Chinese Medicine table of costs
Effective 1 July 2020

Service	Descriptor	Insurer prior approval required[1]	Item number	Fee – GST not included[2]
Initial Consultation	First consultation with worker for acupuncture.	No	300004	$89
Subsequent Consultation for Acupuncture	Subsequent consultation for acupuncture. Session/s require prior approval.	Yes	300005	$78
Communication - 3 to 10 mins	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 three (3) minutes. Consult list of exclusions before using.	No	300079	$31
Communication - 11 to 20 mins	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 11 minutes. Consult list of exclusions before using.	No	300100	$62
Case Conference	Face-to-face or phone 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	$186 ^ 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	$62

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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	$157
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	$186 ^ 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

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 www.ato.gov.au/Business/GST/In-detail/Your-industry/GST-and-health/.
^ Hourly rates are to be charged pro-rata.

Who can provide Chinese medicine services to injured workers?

All acupuncture services performed must be provided by a Chinese Medicine Practitioner who has a current registration in the Division of Acupuncture with the Chinese Medicine Board of Australia.

Service conditions

Services provided to injured workers are subject to the following conditions:

- **Treatment sessions** – where the claim has been accepted, the insurer will pay for the initial acupuncture sessions without prior approval. Any subsequent consultation for acupuncture requires insurer approval.
- **Incidentals –** all acupuncture needles are consumables and are not subsidised by the insurer.
- **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 Chinese Medicine Practitioner 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 300004, 300005)

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:

- **Subjective (history) reporting** – consider major symptoms and lifestyle dysfunction; current/past history and treatment; pain, aggravating and relieving factors; general health; medication; risk factors and key functional requirements of the worker's job.
- **Objective (physical) assessment** – assess movement – e.g. active, passive, resisted, repeated, muscle tone, spasm, weakness, accessory movements, passive intervertebral movements – and pain by carrying out appropriate procedures and tests.
- **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 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.
- **Treatment (intervention)** – formulate and discuss the treatment goals, progress and expected outcomes with the worker. Provide treatment modalities including exercise programs according to the goals of therapy.
- **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.

Communication (Item Codes 300079, 300100)

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. Note: most communication would be of short duration and would only exceed 10 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, e.g.:
    - 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 (1) 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 Codes 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 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 e.g. a neuropsychological report or multi-trauma patient.

Patient Records (Item Code 300093)

The fee is payable upon request from the insurer for copies of patient records relating to the worker's 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.

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.