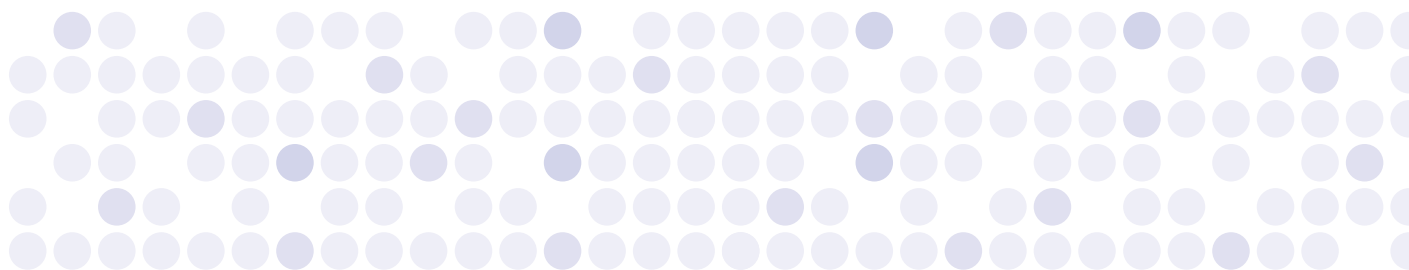


Supplementary services

Table of costs and guidelines
Effective from 1 July 2009

[View table of costs only](#)



Developed by Q-COMP in partnership with the Australian Association of Occupational Therapists Queensland Inc, Australian Psychology Society (Qld), Australian Chiropractic Association, Australian Osteopathic Association, Australian Podiatry Association (Qld), Australian Rehabilitation Providers Association (Qld), Australian Association for Exercise and Sport Science, WorkCover Queensland and the Association of Self-Insured Employers of Queensland..

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Table of costs and guidelines

Section A

1. Introduction

This document outlines the general standards and expectations, procedures and conditions for delivering allied health services to workers. It also explains and clarifies the use of specific item codes. This information should assist the treating medical practitioner, employer, the insurer and you, the provider by promoting quality service provision and timely, relevant rehabilitation information.

In the majority of cases, the rehabilitation goal is for the worker to return to work. In situations where the injury prevents the worker returning to work, rehabilitation must focus on maximising functional independence.

1.1 Who is approved to deliver supplementary services?

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

Please make sure you are **approved** to provide the services detailed **before** billing for services under this Table of costs and guidelines.

| Provider (Definition) | Communication /consultation | Case conference | Progress report | Standard report | Comprehensive report | Travel | Incidental expenses/ Supportive devices |
|--|--------------------------------|--------------------|--------------------|--------------------|-------------------------|--------|--|
| Occupational therapist (a person registered as an occupational therapist with the Queensland Registration Board) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Physiotherapist (a person registered as a physiotherapist with the Queensland Registration Board) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Psychologist (a person registered as a psychologist with the Queensland Registration Board) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Chiropractor (a person registered as a chiropractor with the Queensland Registration Board) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Registered nurse (a person registered as a registered nurse with the Queensland Registration Board) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

Table of costs and guidelines

| Provider (Definition) | Communication /consultation | Case conference | Progress report | Standard report | Comprehensive report | Travel | Incidental expenses/ Supportive devices |
|---|--|----------------------------|----------------------------|----------------------------|---------------------------------|---------------|--|
| Osteopath (a person registered as an osteopath with the Queensland Registration Board) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Podiatrist (a person registered as a podiatrist with the Queensland Registration Board) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Speech pathologist (a person registered as a speech pathologist with the Queensland Registration Board) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Dietician (a person with a tertiary degree in dietetics) | ✓ | x | ✓ | x | x | x | x |
| Diversional therapist (a person with a minimum of an Associate Diploma in Diversional Therapy) | ✓ | x | ✓ | x | x | x | x |
| Domestic worker (a person who is provided through an agency) | 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 accredited by the Australian Association for Exercise and Sports Science (AAESS)) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 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 |

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| Provider (Definition) | Communication /consultation | Case conference | Progress report | Standard report | Comprehensive report | Travel | Incidental expenses/ Supportive devices |
|--|--------------------------------|--------------------|-----------------|-----------------|-------------------------|--------|--|
| Social worker (a person with a tertiary degree in social work) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | * |

2. Procedures and conditions

Payment for services outlined in this document is subject to the following procedure and conditions.

2.1 Referral

The worker may only be referred by a registered medical practitioner and must have a **current** medical certificate to cover any provider services supplied.

Insurers will not pay for general communication such as receiving and reviewing referrals.

