Physiotherapy table of costs  
Effective 1 July 2017

<table>
<thead>
<tr>
<th>Service</th>
<th>Descriptor</th>
<th>Insurer prior approval required¹</th>
<th>Item number</th>
<th>Fee – GST not included²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Consultation</td>
<td>First consultation with worker</td>
<td>No</td>
<td>100021</td>
<td>$84</td>
</tr>
<tr>
<td>Initial Consultation (Multiple Area)</td>
<td>Two or more entirely separate injuries/conditions are assessed and treated; treatment applied to one condition does not affect the symptoms of the other injury; must relate to the compensable injury; does not include a condition with referred pain to another area; requires workers’ compensation certificate detailing each area/condition to be treated.</td>
<td>No</td>
<td>100313</td>
<td>$125</td>
</tr>
<tr>
<td>Subsequent Consultation (Level A)</td>
<td>Selective review of treatment or exercise program where a standard consultation (Level B) is not required; may include brief or partial reassessment. This may also be where the practitioner may be seeing multiple clients and treatment is not strictly one-on-one. The first five (5) sessions (including initial consultation) are pre-approved. Additional session/s require prior approval.</td>
<td>Yes</td>
<td>100108</td>
<td>$56</td>
</tr>
<tr>
<td>Subsequent Consultation (Level B)</td>
<td>Standard treatment consultation - management of one area/condition only. The first five (5) sessions (including initial consultation) are pre-approved. Additional session/s require prior approval.</td>
<td>Yes</td>
<td>100006</td>
<td>$75</td>
</tr>
</tbody>
</table>

¹The first five (5) sessions (including initial consultation) are pre-approved. Additional session/s require prior approval.
²Fee – GST not included.

The information provided in this publication is distributed by WorkCover Queensland an information source only. The information is provided solely on the basis that readers will be responsible for making their own assessment of the matters discussed herein and are advised to verify all relevant representations, statements and information.
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Details</th>
<th>Approved?</th>
<th>Code</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsequent Consultation (Level C)</td>
<td>Two 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; does not include a condition with referred pain to another area; requires workers' compensation certificate detailing each area/condition to be treated. The first five (5) sessions (including initial consultation) are pre-approved. Additional session/s require prior approval.</td>
<td>Yes</td>
<td>100101</td>
<td>$107</td>
</tr>
<tr>
<td>Subsequent Consultation (Level D)</td>
<td>More than two entirely separate injuries/conditions assessed and treated; treatment applied to one condition does not affect the symptoms of the others; must relate to the compensable injury; does not include a condition with referred pain to another area; requires workers' compensation certificate detailing each area/condition to be treated. The first five (5) sessions (including initial consultation) are pre-approved. Additional session/s require prior approval.</td>
<td>Yes</td>
<td>100102</td>
<td>$143</td>
</tr>
<tr>
<td>Reassessment/Program Review</td>
<td>Indicated when the worker has been in active rehabilitation for six weeks and further treatment is likely; there are new clinical findings that might affect treatment; there is a rapid change in the worker’s status or there is no response to therapeutic interventions.</td>
<td>Yes</td>
<td>100555</td>
<td>$104</td>
</tr>
<tr>
<td>Complex Physiotherapy Assessment</td>
<td>Used for assessing complex conditions that cannot be adequately assessed within a standard (100021) or multiple areas (100313) consultation due to the complexity of the condition. These may include but are not limited to: extensive burns; acquired brain injuries; complex neurological and/or chronic pain conditions; specific assessments requested by insurer such as rehabilitation needs assessment. Seating assessment, assessment for wheelchairs, diagnostic ultrasound or assessment for the provision of gym equipment.</td>
<td>Yes</td>
<td>100406</td>
<td>$176(^\text{per hour})</td>
</tr>
<tr>
<td>Service Description</td>
<td>Description</td>
<td>Yes</td>
<td>Code</td>
<td>Rate</td>
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<tr>
<td>Complex Physiotherapy Intervention</td>
