

Allied Health - Supplementary services table of costs

Effective 1 July 2011



Service	Descriptor	Insurer prior approval required ¹	Item number	Fee – GST not included ²
Communication	Communication: less than 10 mins	No	300079	\$25.00
	Communication: 11 to 20 mins	No	300100	\$50.00
	Consult list of exclusions before using this item Communication between practitioners and stakeholders (insurer, employer and doctors) should be purposeful and direct, to assist faster and more effective rehabilitation and return to work for the worker.			
Case conference	Face-to-face or telephone communication involving the treating practitioner, insurer and one or more of the following: treating medical practitioner; specialist; employer or employee representative; worker; allied health providers or other	Yes	300082	\$154.00 ^ per hour
Progress report	Brief summary of the worker's progress	Yes (must be requested by the insurer)	300086	\$50.00
Standard report	Provides relevant information about the worker's compensable injury where there has been a shift or change in the original/initial goals for the program		300088	\$131.00
Comprehensive report	Only required in a limited number of cases where the case and the treatment are extremely complex; charged at an hourly rate; negotiate the number of hours with the insurer prior to providing the report		300090	\$154.00 ^ per hour
Travel	Only paid where the practitioner is required to leave their normal place of practice to provide a service to a worker at their place of residence, rehabilitation facility, hospital or the workplace; for visits to multiple workers or facilities, divide the travel charge accordingly between workers assessed/treated at each location	Yes (for return trips greater than 60 minutes)	300092	\$115.00 ^ per hour
Patient records	Copies of patient records relating to the workers' compensation claim including file notes; results of relevant tests eg. pathology, diagnostic imaging and reports from specialists	Yes (for more than 50 pages)	300093	\$21.00 plus \$1 per page
Incidental expenses	Reasonable charges for incidental items the worker takes with them	No ³	300094	Up to \$50.00 per claim
	Reasonable charges for supportive devices			Up to \$100.00 per claim
	Hire of equipment	Yes ³		Fee by negotiation
Gym and pool entry fees	Entry fee to gym or pool for treatment or assessment	Yes	300228	As per individual facility
External case management	Includes an initial needs assessment and report; should outline a case management plan indicating goals of program, services required, timeframes and costs	Insurer request only	300295	\$154.00 ^ 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.

3 If costs exceed pre-approved levels, or the hire equipment is required the practitioner must submit a *Request for incidental expenses, supportive devices or equipment hire* form detailing items and cost to the insurer

^ Hourly rates are to be charged pro-rata.

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Who can provide supplementary services to injured workers?

The table below provides an overview of who is approved to deliver supplementary services within this table of costs.

Provider	Communication/ consultation	Case conference	Progress report	Standard report	Comprehensive report	Travel	Incidental expenses/ Supportive devices	External Case Management
Chiropractor (a person registered as a chiropractor with the Chiropractic Board of Australia)	✓	✓	✓	✓	✓	✓	✓	x
Dietician (a person with a tertiary degree in dietetics)	✓	x	✓	x	x	x	x	x
Diversional therapist (a person with a minimum of an Associate Diploma in Diversional Therapy)	✓	x	✓	x	x	x	x	x
Domestic worker (a person who is provided through an agency)	x	x	x	x	x	x	x	x
Exercise physiologist (a person with at least a tertiary degree in human movement studies, exercise science or equivalent and preferably an accredited exercise physiologist accredited by Exercise and Sports Science Australia – ESSA)	✓	✓	✓	✓	✓	✓	✓	✓*
Nurse (a person registered as a registered nurse with the Nursing & Midwifery Board of Australia)	✓	✓	✓	✓	✓	✓	✓	x
Occupational therapist (a person registered as an occupational therapist with the Queensland Registration Board)	✓	✓	✓	✓	✓	✓	✓	✓*
Osteopath (a person registered as an osteopath with the Osteopathy Board of Australia)	✓	✓	✓	✓	✓	✓	✓	x
Physiotherapist (a person registered as a physiotherapist with the Physiotherapy Board of Australia)	✓	✓	✓	✓	✓	✓	✓	✓*
Podiatrist (a person registered as a podiatrist with the Podiatry Board of Australia)	✓	✓	✓	✓	✓	✓	✓	x
Psychologist (a person registered as a psychologist with the Psychology Board of Australia)	✓	✓	✓	✓	✓	✓	✓	✓*
Rehabilitation counsellor (a person with a tertiary qualification in an accredited rehabilitation counselling course or other recognised counselling course and preferably a member of the Australian Society of Rehabilitation Counsellors – ASORC. Due to the diversity of backgrounds of rehabilitation counsellors, the qualifications and experience must be acceptable to the insurer for type of service being undertaken)	✓	✓	✓	✓	✓	✓	x	✓*
Social worker (a person with a tertiary degree in social work)	✓	✓	✓	✓	✓	✓	x	✓*
Speech pathologist (a person registered as a speech pathologist with the Queensland Registration Board)	✓	✓	✓	✓	✓	✓	✓	x

* Must be able to provide proof that they have the appropriate skills and demonstrated experience in the area of external case management to a level acceptable to the insurer.

