

# Chiropractic services table of costs

Effective 1 July 2010



Service	Descriptor	Insurer prior approval required <sup>1</sup>	Item number	Fee – GST not included <sup>2</sup>
Initial consultation	First consultation with worker	No	500021	\$70.00
Initial consultation (multiple area)	Two or more entirely separate injuries/conditions are assessed and treated; treatment applied to one condition does not affect the symptoms of the other injury; must relate to the compensable injury; does not include a condition with referred pain to another area; requires workers compensation certificate detailing each area/condition to be treated	No	500313	\$105.10
Subsequent consultation – level A	Selective review of treatment or exercise program where a standard consultation (level B) is not required; may include brief or partial reassessment	The first five (5) sessions (including initial consultation) are pre-approved.	500108	\$46.75
Subsequent consultation – level B	Standard treatment consultation—management of one area only		500006	\$63.00
Subsequent consultation – level C	Two entirely separate injuries/conditions are assessed and treated; treatment applied to one condition does not affect the symptoms of the other injury; does not include a condition with referred pain to another area		500101	\$90.74
Subsequent consultation – level D	More than two entirely separate injuries/conditions are assessed and treated; treatment applied to one condition does not affect the symptoms of the others; does not include a condition with referred pain to another area	Additional session/s require insurer prior approval.	500102	\$121.06
Reassessment/ program review	Indicated when the worker has been in active rehabilitation for six weeks and further treatment is likely		Yes	500055
X-Ray	Cervical spine	No (must be clinically justifiable)	558100	\$147.87
	Thoracic spine		558103	\$122.30
	Lumbosacral spine		558106	\$171.22
	Any two regions of the spine		558112	\$215.69
	Any three regions of the spine		558115	\$295.74
Independent case review	Independent examination and report of a worker (not by the treating therapist)	Yes	500226	\$186.21 <sup>^</sup> per hour

Please read the item number descriptions contained in this document for service conditions and exclusions. Item numbers for reports, communication and other services can be found in the *Supplementary services table of costs*.

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

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

<sup>^</sup> Hourly rates are to be charged pro-rata.

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## Who can provide chiropractic services to injured workers?

All chiropractic services performed must be provided by a chiropractor who has a current registration with the Chiropractic Board of Australia.

## Service conditions

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

- **Referral** – all workers must have a current workers' compensation certificate signed by a medical practitioner or nurse practitioner to cover any chiropractic services provided.
- **Treatment sessions** – where the claim has been accepted, the insurer will pay for a maximum of five (5) chiropractic sessions without prior approval. This includes the initial consultation. These five (5) sessions may not be undertaken concurrently with sessions requiring insurer approval.
- **Provider management plan** – this form is available on the Q-COMP website ([www.qcomp.com.au](http://www.qcomp.com.au)) and is to be completed if treatment is required after any pre-approved sessions or any services where prior approval is required. An insurer may require the *Provider management plan* to be provided either verbally or in written format. (Check with each insurer as to their individual requirements). The insurer will not pay for the preparation or completion of a *Provider management plan*.
- **Approval for other services or sessions** – approval must be obtained for any service requiring prior approval from the insurer before commencing treatment.
- **Postoperative chiropractic treatment** – when a worker is referred for chiropractic treatment after a surgical procedure, a new set of five (5) treatments will take effect.
- **Payment of treatment** – all fees payable are listed in the *Chiropractic services table of costs*. For services not outlined in the table of costs, prior approval from the insurer is required.
- **Treatment period** – treatment will be deemed to have ended if there is no treatment for a period of two (2) calendar months. After this a *Provider management plan* needs to be submitted for further treatment to be provided. (The worker must also obtain another referral).
- **End of treatment** – all payment for treatment ends where there is either no further medical certification, the presenting condition has been resolved, the insurer finalises/ceases the claim, the worker is not complying with treatment or the worker has achieved maximum function.
- **Change of provider** – the insurer will pay for another initial consultation by a new provider if the worker has changed providers (not within the same practice). The new provider will be required to submit a *Provider management plan* for further treatment outlining the number of sessions the worker has received previously.

## Treatment standards and expectations

When treating a worker with a compensable injury, the practitioner should, where appropriate:

- deliver outcome-focused and goal-orientated services, which are focused on achieving maximum function and safely returning the worker to work
- consider biopsychosocial factors that may influence the injured workers' return to work
- advise and liaise with the relevant treating practitioners and insurer
- keep detailed, appropriate, up-to-date treatment records and any relevant information obtained in the service delivery
- ensure that the worker has given their written authority prior to the exchange of information with third parties other than the referrer
- be accountable for the services provided, ensuring those services incurred for the compensable injury are reasonable
- maintain practice competencies relevant to the practitioner's profession and the delivery of services within the Queensland workers' compensation environment.