2.2 Approval for services

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 or insurer.

For services requiring **prior approval** – you must obtain prior approval from the insurer or you will not be paid for the service.

For services which **must be requested by insurer** – you will not be reimbursed for this service if the insurer did not request it.

For services not outlined in this schedule – you must obtain **prior approval** from the insurer.

2.3 Payment of services

Payment for services outlined in this document is allowed subject to the relevant conditions of service outlined in section 5 for the relevant item number.

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 during any period remains a matter between you and the worker or the employer (where services have been requested by the Rehabilitation and Return to Work Coordinator).

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Send all invoices to the relevant insurer for payment—check whether the worker is employed by a self-insured employer or an employer insured by WorkCover Queensland. For a current list of insurers visit Q-COMP's website at www.qcomp.com.au or call Q-COMP on 1300 789 881.

Identify the appropriate item in this *Table of costs and guidelines* for services or treatment provided. The insurer will only consider payment for services or treatments for the compensable injury, not other pre-existing conditions.

3. Provider invoice

3.1 Payment for services

Insurers will pay for services in accordance with this *Table of costs and guidelines*. To ensure payment, your invoice must contain the following information:

- the words 'Tax Invoice' stated prominently
- your name and practice details
- tax invoice issue date
- your Australian Business Number (ABN)
- worker's name, residential address and date of birth
- worker's claim number (if known)
- referring medical practitioner's name
- date of each attendance
- appropriate table of costs item number/s
- a brief description of each service item supplied, including areas treated
- treatment cost
- name of your staff member who provided the service.

Fees listed in the tables of costs and guidelines **do not include** GST. You are responsible for incorporating any applicable GST on taxable supplies into your invoice. Refer to a taxation advisor or the Australian Taxation Office for help on the taxability of certain services.

Self-insurers require **separate tax invoices** for services to individual workers. The self-insurer will return an invoice to you where the services are for more than one injured worker. For a current list of self-insurers, visit Q-COMP's website at www.qcomp.com.au.

WorkCover Queensland will accept billing for more than one worker on a single invoice.

4. Inquiries

4.1 Claims issues

Contact the appropriate insurer for claims issues, including:

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

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For a current list of insurers, visit Q-COMP's website at www.qcomp.com.au or call Q-COMP on 1300 789 881.

4.2 General inquiries

For advice about the tables of costs and guidelines, call Q-COMP on 1300 789 881.

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Section B

5. Service type (service codes)

The following service items are for services provided within the practitioner's rooms, gymnasium, pool, a hospital, the workplace or at the worker's home.

Before providing services to workers, you are responsible for ensuring that you understand the service conditions and objectives of the *Tables of costs and guidelines*.

5.1 Communication (300079 & 300082)

| Item number | Descriptor |
|-------------|---|
| 300079 | <p>Communication Important – consult list of exclusions before using this code Communication between providers 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>This does not include contact on initial referral, or request for reports or other calls/faxes/emails of a general administrative nature.</p> <p>Note: most communication would be of short duration and would only exceed five to ten minutes in exceptional or unusual circumstances. For extended communication the provider should be able to provide documentation or communication notes to support the time invoiced.</p> |

Service conditions

Prior approval required from the insurer – No

Service objective

Communicate with relevant stakeholders about progress or issues related to a return to work program or treatment program, where shared understanding is important to the process.

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.

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.

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Your communication (call/fax/email) should:

- be relevant to the compensable injury
- assist the relevant parties to resolve barriers and/or agree to strategies or intervention/s proposed
- have supporting documentation or communication notes to support the time invoiced.

Communication time – each call fax/email preparation must be more than three (3) minutes in duration to be billable.

You should be able to provide documentation or communication notes to support the time invoiced for extended communication.

Invoicing

You must submit your reason for contact with the account (supporting documentation or communication notes).

You must identify involved parties.

You will only be paid once regardless of the number of recipients of the email or fax.

Exclusions

Calls where party phoned is unavailable.

Forwarding email/fax information as attachments—suitable duties program, *Provider management plan* and reports.

Calls/emails/faxes:

- to and from the worker
- from employer representatives for guidance on case management (they should be referred to the insurer)
- about the referral
- 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*
- 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.

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

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| Item number | Descriptor |
|-------------|--|
| 300082 | 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 providers or other. |

Service conditions

Prior approval required from the insurer – Yes

Service objective

To plan, implement, manage or review treatment options and/or rehabilitation plans—this should result in an agreed direction for managing the worker's return to work.

Include details of limitations/recommendations for a sustainable return to work; options for managing the worker's recovery and other relevant information.

