

Occupational therapy services

Table of costs and guidelines
Effective from 1 July 2008

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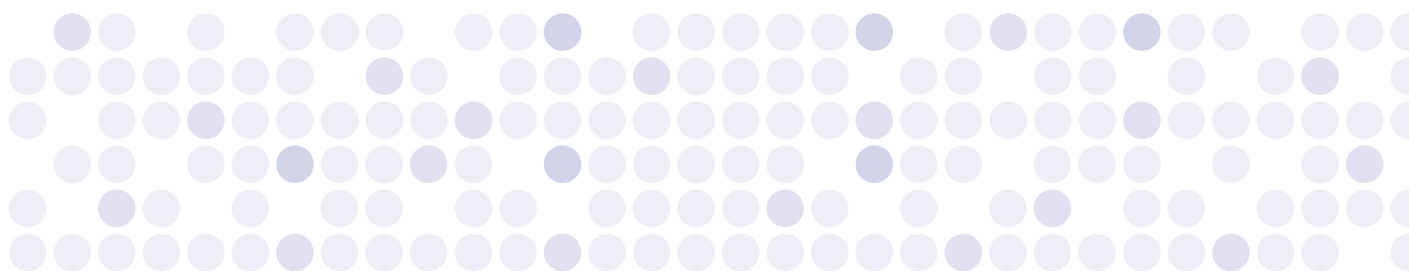


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Section A

1. Introduction

This document outlines the general standards and expectations, procedures and conditions for delivering occupational therapy services to workers. It also explains and clarifies the use of specific item codes. This information should assist the treating medical practitioner, the employer, the insurer and you, the occupational therapist, 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 qualified to deliver occupational therapy services?

Only a person registered as an occupational therapist with the Queensland Registration Board is qualified to deliver occupational therapy services to workers in Queensland. For services provided to workers outside Queensland, the treating occupational therapist must be eligible for registration in Queensland.

For specialised occupational therapy services see specific qualifications within the services descriptor before billing for services.

2. Procedures and conditions

Payment for services outlined in this document is subject to the following procedures 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 occupational therapy services provided.

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

2.2 Assessment

You are expected to assess the needs of the worker in the initial consultation session and then notify the referrer of the outcome of the assessment and future treatment goals.

You **may not** invoice for both an initial and subsequent consultation on the same day without **prior** approval from the insurer.

2.3 Treatment approval

For an accepted claim, the insurer will pay the cost of an initial consultation and report where it has been requested by the treating medical practitioner or an accredited workplace/employer or insurer.

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Where the claim has been accepted, the insurer will pay for a maximum of **seven (7)** occupational therapy sessions **without prior approval**.

For any service which requires **prior approval** from the insurer, you must submit a *Provider management plan* and obtain approval before treatment commences—for example—Item 600292 – Specific occupational therapy intervention requires you to submit a *Provider management plan* after the assessment (600170).

For services not outlined in this *Table of costs and guidelines*, you must obtain **prior approval** from the insurer by submitting a *Provider management plan* (see the *Allied health provider form guidelines*).

Where you are required to submit a *Provider management plan*, the insurer will advise you of their decision about approval of the plan as soon as possible. The insurer **will not pay** for any services provided **without prior approval**.

The insurer will not pay you for preparing or completing the *Provider management plan*.

2.3.1 Allowable treatment period

For hand/upper limb treatment referred by a treating medical specialist, you may deliver up to seven (7) sessions without prior approval from the insurer. If more treatment is needed, you must submit a *Provider management plan*.

The insurer will pay for a maximum of **seven (7)** occupational therapy sessions **without prior approval**.

The seven (7) sessions may be a combination of various services—for example in-rooms treatment, group education sessions and hospital. This excludes those services where prior approval is required.

The insurer **will not pay** for more than seven (7) sessions unless you have obtained their **prior approval** by submitting a *Provider management plan* (see *Allied health provider form guidelines*).

The initial seven (7) pre-approved sessions may not be undertaken concurrently with sessions requiring the insurer's prior approval.

