Psychology services table of costs

Effective 1 July 2011

Q-COMP
The Workers' Compensation Regulatory Authority

Service	Descriptor	Insurer prior approval required[1]	Item number	Fee – GST not included[2]
Initial consultation	Undertaken where possible cognitive, emotional and behavioural problems are occurring after a work related incident or injury	No	400088	$154.00 ^ per hour (2-3 hours direct contact and test scoring time)
Subsequent consultation	Ongoing management and treatment of compensable components of presenting psychological/psychiatric issues; intervention would be based on treatment formulated from the initial assessment and in accordance with the approved *Provider management plan* (approval of four to six hours)	Yes	400095	$154.00 ^ per hour (maximum 2 hours on any one day)
Critical incident debriefing sessions	A process where, following exposure to a critical incident, an individual worker or group of workers are debriefed by a psychologist to assist them to deal more effectively with their experience	Yes (after the first two sessions)	400184	$154.00 ^ per hour
Neuro-psychological assessment	Assessment to clarify the presence of possible acquired brain injury or brain dysfunction where possible cognitive, emotional and behavioural problems are occurring after a work-related incident	Yes	400091	$154.00 ^ per hour (4-5 hours direct contact and test scoring time)
Clinical psychological assessment	Assessment to clarify the presence of possible psychological and psychiatric condition/s and provide recommendations for treatment where cognitive, emotional and behavioural problems are occurring after a work-related incident	Yes	400092	$154.00 ^ per hour (2-3 hours direct contact and test scoring time)
Group education sessions	Group education programs; maximum eight persons per group ##	Yes	400097	$39.00 ^ per person per hour
Independent case review	Independent examination and report of a worker (not by the treating therapist)	Yes	400226	$193.00 ^ 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.*

[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.
Insurer will only pay for the attendance of workers' compensation claimants.

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Who can provide psychology services to injured workers?

All psychology services performed must be provided by a psychologist who:

- has a full general registration as a psychologist under the Psychology Board of Australia **or**
- is a provisional registrant with at least two (2) years rehabilitation and social insurance experience **or**
- is a provisional registrant with a supervisor having post-graduate qualifications and at least five (5) years experience in these areas.

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 psychology services provided.
- **Assessment** – after the initial consultation a completed *Provider management plan* must be provided to the insurer to advise of assessment outcome.
- **Therapy** – the insurer will normally approve between 4–6 hours of treatment/therapy with no more than a maximum of two (2) hours to be delivered on any one day.
- **Provider management plan** – this form is available on the Q-COMP website (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.
- **Payment of treatment** – all fees payable are listed in the *Psychology 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.

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 *Psychology 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 e.g. 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 *Psychology 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.

347 Ann Street Brisbane Q 4000
PO Box 10119 Brisbane Adelaide Street Q 4000
ABN 67 668 330 900
www.qcomp.com.au

Item number descriptions and conditions

Consultations

Item number	Descriptor
400088	**Initial assessment** An assessment is undertaken where there are possible cognitive, emotional and behavioural problems occurring after a work-related incident or injury. The purpose of the assessment is to identify appropriate interventions/treatments to optimise rehabilitation outcomes.
400095	**Subsequent consultation** The ongoing management and treatment of compensable components of presenting psychological/psychiatric issues. The intervention would be based on treatment formulated from the initial assessment and in accordance with the approved *Provider management plan*. (Approval of four (4) to six (6) hours with maximum of two (2) hours on any one (1) day). **Prior approval from the insurer is required**

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:

- **Assessment time (initial consultation)** – includes **one-on-one** time with the worker and where necessary their significant other; psychologist-administered tests and the scoring of the tests—self-administered tests are not included in the assessment time. Generally, an assessment will take two (2) to three (3) hours to complete. The practitioner must obtain prior approval from the insurer for additional time if an assessment is likely to take longer than three (3) hours.
- **Subjective (history) reporting** – consider major symptoms and lifestyle dysfunction; current/past history and treatment; aggravating and relieving factors; general health; medication; risk factors and key functional requirements of the worker's job.
- **Objective (psychological) assessment** – assess using standardised outcome measurements to provide a base line prior to commencing treatment. The assessment should include psychological function, activity and participation and the impact of environmental and personal factors on recovery relevant to the worker's compensable injury. The outcome measurement tools should be reliable, valid and sensitive to change.
- **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 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 and implement strategies to improve the worker's ability to return to work and normal functional activities.
- **Treatment (intervention)** – formulate and discuss the treatment goals, progress and expected outcomes; goal setting; strategies to improve return to work with the worker. Provide advice on homework to promote self-management strategies.
- **Clinical records** – record information in the worker's clinical records, including the purpose and results of procedures and tests.
- **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.