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.

The case conference must be authorised by the insurer prior to the service.

Case conferences would typically be for a maximum of one hour.

The hourly rate excludes travelling from normal place of practice or other appropriate departure point to the venue and return. Travel charged separately and requires the insurer's **prior approval**.

Table of costs and guidelines

5.2 Clinical reports (300086, 300088 & 300090)

| Item number | Descriptor |
|-------------|--|
| 300086 | Progress report A brief summary of the worker's progress. |
| 300088 | 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. |
| 300090 | 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. |

Service conditions

Prior approval required from the insurer – Yes. Only to be provided following a request from the insurer.

When should a report be used?

Only following a request from the insurer or where you have spoken with the insurer and you both agree that the worker's status should be documented.

General features of reports

- you should clarify the report intent with the referrer
- reports should address specific questions posed by the insurer
- all reports should relate to the worker's status for the compensable injury
- the report should communicate the worker's progress or otherwise
- where the claim has been accepted, the insurer will pay the cost of an initial assessment and report where it has been requested by the treating medical practitioner or an accredited workplace/employer or insurer
- reports should be received by the insurer within ten (10) working days from receiving request.

Minimum report requirements

All reports should have 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

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

Note: refer to the specific report type for additional information requirements.

Progress report (must be requested by insurer) – 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.

There are two types of progress reports—clinical and return to work progress report.

A clinical progress report includes 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 the prior progress report, including objective measures of the individual’s function relating to the treatment goals
- prognosis update
- progress with plan of care
- completion of goals to date
- future recommendations/durations if appropriate.

A return to work (RTW) progress report includes 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 the prior progress report, including objective measures of the individual’s function relating to RTW goals
- prognosis update
- progress with RTW plan
- completion of RTW goals to date
- future recommendations/durations if appropriate.

Standard report (must be requested by insurer) – 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.

A standard report:

- relates to the status of the claim and comprises a clinical/professional opinion, statement or response to specific questions
- must include all information relevant to the worker’s compensable injury.

Note: you may need to complete a *Provider management plan* to support report recommendations if more treatment services are required.

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There are two types of standard reports—clinical and workplace evaluation.

A clinical standard report includes 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 the prior progress report, including objective measures of the individual's function that relate to the treatment goals
- changes in prognosis and the reasons for the changes
- changes in plan of care and the basis for the changes
- changes in goals and reasons for the changes
- future recommendations/durations if appropriate.

A workplace evaluation standard report includes some or all of the following elements:

- return to work status (RTW)—statement of the individual's current status as compared to evaluation baseline data and the prior progress report, including objective measures of the individual's function that relate to RTW goals
- barriers to RTW
- changes in RTW plan of care and the reasons for the changes
- changes in goals and the basis for the changes
- future recommendations/durations if appropriate.

Comprehensive report (must be requested by insurer) – 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.

There are two types of comprehensive reports—clinical and workplace.

Comprehensive clinical report

Deemed comprehensive when an examination or re-examination of the worker is a pre-requisite for the preparation of the report—for example neuropsychological report, multi-trauma client, and review by independent/ non-treating allied health provider.

Consultation with the worker for the purpose of re-assessment should be charged under the appropriate assessment item code for the treating/assessing provider.

Comprehensive workplace report

Deemed comprehensive when the issues and barriers to RTW are complex and detailed documentation of the requisites for RTW are critical for a successful outcome—for example 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.

Note: when you charge for a consultation with the worker for a re-assessment, make sure you use the appropriate *Table of costs and guidelines* for you as the treating/assessing provider.

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5.3 Ancillary services (300092 & 300094)

| Item number | Descriptor |
|-------------|---|
| 300092 | Travel Travel time will only be paid where the provider is required to leave their normal place of practice to deliver a service to a worker at their place of residence, rehabilitation facility, hospital or the workplace. |

Service conditions

Prior approval required from the insurer – Yes (see other travel conditions below)

You should only charge for travel time when:

- it is appropriate to attend the worker somewhere other than your normal place of practice—for example:
 - to assist therapy*—where you do not have the facilities at your practice
 - to attend a case conference*
 - to perform a workplace assessment*
- a worker is unable to attend your normal place of practice and you treat them at their home. In this case, the treating medical practitioner must certify the worker as unfit for travel.

*Note: you should check procedures and conditions to determine if you need to obtain prior approval from the insurer for these items.

Normal place of practice/multiple practice sites

Where your business consists of multiple practice sites, you **may not charge** travel from one site to another.