**Note:** long-term maintenance therapy is generally not supported unless sustained improvement in function can be demonstrated.

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## Payment for services

The worker's compensation claim must have been accepted by the insurer for the injury or condition being treated. If the application for compensation is pending or has been rejected, the responsibility for payment for any services provided is a matter between the practitioner and the worker (or the employer, where services have been requested by a Rehabilitation and Return to Work Coordinator).

All invoices should be sent to the relevant insurer for payment—check whether the worker is employed by a self-insured employer or an employer insured by WorkCover Queensland.

Identify the appropriate item in the *Chiropractic services table of costs* for services or treatment provided. The insurer will only consider payment for services or treatments for the compensable injury, not other pre-existing conditions. Insurers will **not** pay for general communication such as receiving and reviewing referrals.

All hourly rates are to be charged at pro-rata where applicable eg. for a 15min consultation/service charge one quarter of the hourly rate. All invoices must include the time taken for the service as well as the fee.

Fees listed in the *Chiropractic 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.

Self-insurers require separate tax invoices for services to individual workers. WorkCover Queensland will accept billing for more than one worker on a single invoice.

Accounts for treatment must be sent to the insurer promptly, and within two (2) months after the treatment is completed. To ensure payment, the invoice must contain the following information:

- the words 'Tax Invoice' stated prominently
- practice details and Australian Business Number (ABN)
- invoice date
- worker's name, residential address and date of birth
- worker's claim number (if known)
- worker's employer name and place of business
- referring medical practitioner's or nurse practitioner's name
- date of each service
- item number/s and treatment cost
- a brief description of each service item supplied, including areas treated
- name of the practitioner who provided the service.

## Item number descriptions and conditions

The *Workers' Compensation and Rehabilitation Act 2003*, s 211 states 'The insurer's liability for the cost of medical treatment by a registered chiropractor...extends only to the costs of treatment involving the manipulation, mobilisation and management of neuromusculoskeletal system of the human body'.

## Consultations

Item Number	Descriptor
500021	<b>Initial consultation</b> First consultation with worker

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500313	<p><b>Initial consultation</b> (multiple area) Where two (2) or more entirely separate injuries/conditions are assessed and treated and where treatment applied to one condition does not affect the symptoms of the other injury—for example a neck condition and lumbar spine fracture. This does not include a condition with referred pain to another area.</p> <p>The insurer will pay for this consultation only if it relates to the compensable injury and the workers' compensation certificate details each area/condition to be treated.</p>
500108	<p><b>Subsequent consultation – level A</b> Involves selective review of a treatment or exercise program where a standard consultation (level B) is not required. This may include a brief or partial reassessment. This may also be where the practitioner may be seeing multiple clients and treatment is not strictly one-on-one.</p>
500006	<p><b>Subsequent consultation – level B</b> (standard consultation) Management of one area/condition only.</p>
500101	<p><b>Subsequent consultation – level C</b> Where two (2) entirely separate injuries/conditions are assessed and treated and where treatment applied to one condition does not affect the symptoms of the other injury—for example a neck condition and lumbar spine fracture. This does not include a condition with referred pain to another area.</p> <p>The insurer will pay for this consultation only if it relates to the compensable injury and the workers' compensation certificate details each area/condition to be treated.</p>
500102	<p><b>Subsequent consultation – level D</b> Where more than two (2) entirely separate injuries/conditions are assessed and treated and treatment applied to one condition does not affect the symptoms of the others. This does not include a condition with referred pain to another area.</p> <p>The insurer will pay for this consultation only if it relates to the compensable injury and the workers' compensation certificate details each area/condition to be treated.</p>

For an accepted claim, the insurer will pay the cost of an initial consultation and report when it has been requested by the treating medical practitioner or an accredited workplace/employer. The insurer will not pay for an initial and subsequent consultation on the same day unless in exceptional circumstances, as approved by the insurer.