Critical incident debriefing sessions

Item number	Descriptor
400184	**Critical incident debriefing sessions** This is a process where, following exposure to a critical incident, an individual worker or group of workers are debriefed by a psychologist to assist them to deal more effectively with their experience. **Prior approval is required by the insurer after the first two (2) sessions**

Critical incident debriefing is a process whereby an individual or a group debriefing is conducted by a psychologist to assist persons involved to deal more effectively with their experiences. Debriefing is likely to occur up to 48 hours after a traumatic incident. During the debrief participants are encouraged to speak freely about the experience, given reassurance and provided with strategies for coping with the after effects of the event.

Mandatory requirements of critical incident debriefing sessions

Following a critical incident, the employer may initiate debriefing sessions for which the insurer will meet reasonable costs of one (1) or two (2) counselling sessions (without their prior approval) if the claim is accepted.

A *Provider management plan* must be submitted if ongoing therapy is required beyond the two (2) sessions.

Psychology assessment

Item number	Descriptor
400091	**Neuro-psychological assessment** Assessment to clarify the presence of possible acquired brain injury or brain dysfunction where possible cognitive, emotional and behavioural problems are occurring, after a work-related incident. **Prior approval is required by the insurer**
400092	**Clinical psychological assessment** Assessment to clarify the presence of possible psychological and psychiatric condition(s) and provide recommendations for treatment where cognitive, emotional and behavioural problems are occurring after a work related incident/s. **Prior approval is required by the insurer**

A neuro-psychological assessment may be appropriate where the worker presents with a range of problems related to brain dysfunction that impact on their ability to remain or return to work. Areas for assessment may include, but are not limited to:

- memory problems
- concentration problems
- attention difficulties
- problems thinking clearly and logically
- problems making important decisions
- language and learning difficulties.

Mandatory requirements (Neuro-psychological assessment) – the practitioner must be a fully registered psychologist who has completed a minimum of six (6) years full-time university training, including postgraduate study in a recognised clinical neuropsychology training program, plus further supervised experience; or have recognised expertise according to the Psychology Board of Australia.

Mandatory requirements (Clinical psychological assessment) – the practitioner must be a fully registered psychologist with appropriate experience in clinical assessment, workplace issues and an understanding of Queensland's workers' compensation system—to the insurer's satisfaction.

Assessment time* – includes one-on-one time with the worker and where necessary their significant other; psychologist-administered tests and the scoring of the tests—self-administered tests are not included in the assessment time. Generally, assessments will take up to:

- four (4) to five (5) hours for neuro-psychology
- two (2) to three (3) hours for clinical psychology.

For additional time the practitioner must obtain prior approval from the insurer. Assessment time does not include the report.

(*Note: if the worker is unable to undertake all assessment requirements in one session the time can be broken up over multiple days.)

An assessment may include all or some of the following elements:

- **Subjective (history) reporting** – consider major symptoms and lifestyle dysfunction; current/past history; aggravating and relieving factors; general health; medication and risk factors; and where appropriate, behavioural information from significant others about the worker's present functioning.
- **Objective assessment** – assess face-to-face using standardised outcome measurements to assess brain functioning or psychological and mental illness.
- **Assessment results (prognosis formulation)** – provide a provisional prognosis for treatment, limitations to function and progress for return to work.
- **Treatment (intervention)** – give feedback to the worker at a later date where requested by the insurer. This may be in a case conference format and includes the neuro-psychologist, worker, insurer and where appropriate, treating psychologist.
- **Clinical records** – record information in the worker's clinical records, including the purpose and results of procedures and tests.
- **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.

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Group sessions

Item number	Descriptor
400097	**Group education sessions** A group/class intervention delivers common learning or education to more than one (1) client at the same time. This includes conducting education and group therapy classes. A psychologist must conduct the class with a maximum of eight (8) persons in the group. **Prior approval is required from the insurer**

The insurer will only pay for the attendance of workers' compensation claimants in a group education session.

Education programs developed by psychologists should:

- aim to increase the worker's understanding of their injury
- provide workers with self-management strategies
- overcome unhelpful beliefs
- be outcome-focused
- use accepted best practice guidelines.

Independent case review

Item number	Descriptor
400226	**Independent case review – includes assessment and report** 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 psychologist) to provide the insurer with an assessment and recommendations for ongoing treatment and prognosis. **Prior approval is required by the insurer**

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

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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** or call 1300 789 881.

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