Where you conduct regular sessional visits to particular hospitals, medical specialist rooms or other sessional rooms/facilities, you **may not charge** travel for such visits.

Travel that involves multiple worker visits

Where you visit multiple workers in a workplace or other locations not deemed your normal place of practice, you should divide the travel charge accordingly between workers assessed/treated at each location.

Where you visit multiple worksites or other locations not deemed your normal place of practice in the same journey, you should divide the travel time accordingly between the workers involved.

Other travel conditions

You should seek prior approval from the insurer for treatment or rehabilitation services requiring travel **in excess of one (1) hour return trip**.

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

Travel time is not included in any of the rates for services provided to workers. You should itemise travel time separately on accounts.

The travel must relate to service delivery for the worker's compensable injury.

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| Item number | Descriptor |
|-------------|--|
| 300094 | <p>Incidental expenses/supportive devices The insurer will pay reasonable charges for incidental expenses or supportive devices which are appropriately and directly related to the compensable injury (values are specified in the <i>Supplementary services table of costs and guidelines</i>).</p> <p>Upon request, you 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 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> |

Service conditions

Prior approval required from the insurer

Incidental expenses/supportive devices – Yes if amount allowed for claim is exceeded.

Hire equipment – Yes.

You should consult the table in the section 1.1 for eligibility to charge for the expenses above.

Maximum fee payable

The values specified in the *Supplementary services table of costs and guidelines* for incidental expenses and supportive devices are per claim **not** per consultation.

If required, you must obtain prior approval from the insurer using a request for incidental expenses, supportive device or equipment hire. The form is available from Q-COMP's website at www.qcomp.com.au or telephone Q-COMP 1300 789 881.

You must itemise items provided and quantities used on your invoice.

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, education booklets—for example back education booklets. You may only charge for tape where a significant quantity is used.

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

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The insurer will not pay for:

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

You should contact the insurer if you are not sure of what qualifies as an incidental expense.

Hire/loan items

You must obtain **prior approval** from the insurer for payments for hire or loan of items—for example TENS units, biofeedback monitors—the insurer will determine the reasonable cost and period for hire or loan.

The insurer is not liable for the deposit, maintenance, repair or loss of the hire equipment.

You must obtain prior approval from the insurer using a request for incidental expenses, supportive device or equipment hire available from Q-COMP's website at www.qcomp.com.au or by calling Q-COMP on 1300 789 881.

Supplementary services table of costs

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Important note – the worker must always be referred by a registered medical practitioner and have a current medical certificate to cover any services provided.

| Service | Descriptor | Insurer prior approval required ¹ | Item number ² | Fee GST excluded [#] |
|-------------------------|---|--|--------------------------|--|
| Communication | | | | |
| Communication | Consult list of exclusions in the guidelines before using this code Communication between providers 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— only to exceed 5 to 10 minutes in exceptional or unusual circumstances . | No | 300079 | \$12.38 per 5 min blocks |
| 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; allied health providers or other. | Yes | 300082 | \$149.02 per hour |
| Clinical reports | | | | |
| Progress report | Brief summary of the worker's progress. | Yes (must be requested by the insurer) | 300086 | \$44.72 |
| 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 | \$126.69 |
| 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 | \$149.02 per hour (negotiate hours with the insurer) |

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

² Before billing for services please read the *Supplementary services table of costs and guidelines* available from Q-COMP's website at www.qcomp.com.au.

[#] Rates do not include GST. If GST is required it is up to the provider to include it in the invoice. For clarification regarding GST contact the Australian Taxation Office.

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| Service | Descriptor | Insurer prior approval required ¹ | Item number ² | Fee GST excluded [#] |
|---------------------------|--|---|--------------------------|-------------------------------|
| Ancillary services | | | | |
| Travel | Only paid where the provider is required to leave their normal place of practice to deliver 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 | \$111.03 per hour |
| Incidental expenses | Reasonable charges for incidental items the worker takes with them. | No ³ | 300094 | Up to \$45.00 per claim |
| | Reasonable charges for supportive devices. | | | Up to \$90.00 per claim |
| | Hire of equipment. | Yes ³ | | Negotiate with the insurer |

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

² Before billing for services please read the *Supplementary services table of costs and guidelines* available from Q-COMP's website at www.qcomp.com.au.

³ If costs exceed pre-approved levels, or you need to hire equipment, you must submit a *Request for incidental expenses, supportive devices or equipment hire* detailing items and cost to the insurer available from Q-COMP's website at www.qcomp.com.au.

[#] Rates do not include GST. If GST is required it is up to the provider to include it in the invoice. For clarification regarding GST contact the Australian Taxation Office.