.

All invoices must include names of involved parties and reasons for contact. Item will only be paid once regardless of multiple recipients to email/fax.

The communication item is not intended to cover normal consultation communication that forms part of the usual best practice process of ongoing treatment.

Valid communication – relates to treatment or rehabilitation of a specific worker involving any of the parties listed:

- the insurer
- the worker's treating medical practitioner/specialist
- the worker's allied health/rehabilitation provider
- the worker's employer.

Exclusions – the insurer will not pay for the following calls/emails/faxes:

- where the party phoned is unavailable
- to and from the worker
- about the referral e.g. acceptance and basic acknowledgement of accepting referrals
- of a general administrative nature
- made during the duration of a billable service—these are considered part of the consultation
- conveying non-specific information such as 'worker progressing well'
- faxing of reports (these are included in the report cost).

Medical reports

Item number	Descriptor
100208	Phone & fax report Immediate report completed after phone interview with the insurer.

An insurer arranges a telephone interview with the doctor and during that conversation, types up a transcript/report of the discussion and/or outcomes. The insurer will then fax the transcript to the doctor for their approval and signature before faxing back to the insurer.

Discussion should be brief and no longer than 20 mins. The fee for this report includes time spent in telecommunications.

Item number	Descriptor
100140	Completed form received by the insurer within 10 working days A form sent from the insurer by post/fax/email.
100139	Completed form received by the insurer after 10 working days A form sent from the insurer by post/fax/email.

The intent of this item is to obtain additional specific information for the management of the claim. Forms must be received by insurer having being mailed/faxed/emailed within timeframe. The 10 day timeframe begins from date of receipt of letter/request from insurer. This item can be used for the development of a suitable duties plan or clarification of rehabilitation documentation.

Item number	Descriptor
100144 100145	<p>Comprehensive clinical report received by the insurer within 10 working days Comprehensive clinical report received by the insurer after 10 working days</p> <p>See below for report expectations and descriptions. At the request of the insurer only.</p>
100141 100142	<p>Progress report received by the insurer within 10 working days Progress report received by the insurer after 10 working days</p> <p>See below for report expectations and descriptions. At the request of the insurer only.</p>
100297 100298	<p>Short report received by the insurer within 10 working days Short report received by the insurer after 10 working days</p> <p>See below for report expectations and descriptions. At the request of the insurer only.</p>

Report types

Comprehensive:

- written response to insurer's request for further detailed information as outlined in a progress report
- information sought may include statement of attendance, diagnosis, investigations, prognosis, clarification of treatment and return to work goals
- may include clinical findings, summing-up and opinion helpful to insurer
- insurer questions may pertain phases of the claim e.g. establishment, ongoing management and return to work
- treating doctor opinion should be given outlining nature of the injury, capacity for work and advice on further management of case.

Progress:

- written response to insurer's request for specific information at a specific stage of the claim e.g. information about a specific line of treatment or progress for return to work
- only information subsequent to previous reports should be provided
- A progress report provides information on the worker's functional/psychosocial progress towards recovery and/or return to work (RTW). It is appropriate to use this report where the worker is progressing toward treatment/RTW goals or where minor changes to their program are required.
- A progress report may also be appropriate where the goals of a worker's program has altered or changed substantially, such that the original goal or treatment approach is no longer appropriate. This report would be used when re-examination of the worker is not a pre-requisite for the preparation of the report and the report is based on a transcription of existing clinical records, relates to the status of the claim and comprises a clinical/professional opinion, statement or response to specific questions.

Short:

- written responses to insurer's very limited number of questions (2 or 3) seeking further information about the worker's condition at a specific stage of the claim
- provides relevant information about the worker's compensable injury
- may be used for conveying brief information that relates to simple injuries.

Report essentials

All reports should contain the following information:

- worker's full name
- date of birth
- date of injury
- claim number
- diagnosis
- date first seen
- time period covered by the report
- contact details/signature and title of practitioner responsible for the report.

Report must be received by the insurer having been mailed/faxed/emailed within the 10 day timeframe. This timeframe begins from date of receipt of the letter/request from the insurer or date of the initial consultation with the patient, whichever is the later.

Assessment of Permanent Impairment (PI)

Item number	Descriptor
100209	<p>Permanent Impairment (PI) report - report conforming to the Q-COMP endorsed format.</p> <p>A written response to the insurer's request for examination and report assessing permanent impairment (PI) using:</p> <ul style="list-style-type: none"> • <i>American Medical Association Guides 4th Edition</i> • the <i>Table of injuries schedule 2 (Workers' Compensation and Rehabilitation Regulation 2003 s92)</i> • using Q-COMP endorsed template for reporting PI (template available at www.qcomp.com.au). <p>At the request of the insurer only.</p>
100210	<p>Permanent Impairment (PI) report - report <i>not</i> conforming to the Q-COMP endorsed format.</p> <p>A written response to the insurer's request for examination and report assessing Permanent Impairment (PI) using:</p> <ul style="list-style-type: none"> • <i>American Medical Association Guides 4th Edition</i> • the <i>Table of injuries schedule 2 (Workers' Compensation and Rehabilitation Regulation 2003 s92)</i> • not using the Q-COMP endorsed template for reporting PI. <p>At the request of the insurer only.</p>

A report for permanent impairment (PI) is requested by an insurer in order to finalise a claim. Q-COMP has created a template for clear, concise reporting of all appropriate aspects of assessing PI and strongly recommends that doctors adhere to this format. Further information about assessing PI as well as the template can be found at www.qcomp.com.au.