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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 supplementary services provided.
- **Approval for other services** – approval must be obtained for any service requiring prior approval from the insurer before commencing treatment.
- **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.

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.

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 *Supplementary 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 *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.

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 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.

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Item number descriptions and conditions

Communication

Item number	Descriptor
300079 300100	<p>Communication: less than 10 mins Communication: 11 to 20 mins</p> <p>Important – consult list of exclusions before using this item Communication between practitioners and stakeholders (insurer, employer and doctors). Should be purposeful and direct, to assist a faster and more effective rehabilitation and return to work for the worker.</p> <p>Does not include contact on initial referral, or request for reports or other calls/faxes/emails of a general administrative nature.</p>

Note: most communication would be of short duration and would only exceed ten minutes in exceptional or unusual circumstances.

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.

Communication time – each call, fax/email preparation must be more than three (3) minutes in duration to be billable. Supporting documentation is required for all invoices that include communication. The communication item is not intended to cover normal consultation communication that forms part of the usual best practice process of ongoing treatment.

Invoices – must include the reason for contact, names of involved parties and will only be paid once regardless of the number of recipients of the email/fax.

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

- the insurer
- the worker's referring/treating medical practitioner
- the worker's 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
- from employer representatives for guidance on case management (they should be referred to the insurer)
- about the referral eg. 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
- for approval/clarification of a *Provider management plan* or a *Suitable duties plan* by the insurer
- conveying non-specific information such as 'worker progressing well'
- made or received from the insurer as part of a quality review process
- calls about job seeking, job placement and job preparation
- forwarding email/fax information as an attachment e.g. Suitable duties program, report or *Provider management plan*

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Case Conference

Item number	Descriptor
300082	<p>Case conference Face-to-face or telephone communication involving the treating provider, insurer and one or more of the following: treating medical practitioner, specialist, employer or employee representative, worker, other 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.

Clinical and return to work reports

Item number	Descriptor
300086	<p>Progress report A brief summary of the worker's progress.</p> <p>Prior approval is required by the insurer</p>
300088	<p>Standard report Provides relevant information about the worker's compensable injury where there has been a shift or change in the original/initial goals for the program.</p> <p>Prior approval is required by the insurer</p>
300090	<p>Comprehensive report Only required in a limited number of cases where the case and the treatment are extremely complex. Fee is charged at an hourly rate with the number of hours negotiated with the insurer prior to providing the report.</p> <p>Prior approval is required by the insurer</p>

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A report should be provided only following a request from the insurer or where the practitioner has spoken with the insurer and both parties agree that the worker's status should be documented.

The practitioner should ensure:

- the report intent is clarified with the referrer
- reports address the specific questions posed by the insurer
- all reports relate to the worker's status for the compensable injury
- the report communicates the worker's progress or otherwise
- all reports are received by the insurer within ten (10) working days from when the practitioner received request.

In general, reports delayed longer than six (6) weeks are of little use to the insurer and will not be paid for without prior approval from the insurer.

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
- referring medical practitioner
- contact details/signature and title of practitioner responsible for the report.

Different types of report

Progress – A progress report provides an update 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.

Standard – A standard report may 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. A report is deemed to be standard 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

Comprehensive – A comprehensive report contains all the elements of a standard report but with more detailed information of the assessment and interventions performed. This type of report would only be required in a limited number of cases where the case and the treatment are extremely complex.

Generally a practitioner may be requested to provide either a clinical report or a return to work report.

Clinical reports

A clinical report will include some or all of the following elements:

- interventions to date—type of treatment provided
- functional status—statement of the individual's current status as compared to evaluation baseline data and any prior reports, including objective measures of the individual's function relating to the treatment goals
- progress with plan of care
- completion of goals to date
- future recommendations/durations if appropriate.

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Insurers may request either a progress clinical report, a standard clinical report or a comprehensive clinical report. Each report should include the basic report elements and further information as outlined:

- Progress report – a prognosis update
- Standard report – any changes in prognosis, plan of care and goals along with the reasons for those changes
- Comprehensive report – an examination or re-examination of the worker is a pre-requisite for the preparation of the report e.g. neuropsychological report, multi-trauma patient.

Return to work reports

A return to work (RTW) report will include some or all of the following elements:

- return to work status—statement of the individual's current status as compared to evaluation baseline data and any prior reports, including objective measures of the individual's function relating to RTW goals
- progress with RTW plan
- completion of RTW goals to date
- future recommendations/durations if appropriate.

Insurers may request either a progress RTW report, a standard RTW report or a comprehensive RTW report. Each report should include the basic elements and further information as outlined:

- Progress report – a prognosis update
- Standard report – barriers to RTW, any changes in RTW plan of care and goals along with the reasons for those changes
- Comprehensive report – issues and barriers to RTW are complex and detailed documentation of the requisites for RTW are critical for a successful outcome e.g. where extensive workplace modifications are required, or there are complex psychosocial issues to be addressed as part of the RTW process includes future recommendations/durations if appropriate.

