WorkCover QUEENSLAND

# Psychology table of costs

## Effective 1 July 2019

| 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. The purpose of the assessment is to identify appropriate interventions/treatments to optimise rehabilitation outcomes (2-3 hours direct contact and test scoring time). | No | 400088 | $183 ^ per hour |
| 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 (4) to six (6) hours with maximum of two (2) hours on any one day. | Yes | 400095 | $183 ^ per hour |
| Critical Incident Debriefing Sessions | A process where, following exposure to a critical incident, an individual or group of workers are debriefed by a psychologist to assist them to deal more effectively with their experience. Approval required after the first two (2) sessions. | Yes | 400184 | $183 ^ 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 (4-5 hours direct contact and test scoring time). | Yes | 400091 | $183 ^ per hour |

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| 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 (2-3 hours direct contact and test scoring time). | Yes | 400092 | $183 ^ per hour |
| Group Education Sessions | Group education programs; maximum eight persons per group. | Yes | 400097 | $47 ^ per person per hour |
| Independent Case Review | Independent examination and report of a worker (not by the treating therapist). Only provided following a request from the insurer. | At the request of the insurer | 400226 | $228 ^ per hour |
| Communication | Direct communication between treating practitioners and insurer, employer, insurer referred allied health practitioner and doctors to assist with faster and more effective rehabilitation and return to work for a worker. Excludes communication of a general administrative nature or with a worker. Must be more than 3 minutes and is to be billed in 10 minute increments. Consult list of exclusions before using. | No | 300079 | $30 ^ per ten minute increment |
| 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 | $183 ^ per hour |
| Progress Report | A written report providing a brief summary of the worker's progress towards recovery and return to work. | At the request of the insurer | 300086 | $61 |
| Standard Report | A written report used for conveying relevant information about a worker's compensable injury where the case or treatment is not extremely complex or where responses to a limited number of questions have been requested by the insurer. | At the request of the insurer | 300088 | $154 |
| Comprehensive Report | A written report only used where the case and treatment is extremely complex. Hours to be negotiated with the insurer prior to providing the report. | At the request of the insurer | 300090 | $183 ^ per hour |

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| Travel - Treatment | Only paid where the provider 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 | 300092 | $134 ^ per hour |
| Copies of Patient Records relating to claim | Copies of patient records relating to the worker's compensation claim including file notes, results of relevant tests e.g. pathology, diagnostic imaging and reports from specialists. Paid at $25 flat fee plus $1 per page. | No | 300093 | $25 plus $1 per page |
| Incidental Expenses | Reasonable charges for incidental items the worker takes with them up to $57.00 per claim without prior approval. Reasonable charges for supportive devices up to $199.00 per claim without prior approval. Hire of equipment to be negotiated with insurer. | Yes | 300094 | Incidental - $57 per claim<br><br>Supportive - $199 per claim |
| External Case Management | Includes an initial needs assessment and report; should outline a case management plan indicating the goals of the program, services required, timeframes and costs. Insurer request only. | At the request of the insurer | 300295 | $183 ^ per hour |

Please read the item number descriptions contained in this document for service conditions and exclusions.

[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. See https://www.ato.gov.au/Business/GST/In-detail/Your-industry/GST-and-health/
[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 available from www.worksafe.qld.gov.au
^ Hourly rates are to be charged pro-rata.
## Insurer will only pay for the attendance of workers' compensation claimants.

## 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:

- **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. For complex assessments, contact the insurer to discuss the case and to negotiate further hours if necessary.
- **Provider management plan** – this form is available on the Workers' Compensation Regulator's website (www.worksafe.qld.gov.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 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.

## Telehealth services

Telehealth services are only related to video consultations. Phone consultations are not covered under the current Table of Costs.

The following should be considered prior to delivering the service:

- Providers must consider the appropriateness of this mode of service delivery for each worker on a case-by-case basis i.e. the principles and considerations of good clinical care continue to be essential in telehealth services.
- Providers are responsible for delivering telehealth services in accordance with the principles of professional conduct and the relevant professional and practice guidelines to ensure that all care is taken to ensure the privacy, confidentiality, safety, appropriateness and effectiveness of the service.
- As with any consultation, it is important to provide sufficient information to enable workers to make informed decisions regarding their care.
- All telehealth services require prior approval from the insurer and must be consented to by all parties – the worker, provider and insurer.