<td>One-on-one session for complex conditions of recommended interventions identified during a complex physiotherapy assessment (100406). These may include but are not limited to: treatment of severe burns, acquired brain injuries, neurological injuries or severe spinal injuries. Note: This service or treatment should not be already classified elsewhere in this table of costs - maximum one hour. Prior approval required before providing service.</td>
<td></td>
<td>100407</td>
<td>$176 ^ per hour</td>
</tr>
<tr>
<td>Specialised Hand/Upper Limb Consultation</td>
<td>An advanced clinical specialty area devoted to treating a variety of upper extremity physical conditions. One-on-one consultation and treatment services to workers with upper extremity injuries below shoulder level; provide early, specialised hand therapy services in accordance with the worker's specific injury and needs to achieve maximal use of the injured extremity and to achieve early return to work; apply evidence-based protocols where applicable; treatment offered is considered specialist hand therapy provided by a qualified practitioner (see descriptions). The first five sessions are pre-approved if referred by medical hand specialist.</td>
<td></td>
<td>100287</td>
<td>$176 ^ per hour</td>
</tr>
<tr>
<td>Initial Therapeutic Exercise Program Development And Instruction</td>
<td>Development of gym/pool-based program with individual one-on-one instructions and/or demonstration of the program at an appropriate venue. This may only be charged once when worker's condition requires the expertise of a Physiotherapist for the successful transition of their program to a gym/pool-based setting to meet their functional goals maximum one hour.</td>
<td></td>
<td>100314</td>
<td>$176 ^ per hour</td>
</tr>
<tr>
<td>Therapeutic Exercise Program Instruction Subsequent Consultation</td>
<td>Subsequent monitoring of gym/pool-based program and individual one-on-one instruction at an appropriate venue; worker's condition requires the continued expertise of a Physiotherapist for the successful progression to meet their functional goals in a gym/pool-based program maximum one hour. Prior approval required before providing service.</td>
<td></td>
<td>100402</td>
<td>$176 ^ per hour</td>
</tr>
<tr>
<td>Service Type</td>
<td>Description</td>
<td>Available</td>
<td>Code</td>
<td>Fee</td>
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<tr>
<td>Group Exercise Sessions</td>
<td>Group exercise programs, maximum eight persons per group. Where a common program is delivered to more than one individual at the same time. The group must be attended, conducted and supervised by a Physiotherapist. Prior approval required before providing service.</td>
<td>Yes</td>
<td>100106</td>
<td>$45^ per person per hour</td>
</tr>
<tr>
<td>Group Education Sessions</td>
<td>Group education programs - maximum eight persons per group. A group/class intervention delivers a common learning or education objective to more than one (1) client at the same time. This includes education and exercises. A Physiotherapist must conduct the class. Prior approval required before providing service.</td>
<td>Yes</td>
<td>100171</td>
<td>$45^ per person per hour</td>
</tr>
<tr>
<td>Independent Case Review</td>
<td>Independent examination and report of a worker (not by the treating therapist) Referred by the insurer where progress of treatment and/or rehabilitation falls outside the plan or expected course of injury management. Examination and report of a work by the reviewer to provide the insurer with an assessment and recommendations for ongoing treatment and prognosis. To be provided only following a request from the insurer.</td>
<td>At the request of the insurer</td>
<td>100226</td>
<td>$220^ per hour</td>
</tr>
<tr>
<td>Communication - 3 to 10 minutes</td>
<td>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 patient. Excludes communication of a general administrative nature or with a worker. Consult list of exclusions before using.</td>
<td>No</td>
<td>300079</td>
<td>$29</td>
</tr>
<tr>
<td>Communication - 11 to 20 mins</td>
<td>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 patient. Excludes communication of a general administrative nature or with a worker. Consult list of exclusions before using.</td>
<td>No</td>
<td>300100</td>
<td>$59</td>
</tr>
<tr>
<td>Service Description</td>
<td>Details</td>
<td>Available</td>
<td>Code</td>
<td>Fee</td>
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</tr>
<tr>
<td>RTW Communication 3 to 10 mins</td>