Travel

Item number	Descriptor
300092	<p>Travel Travel time will only be paid where the practitioner is required to leave their normal place of practice to provide a service to a worker at their place of residence, rehabilitation facility, hospital or the workplace.</p> <p>Prior approval is required by the insurer if more than 1 hour return trip</p>

Travel should only be charged when:

- it is appropriate to attend the worker somewhere other than the normal place of practice—for example:
 - to assist therapy*—where the practitioner does not have the facilities at their practice
 - to attend a case conference*
 - to perform a workplace assessment*
- a worker is unable to attend the practitioners normal place of practice and they are treated at their home. In this case, the treating medical practitioner must certify the worker as unfit for travel.
- the travel relates directly to service delivery for the worker's compensable injury.

*Note: Please check procedures and conditions of service to determine if prior approval is required from the insurer.

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.

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Exclusions

Travel may not be charged when:

- travelling between one site or another if the practitioner' 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.

Patient records

Item number	Descriptor
300093	<p>Patient records</p> <p>The insurer will pay for copies of patient records relating to the workers' compensation claim on request. Patient records include, but are not limited to:</p> <ul style="list-style-type: none">• file notes• results of relevant tests e.g. pathology, diagnostic imaging etc• reports from specialists <p>Prior approval is required by the insurer if more than 50 pages</p>

The fee is payable upon request from the insurer for copies of patient records relating to the workers compensation claim. If the copies of records are to exceed 50 pages the practitioner is required to seek approval from the insurer before finalising the request.

Incidental expenses

Item number	Descriptor
300094	<p>Incidental expenses/supportive devices</p> <p>The insurer will pay reasonable charges for incidental expenses or supportive devices which are appropriately and directly related to the compensable injury.</p> <p>Upon request, the practitioner must present clinical evidence to support the need for the use of the item/s requested and explain how the item/s relates to the treatment of the compensable injury.</p>
	<p>Hire equipment</p> <p>The insurer will pay reasonable expenses for hire of equipment where there is clinical evidence supporting a need for the use of the item.</p> <p>Prior approval is required by the insurer</p>

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The values specified in the *Supplementary services table of costs* for incidental expenses and supportive devices are per claim and not per consultation. Contact the insurer for further clarification of what qualifies as an incidental expense.

For items exceeding the pre-approved values listed in the *Supplementary services table of costs* practitioners should discuss the request with the insurer. Approval must be obtained by contacting the insurer and submitting a *Request for incidental expenses, supportive devices* from available at www.qcomp.com.au. All items must be itemised on invoices.

Reasonable expenses

Items considered to be reasonable incidental expenses are those that the worker actually takes with them—including bandages, elastic stockings, tape, crutches, theraband, putty, audio tapes/CD, and education booklets. Tape may only be charged where a significant quantity is used.

Items considered reasonable supportive device expenses—including splinting material, prefabricated splints, and braces—must be shown to be necessary items for successful treatment of the compensable injury.

The insurer will not pay for:

- items regarded as consumables used during the course of treatment—including towels, pillowcases, antiseptics, gels, tissues, disposable electrodes, bradflex tubing, and small non-slip matting
- items/procedures that are undertaken in the course of normally doing business— including autoclaving/sterilisation of equipment, and laundry.

Hire/loan items

Prior approval must be obtained from the insurer for payments for hire or loan of items e.g. biofeedback monitors. The insurer will determine the reasonable cost and period for hire or loan and is not liable for the deposit, maintenance, repair or loss of the hire equipment.

Gym and pool entry fees

Item number	Descriptor
300228	<p>Gym and pool entry fees The cost of the entrance fee to the gymnasium or pool for treatment or assessment.</p> <p>Prior approval is required by the insurer</p>

The insurer will not pay an entrance fee if the practitioner owns or operates the gymnasium or pool. Exceptions to this may be approved by the insurer where unusual circumstances apply.

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External case management

Item number	Descriptor
300295	<p>External case management This includes an initial needs assessment and report. It should outline a case management plan indicating goals of program, services required, timeframes and costs. The insurer will outsource external case management on a case-by-case basis.</p> <p>Prior approval is required by the insurer</p>

External case management services would only be required in a very limited number of situations—for example interstate cases or very serious / catastrophic injuries where the insurer requires specialised skills of the provider. The insurer will determine the needs on a case-by-case basis. A practitioner may be requested to provide case management for the entirety or for a portion of the injured workers claim.

External case management may require the practitioner to co-ordinate equipment prescription, assistive technology and/or home modifications for the injured worker. It also requires the development of non-medical strategies in consultation with the employer, worker, treating medical practitioner, allied health professional and insurer to assist the worker's return to the workplace, in keeping with their level of functional recovery. Fee is charged at an hourly rate (pro rata) with the number of hours negotiated with the insurer. Services must be provided by a person who has the appropriate skills and demonstrated experience in this area to a level acceptable to 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 or call 1300 789 881.