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2.4 Treatment

2.4.1 General standards and expectations

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

- liaise with relevant parties involved in managing the claim to coordinate medical treatment for the worker, promoting an early and safe return to work
- advise and liaise with the relevant treating practitioners and insurer at the start of a treatment program for each new claim or re-opening of a claim where it is in the best interest of the worker's ongoing management
- regularly review and document the worker's work capacity and treatment progress in case notes, and where appropriate provide timely recommendations about return to work/suitable duties to relevant parties
- ensure that the worker has given their written authority prior to the exchange of information with third parties other than the referrer
- deliver outcome-focused and goal-orientated services, which are focused on achieving maximum function and safely returning the worker to work
- be accountable for the services provided, ensuring those services incurred for the compensable injury are reasonable
- maintain practice competencies relevant to occupational therapy and the delivery of services within the Queensland workers' compensation environment. This includes maintaining currency of skills and knowledge of specific occupational therapy modalities
- keep detailed, appropriate, up-to-date treatment records and any relevant information obtained in the service delivery.

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

2.4.2 Treatment period

When a worker returns to work (including suitable duties) and needs more occupational therapy, treatment will be considered as continuing and the seven (7) session rule applies.

In all cases, treatment will be deemed to have ended if there is no treatment for a period of **two (2) calendar months**. You need to conduct a new initial consultation and submit a *Provider management plan* for approval of any subsequent treatment. In this situation, the worker must obtain another referral from a registered medical practitioner.

All insurer payments for treatment end when there is no further medical certification or the insurer finalises/ceases the claim.

2.4.3 Postoperative occupational therapy treatment

When a worker is referred for occupational therapy treatment after a surgical procedure, a new set of seven (7) treatments will take effect.

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2.4.4 Change of provider

When a worker changes occupational therapists from one to another—not within the same practice—the insurer will pay the cost of an initial consultation by the new occupational therapist to:

- determine the number of sessions already provided
- allow for an assessment and appropriate treatment
- submit a *Provider management plan*.

You are responsible for determining if the worker has received previous occupational therapy treatment, including when and how many sessions, so that a *Provider management plan* can be submitted.

2.5 Provider management plans

For details of when and how to use *Provider management plans* see the *Allied health provider form guidelines*.

Obtain the *Provider management plan* and *Allied health provider form guidelines* from Q-COMP's website at www.qcomp.com.au or call 1300 789 881.

3. Indicators for ending treatment/intervention

There are a number of indicators highlighting that treatment is no longer needed or should be stopped. These include:

- the outcome and goals are achieved
- the presenting condition has been resolved
- the worker is not complying and there is lack of progress (you must discuss this with the insurer)
- the worker has achieved maximum function of the injured area, meaning progress has reached a plateau.

4. Payment for services

Payment for services outlined in this document is allowed subject to the relevant conditions of service outlined in section B 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).

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.

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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.

4.1 Provider invoice

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.

5. Inquiries

5.1 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*.

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

5.2 General inquiries

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

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Section B

6. Service type (service codes)

The following service items are for occupational therapy services provided within the provider's rooms, a hospital 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.

6.1 Initial consultation (600015 & 600020)

Item number	Descriptor
600015	Initial consultation Initial occupational therapy consultation, including activities outlined below.
600020	Initial consultation (multiple area) Where two (2) or more entirely separate injuries or conditions are assessed and treated and where treatment applied to one condition does not affect the symptoms of the other injury—for example neck condition plus post fracture wrist. This does not include a condition with referred pain to another area. Consultations billed under this item number are for multiple clinical conditions/areas. The insurer may pay for the consultation if it relates to the compensable injury and there is a medical certificate detailing each area or condition to be treated.

Service conditions

Prior approval required from the insurer – No

An initial consultation by an occupational therapist **may** include all or some of the following elements:

Subjective (history) reporting – consider major symptoms and lifestyle dysfunction; current history and treatment; past history and treatment; pain, aggravating and relieving factors; general health; medication; risk factors and key functional requirements of the worker's job to determine the occupational demand imposed on the worker.

Objective (physical) assessment – carry out appropriate procedures and tests to assess:

- movement—for example active, passive, resisted, repeated, muscle tone, weakness, accessory movements
- posture
- neurological function

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- functional movement patterns
- palpation identifying muscle tension and other soft tissue abnormalities and pain.