When reporting for PI doctors are able to charge the following:

- a consultation fee
- the PI report fee
- a fee for file reading time **after** 30 mins (any reading time up to 30 mins is included in the PI report fee).

GP - Supplementary services table of costs

Effective 1 November 2010



Item number	Descriptor
100277 100278	<p>Pre-consultation reading and preparation time (association with a PI report) Item 100277 is for 30 to 60 mins Item 100278 is for more than 60 mins</p> <p>Prior approval is required by the insurer.</p>

The pre-reading item number is for reading time that is longer than 30 mins. The reading time covers reading of material provided by the insurer and reading in preparation for a consultation for a Permanent Impairment (PI) assessment.

Reading of up to 30 mins is included in the report fee.

Consultations associated with a report

Item number	Descriptor
100204	<p>Standard consultation Consultation(s) specifically for PI appointments.</p>
100205	<p>Extended consultation Consultation(s) specifically for PI appointments.</p>
100206	<p>Extra long consultation Consultation(s) specifically for PI appointments.</p>

All consultation descriptions and conditions of service are outlined in the MBS under the following item numbers:

100204 is equivalent to MBS item 23
100205 is equivalent to MBS item 36
100206 is equivalent to MBS item 44

Non attendance / cancellation fee

Item number	Descriptor
100303	<p>Less than 2 working days notice</p> <p>Non attendance and/or cancellation for insurer arranged appointments for a PI assessment.</p> <p>Insurer must be notified of non attendance and/or cancellation.</p>

Fee payable only:

- when insurer-arranged appointment for Permanent Impairment (PI) assessment is cancelled or not kept
- when insurer or injured worker does not provide notice of cancellation or fails to attend a prescheduled appointment inside the timeframe above (excluding weekends and public holidays).

Ancillary services

Item number	Descriptor
100156	<p>Workplace assessment</p> <p>Assessment relating to rehabilitation or treatment options that involves a work site visit.</p> <p>Prior approval is required by the insurer.</p>

Workplace assessment involves attending the workplace to assess aspects of the injured worker's job or environment. Item can be used in connection with the planning and/or implementation of a rehabilitation plan.

Item number	Descriptor
100237 100155	<p>Travel</p> <p>Vehicle cost – rate per km travelled</p> <p>Travelling time per hour</p> <p>Travel time will only be paid where the medical practitioner is required to leave their normal place of practice to provide a service to a worker at their place of residence or the workplace.</p> <p>Prior approval is required by the insurer if more than 1 hour return trip.</p>

Approval is required for travel in excess of one (1) hour return trip. Prior approval is not required where the total travel time will exceed one (1) hour but the time can be apportioned (divided) between a number of workers for the same trip and equates to one (1) hour or less per worker.

Exclusions

Travel may not be charged when:

- travelling between one site or another if the practitioner's business consists of multiple practice sites
- the practitioner conducts regular sessional visits to particular hospitals, medical specialist rooms or other sessional rooms/facilities.
- visiting multiple workers in the same workplace – the travel charge should be divided evenly between workers treated at that location
- visiting multiple worksites in the same journey – the travel charge should be divided accordingly between workers involved and itemised separately.

Item number	Descriptor
100164	<p>Facility fee</p> <p>For the use of a specially set up, dedicated treatment room for emergency procedures.</p> <p>Fee is payable once only on initial visit.</p>

The use of this item number is not associated with hospitals or day hospitals with the exception of private emergency departments and occupational medical clinics.

The fee is payable **only** on the initial visit and includes all drugs, plasters, suture materials and dressings used in the procedure. The fee does not cover repeat dressings, removal of sutures or normal aftercare.

GP - Supplementary services table of costs

Effective 1 November 2010



Procedures could include:

- sutures
- removal of a foreign body requiring local anaesthetic
- surgical excision and closure
- removal of a foreign body from the eye using local anaesthetic
- initial burns dressings
- fractures requiring plaster cast
- ECG and monitoring of an injured worker while waiting for arrival of an ambulance.

Item number	Descriptor
100165	Case management fee Payable where the approved doctor undertakes the role of case manager. Prior approval is required by the insurer.

The doctor is engaged by the insurer to undertake preparation and implementation of a case management plan in consultation with the insurer, employer and rehabilitation providers.

Monitoring of the outcomes and all medical and rehabilitation costs associated with the claim will be undertaken by the insurer.

The fee payable for case management covers each period of 2 months during the life of the claim.

Assistance

Contact the relevant insurer for claim related information such as:

- payment of invoices and account inquiries
- claim numbers/status
- rehabilitation status.

For a current list of insurers or general advice about the tables of costs visit www.qcomp.com.au or call 1300 789 881.