For billing purposes telehealth services do not have specific item codes and should be invoiced in line with the current item codes and descriptors in each Table of Costs.

“Telehealth” must be noted in the comments section on any invoice submitted to the insurer when this service has been utilised.

### Consultations (Item codes 400088, 400095)

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 code 400184)

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 codes 400091 and 400092)

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 Neuro-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 be practice endorsed by the Psychology Board of Australia.

**Mandatory requirements (Clinical psychological assessment)** – the practitioner must be a fully registered Clinical Psychologist with appropriate experience in clinical assessment, workplace issues and have 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; Clinical Psychologist/Neuro-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

## Group sessions (Item code 400097)

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 code 400226)

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 worker's 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

## Communication (Item codes 300079)

Used by **treating practitioners** for direct communication between a practitioner and any of the following: insurer, employer and/or treating medical or insurer appointed allied health provider to provide detailed information to facilitate faster, safer and more effective rehabilitation and return to work program for a specific worker. 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 includes phone calls, emails and facsimiles.

Each call, fax/email preparation must be more than three (3) minutes in duration to be billable and is to be billed in ten (10) minute increments. Note: most communication would be of short duration and would only exceed ten minutes in exceptional or unusual circumstances.

The insurer will not pay for:

- normal consultation communication that forms part of the usual best practice of ongoing treatment (when not of an administrative nature this should be billed under the appropriate treatment code)
- communication conveying non-specific information such as 'worker progressing well'
- communication made or received from the insurer as part of a quality review process
- General administrative communication, for example:
    - forwarding an attachment via email or fax e.g. forwarding a *Suitable duties plan* or report
    - leaving a message where the party phoned is unavailable
    - queries related to invoices
    - for approval/clarification of a Provider Management Plan or a Suitable Duties Plan by the insurer

Supporting documentation is required for all invoices that include communication. 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 call/email/fax. Line items on an invoice will be declined if the comments on the invoice indicate that the communication was for reasons that are specifically excluded.

If part of the conversation would be excluded, the practitioner can still invoice the insurer for the communication if the rest of the conversation is valid. The comments on the invoice should reflect the valid communication. Providing

comments on an invoice that indicates that the communication was specifically excluded could lead to that line item being declined by the insurer.

## Case Conference (Item code 300082)

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

## Reports (Item code 300086, 300088, 300090)

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. Generally, a report will not be required where the information has previously been provided to the insurer.

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 three (3) weeks are of little use to the insurer and will not be paid for without prior approval from the insurer.

All reports include:

- 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

## Clinical reports

Insurers may request a progress clinical report, a standard clinical report or a comprehensive clinical report.

- **Progress report** – a brief summary of a worker's progress including RTW status, completion of goals, future recommendations and timeframes.

- **Standard report** – conveys relevant information relating to a worker's recovery and return to work where the case or treatment **are not** extremely complex. Includes functional and RTW status, treatment plan, interventions to date, any changes in prognosis along with the reasons for those changes, barriers, recommendations and goals and timeframes. Also includes responses to a limited number of questions raised by an insurer. A standard report would not be appropriate if further examination of the worker was required in order for the report to be completed.

- **Comprehensive report** – conveys all the information included in a standard report however would only be relevant where the case or treatment are **extremely complex** or the questions raised by the insurer are extensive. A standard report would be appropriate if further examination of the worker was required in order for the report to be completed for example a neuropsychological report or multi-trauma patient.

## Travel – Treatment (Item code 300092)

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*
- a worker is unable to attend the practitioner's 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.

### Travel may not be charged when:

- travelling between one site or another if the practitioner's 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 code 300093)

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 code 300094)

The values specified in this *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 this *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* form available at www.worksafe.qld.gov.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, theraputty, theraband, grippers, hand weights, audio tapes/CD, education booklets, and disposable wound management kits (such as those containing scissors, gloves, dressings, etc.). 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.

## External case management (Item code 300295)

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 and for more information on the Table of Costs, visit www.worksafe.qld.gov.au or call 1300 362 128.