Assessment results (prognosis formulation) – provide a provisional prognosis for treatment, limitations to function and return to work progress.

Treatment (intervention) – provide treatment during the initial consultation at your discretion. Discuss working hypothesis, treatment goals and expected outcomes, initial treatment and expected response with the worker. Provide advice on home/workplace care, including any exercise programs to be followed.

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 and return to work, to the insurer. Acknowledge referral and liaise with the treating medical practitioner about treatment.

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6.2 Subsequent consultation (600017, 600016, 600288 & 600289)

Item number	Descriptor
600017	<p>Subsequent consultation level A 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 and clinical record components as described below or where you may be seeing multiple clients and treatment is not strictly one-on-one—for example minor adjustment of a splint, provision of, and training in, a piece of therapeutic equipment.</p>
600016	<p>Subsequent consultation level B (standard consultation) Management of one area/condition only. See below for elements required in the consultation.</p>
600288	<p>Subsequent consultation level C Where two (2) entirely separate injuries or conditions are assessed and treated and where treatment applied to one condition does not affect the symptoms of the other injury—for example neck condition plus post fracture wrist. It does not include a condition with referred pain to another area. See below for elements required in the consultation.</p> <p>Note: Consultations billed under this item number are for multiple clinical conditions/areas. The insurer may pay for the consultation if it relates to the compensable injury and there is a medical certificate detailing each area or condition to be treated.</p>
600289	<p>Subsequent consultation level D Where more than two (2) entirely separate injuries or conditions are assessed and treated and where treatment applied to one condition does not affect the symptoms of the others. This would most likely occur post vehicle accident where there are multiple or serious injuries—for example a fractured pelvis, dislocated shoulder and whiplash injury. It does not include a condition with referred pain to another area. See below for elements required in the consultation.</p> <p>Note: Consultations billed under this item number are for multiple clinical conditions/areas. The insurer may pay for the consultation if it relates to the compensable injury and there is a medical certificate detailing each area or condition to be treated.</p>

Service conditions

Prior approval required from the insurer – the first seven (7) sessions—including the initial—are pre-approved. Additional sessions require prior approval.

A subsequent consultation by an occupational therapist **may** include all or some of the following elements.

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Treatment (intervention) – provide treatment modalities and/or therapeutic exercises according to the therapy goals documented in a *Provider management plan*. May include appropriate home/workplace program modifications in line with progress or otherwise identified from reassessment. Give feedback to the worker on their progress or otherwise and expected outcomes of the plan.

Clinical records – information recorded in the worker's clinical records, including the purpose and results of procedures and tests.

Communication – discuss any relevant factors impeding progress with the worker's treating medical practitioner and/or insurer as soon as possible. Does not include extended communication about suitable duties, or case conferencing, which have specific item numbers (see *Supplementary services table of costs and guidelines*).

Reassessment (subjective & 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 and implement strategies to improve the worker's ability to return to work and normal functional activities. Actively promote self-management (such as ongoing exercise programs) and empower the worker to play an active role in their rehabilitation.

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6.3 Re-assessment/program review (600055)

Item number	Descriptor
600055	<p>Re-assessment/program review is indicated when:</p> <ul style="list-style-type: none">the worker has been in active rehabilitation for six (6) weeks, further treatment is likely and the insurer agrees that reassessment is requiredthere are new clinical findings that might affect treatmentthere is a rapid change in the worker's statusthere is no response to therapeutic interventions.

Service conditions

Prior approval required from the insurer – Yes

Re-assessment/program review – a more comprehensive assessment including all the components of the initial consultation (refer to initial consultation item 600015 or 600020 descriptor for further guidance). You should review the worker's progress based on your objective measures since the initial assessment and recommend effective future treatment and management strategies to assist return to work.

This may include:

- recommendations for referral to other professional disciplines
- change in therapy direction
- change in outcome direction requiring a new return to work goal.

You should submit your findings to the insurer for approval using a

Reassessment/program review provider management plan, which includes:

- assessment of the worker's progress against the outcome measures established during the initial consultation and monitored throughout the treatment period to date. Highlight meaningful changes in function and remaining functional gaps to be addressed (where did you start, where are you now, where are you going?)
- objective measurements based on appropriate and relevant assessment using comparable and consistent methods
- a clinical judgment as to whether intervention/s are effective and if continued treatment is still warranted
- barriers and strategies to overcome issues identified with the worker's ability to return to work and/or function.