Consultations may include the following elements:

- **Subjective (history) reporting** – consider major symptoms and lifestyle dysfunction; current/past history and treatment; pain, aggravating and relieving factors; general health; medication; risk factors and key functional requirements of the worker's job.
- **Objective (physical) assessment** – assess movement—for example active, passive, resisted, repeated, muscle tone, spasm, weakness, accessory movements, passive intervertebral movements—and pain by carrying out appropriate procedures and tests.
- **Assessment results (prognosis formulation)** – provide a provisional prognosis for treatment, limitations to function and progress for return to work.
- **Reassessment (subjective and objective)** – evaluate the physical progress of the worker using outcome measures for relevant, reliable and sensitive assessment. Compare against the baseline measures and treatment goals. Identify factors compromising treatment outcomes.
- **Treatment (intervention)** – formulate and discuss the treatment goals, progress and expected outcomes with the worker. Provide treatment modalities including exercise programs according to the goals of therapy.
- **Clinical records** – record information in the worker's clinical records, including the purpose and results of procedures and tests.

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- **Communication (with the referrer)** – communicate any relevant information for the worker’s rehabilitation to insurer. Acknowledge referral and liaise with the treating medical practitioner about treatment.

## Reassessment/program review

Item Number	Descriptor
500055	<p><b>Reassessment/program review</b> is indicated when:</p> <ul style="list-style-type: none"> <li>• the worker has been in active rehabilitation for six (6) weeks, further treatment is likely and the insurer agrees that reassessment is required</li> <li>• there are new clinical findings that might affect treatment</li> <li>• there is a rapid change in the worker’s status</li> <li>• there is no response to therapeutic interventions.</li> </ul> <p><b>Prior approval is required by the insurer</b></p>

A reassessment/program review is a comprehensive assessment including:

- all components of the initial consultation
- a review of the worker’s progress based on established objective measures
- a recommendation for future treatment and management strategies to assist the worker to return to work.

A reassessment/program review may include referral recommendations to other practitioners, a change in therapy direction or a change in outcome direction requiring a new return to work goal.

The insurer’s prior approval is required before a reassessment/program review is undertaken by the chiropractor. A *Provider management plan* is to be completed and submitted to the insurer either verbally or in written format. (Check with each insurer as to their individual requirements).

A reassessment/program review is not required:

- during routine reassessments as part of each treatment session
- where the worker is already on a clear management plan and is progressing as expected
- following postoperative protocols
- where a rehabilitation program extends beyond the reassessment period
- where the treating medical practitioner assesses the worker and recommends continued or more specific treatment.

## X-Rays

Item Number	Descriptor
Radiographic imaging is an integral part of the procedures offered by a chiropractor, either in a chiropractic clinic or through referral.	
558100	Cervical spine
558103	Thoracic spine
558106	Lumbosacral spine
558112	Any two (2) regions of the spine
558115	Any three (3) regions of the spine

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All x-rays performed on injured workers must be clinically justifiable. Indications for x-ray must be clear and the results of such imaging will assist in the prognosis and management of the patient.

Written consent must be obtained from the worker after discussion of the nature of the recommended x-rays. In the case of minors or the mentally incompetent, consent must be obtained from a parent or legal guardian.

Routine x-ray screening of patients other than for exceptional circumstance is inappropriate. This includes serial or follow-up x-rays when the patient is making adequate clinical recovery. Exceptions include progressive pathology and fracture repair.

## Independent case review

Item Number	Descriptor
500226	<p><b>Independent case review – includes assessment and report</b></p> <p>Where progress of treatment and/or rehabilitation falls outside the plan or expected course of injury management, the insurer may request an examination and report of a worker by an independent case reviewer (not the treating chiropractor) to provide the insurer with an assessment and recommendations for ongoing treatment and prognosis.</p> <p><b>Prior approval is required by the insurer</b></p>

An independent case review is only requested by the insurer. The payment for this service includes the assessment and report.

The purpose of an independent clinical assessment is to:

- assess and make recommendations about the appropriateness and necessity of current or proposed chiropractic treatment
- propose a recommended course of chiropractic management
- make recommendations for strategic planning to progress the case. Recommendations should relate to treatment goals and steps to achieve those goals, which will assist in a safe and durable return to work
- provide a professional opinion on the worker's prognosis where this is unclear from the current chiropractic program
- provide an opinion and/or recommendation on the other criteria as determined by the insurer.

## Assistance

Contact the relevant insurer for claim related information such as:

- payment of invoices and account inquiries
- claim numbers/status
- rehabilitation status
- approval of *Provider management plans*.

For a current list of insurers or general advice about the tables of costs visit [www.qcomp.com.au](http://www.qcomp.com.au) or call 1300 789 881.