When is a reassessment/program review not required?

Reassessment/program reviews are 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.

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6.4 Specific occupational assessment/intervention (complex) (600170 & 600292)

Item number	Descriptor
600170	<p>Specific occupational therapy assessment Used for the assessment of complex conditions that cannot be adequately assessed within a standard (600015) or multiple area consultation (600020) due to their complexity. Only a small number of practitioners will treat conditions that will fall within this category.</p> <p>These include, but are not limited to:</p> <ul style="list-style-type: none"> • extensive burns • complex neurological and/or chronic pain conditions • assessment of a worker's level of functioning for cognitive abilities, driving and activities of daily living • home assessment. <p>Note: if treatment is required, a <i>Provider management plan</i> must be submitted prior to commencement of treatment.</p>
600292	<p>Specific occupational therapy intervention (maximum one hour) A one-on-one session of recommended interventions identified during a specific occupational therapy assessment (600170).</p> <p>Examples include, but not limited to:</p> <ul style="list-style-type: none"> • treatment of severe burns • neurological injuries • severe spinal injuries. <p>Note: This service or treatment should not be already classified elsewhere in this <i>Table of costs and guidelines</i> where an hourly rate may be appropriate.</p>

Service conditions

Prior approval required from the insurer – Yes

For elements required for either of the above, refer to initial consultation (600015) and subsequent consultation (600016) service descriptors.

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6.5 Specialist hand therapy (600287)

Item number	Descriptor
600287	Specialist hand therapy An advanced clinical specialty area devoted to treating a variety of upper extremity physical conditions. The program provides one-on-one consultation and treatment services to workers who have injuries that occur in the upper extremity below the level of the shoulder. The goal of the program is to provide early, specialised treatment to assist the worker to achieve maximal use of the injured extremity and early return to work. Specialist hand therapy services will be provided according to the worker's specific injury and needs, applying evidence-based protocols where applicable.

Service conditions

Prior approval required from the insurer – Yes (see referral requirements below).

Referral requirements for specialist hand therapy services using this item:

- **A medical specialist** must refer the worker for hand therapy—for example hand surgeon, neurosurgeon or orthopaedic specialist—the seven (7) pre-approved sessions rule applies.
- Where a **registered medical practitioner** refers the worker, you must obtain prior approval from the insurer by submitting a *Provider management plan* before commencing treatment.

Who is qualified to deliver specialist hand therapy services?

A **full member** of the Australian Hand Therapy Association is the preferred clinician to deliver specialist hand therapy programs.

If this is not possible—for example a full member is not available in the worker's area or the treating therapist is not a full member—the treating therapist must be able to demonstrate the recognised skills and training that suitably qualifies them to provide specialist hand therapy services.

Generally, a suitably qualified therapist has undertaken further training and developed years of experience specifically delivering specialised hand therapy services to support the service provided—for example:

- advanced training and knowledge of customised and dynamic splinting techniques
- in-depth knowledge of the musculoskeletal system and appropriate exercise regime that run parallel to splinting
- knowledge of post-surgical care, including specific operative procedures and rehabilitation protocols.

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What is specialised hand therapy?

There are numerous types of disorders and trauma to the wrist, hand and fingers that are treated by specialist hand therapists. Some of the most common work-related conditions are:

- fractures
- tendon Injuries
- soft tissue injuries including nerves, ligaments, arteries
- amputations and replants involving the upper limb
- crush injuries
- occupational overuse injuries
- burns
- pain syndromes.

Some examples of evaluations and treatments provided by specialised hand therapists include:

- customised hand splinting
- oedema management
- scar management
- education—self management education, home exercise programs
- mobilisation
- strengthening
- functional retraining
- wound care
- sensory retraining
- scar control and management.

Not all conditions or injuries occurring to the upper extremities require the input and expertise of a specialist hand therapist. These conditions and other similar conditions should be treated using the standard occupational therapy initial consultation and subsequent consultations codes where appropriate.

Use the standard initial consultation and subsequent consultation codes in cases where:

- the patient has not been referred for specialist hand therapy
- the treatment is not one-on-one
- the diagnosis does not involve multiple treatment techniques (as described previously).

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6.6 Group sessions (600171)

Item number	Descriptor
600171	Group education sessions A group/class intervention delivers a common learning or educational objective to more than one (1) client at the same time. This includes education and exercise classes—for example back education or pain management. An occupational therapist must conduct the class, with a maximum of eight (8) persons per group. The insurer will only pay for attendance of workers' compensation claimants.

Service conditions

Prior approval required from the insurer – Yes

Service objectives

The objective of any education session is to assist the worker to understand their injury and the process of rehabilitation. Education programs developed by occupational therapists should:

- aim to increase the worker's understanding of their injury
- provide workers with self-management strategies
- overcome unhelpful beliefs.

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6.7 Other – Independent case review (600226)

Item number	Descriptor
600226	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 occupational therapist) to provide the insurer with an assessment and recommendations for ongoing treatment and prognosis. This service includes assessment and report

Service conditions

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

Service objectives

The purpose of an independent clinical assessment is to:

- assess and make recommendations regarding the appropriateness and necessity of current or proposed occupational therapy treatment
- propose a recommended course of occupational therapy 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 where this is unclear from the current occupational therapy program, or where required, determine a prognosis for return to work
- provide an opinion and/or recommendation on the other criteria as determined by the requestor.

Note: This may also require communication with the current treating provider. **This service includes assessment and report.**

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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 [#]
Initial consultation				
Initial consultation	First consultation with worker.	No	600015	\$64.97
Initial consultation (multiple area)	Two or more entirely separate injuries/conditions assessed and treated; treatment applied to one condition does not affect the symptoms of the other injury; must relate to the compensable injury ; requires medical certificate detailing each area/condition to be treated.	No	600020	\$97.55
Subsequent consultation				
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 seven sessions (including initial consultation) are pre-approved.	600017	\$40.44
Subsequent consultation – level B	Standard treatment consultation—management of one area/condition only.		600016	\$54.49
Subsequent consultation – level C	Two entirely separate injuries/conditions 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.	Additional session/s require prior approval.	600288	\$78.49
Subsequent consultation – level D	More than two entirely separate injuries/conditions 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.		600289	\$104.70
Reassessment/program review				
Reassessment/program review	Indicated when the worker has been in active rehabilitation for six weeks and further treatment is likely.	Yes	600055	\$75.45

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

² Before billing for services please read the *Occupational therapy 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 [#]
Specific occupational assessment/intervention (complex)				
Specific occupational therapy assessment (complex)	Used for assessing complex conditions that cannot be adequately assessed within a standard (600015) or multiple area (600020) consultation due to the complexity of the condition; if treatment is required, you must submit a provider management plan prior to commencing treatment.	Yes	600170	\$144.54 per hour
Specific occupational therapy intervention	One-on-one session of recommended interventions identified during a specific occupational therapy assessment (600170); service/treatment is not classified elsewhere in the table of costs; an hourly rate may be appropriate— maximum one hour.	Yes	600292	\$144.54 per hour
Hand/upper limb consultation	One-on-one consultation and treatment services to workers with upper extremity injuries below shoulder level; provide hand therapy services in accordance with the worker's specific injury and needs; apply evidence-based protocols where applicable; consult the guidelines—ensure that treatment offered is considered specialist hand therapy and you are qualified to provide the treatment.	First seven sessions are pre-approved if referred by medical hand specialist.	600287	\$144.54 per hour
Group sessions				
Group education sessions	Education programs—for example pain management, back education; maximum eight persons per group; conditions apply—consult guidelines; insurer will only pay for the attendance of workers' compensation claimants.	Yes	600171	\$36.77 per person per hour
Other				
Independent case review	Independent examination and report of a worker—not by the treating therapist; includes assessment and report.	To be provided only following a request from the insurer.	600226	\$180.61 per hour

For details of when and how to use a *Provider management plan* see the *Allied health provider form guidelines* – both available from Q-COMP's website at www.qcomp.com.au or call Q-COMP on 1300 789 881.

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

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

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