<td>Used by a provider who has received a referral from an insurer for: worksite assessment/evaluation, development of suitable duties program, functional capacity evaluation, vocational assessment, job seeking, job preparation or job placement services. The provider is able to bill for communication between the provider, insurer, treating allied health or medical providers to assist with faster and more effective rehabilitation and return to work for a specific worker. Consult list of exclusions before using. For WorkCover, service can only be provided by a return to work panel provider**</td>
<td>No</td>
<td>300210</td>
<td>$29</td>
</tr>
<tr>
<td>RTW Communication 11 to 20 mins</td>
<td>Used by a provider who has received a referral from an insurer for: worksite assessment/evaluation, development of suitable duties program, functional capacity evaluation, vocational assessment, job seeking, job preparation or job placement services. The provider is able to bill for communication between the provider, insurer, treating allied health or medical providers to assist with faster and more effective rehabilitation and return to work for a specific worker. Consult list of exclusions before using. For WorkCover, service can only be provided by a return to work panel provider**</td>
<td>No</td>
<td>300211</td>
<td>$59</td>
</tr>
<tr>
<td>Monitoring Suitable Duties Program (SDP) - 3 to 10 mins</td>
<td>Direct communication between provider, worker, employer, treating practitioner and insurer as required to monitor a worker's progress or address issues related to an existing suitable duties program. For WorkCover, service can only be provided by a return to work panel provider**</td>
<td>Yes</td>
<td>300080</td>
<td>$29</td>
</tr>
<tr>
<td>Monitoring Suitable Duties Program (SDP) - 11 to 20 mins</td>
<td>Direct communication between provider, worker, employer, treating practitioner and insurer as required to monitor a worker's progress or address issues related to an existing suitable duties program. For WorkCover, service can only be provided by a return to work panel provider**</td>
<td>Yes</td>
<td>300101</td>
<td>$59</td>
</tr>
<tr>
<td>Service Description</td>
<td>Description</td>
<td>Paid by Insurer</td>
<td>Code</td>
<td>Cost</td>
</tr>
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</tr>
<tr>
<td>Initial Suitable Duties Program (SDP)</td>
<td>Documentation of suitable duties for a worker, detailing specific information necessary for a safe and effective return to the workplace. For WorkCover, service can only be provided by a return to work panel provider**</td>
<td>Yes</td>
<td>300102</td>
<td>$88</td>
</tr>
<tr>
<td>Updated Suitable Duties Program (SDP)</td>
<td>Documentation of an updated or further suitable duties for a worker, detailing specific information necessary for a safe and effective return to the workplace. For WorkCover, service can only be provided by a return to work panel provider**</td>
<td>Yes</td>
<td>300084</td>
<td>$59</td>
</tr>
<tr>
<td>Case Conference</td>
<td>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.</td>
<td>Yes</td>
<td>300082</td>
<td>$176 ^ per hour</td>
</tr>
<tr>
<td>Progress Report</td>
<td>A written report providing a brief summary of the worker's progress towards recovery and return to work.</td>
<td>At the request of the insurer</td>
<td>300086</td>
<td>$59</td>
</tr>
<tr>
<td>Standard Report</td>
<td>A written report used for conveying relevant information about a worker's compensable injury where the case or treatment are not extremely complex or where responses to a limited number of questions have been requested by the insurer.</td>
<td>At the request of the insurer</td>
<td>300088</td>
<td>$149</td>
</tr>
<tr>
<td>Comprehensive Report</td>
<td>A written report only used where the case and treatment are extremely complex. Hours to be negotiated with the insurer prior to providing the report.</td>
<td>At the request of the insurer</td>
<td>300090</td>
<td>$176 ^ per hour</td>
</tr>
<tr>
<td>Travel - RTW</td>
<td>Only paid where the provider is required to leave their normal place of practice to provide a return to work 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. For WorkCover, service can only be provided by a return to work panel provider**</td>
<td>Yes</td>
<td>300091</td>
<td>$131 ^ per hour</td>
</tr>
<tr>
<td>Service Description</td>
<td>Description</td>
<td>Provider Requirement</td>
<td>Charge Code</td>
<td>Fee/Rate</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
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</tr>
<tr>
<td>Travel - Treatment</td>
<td>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.</td>
<td>Yes</td>
<td>300092</td>
<td>$131 ^ per hour</td>
</tr>
<tr>
<td>Copies of Patient Records relating to claim</td>
<td>Copies of patient records relating to the workers’ compensation claim including file notes; results of relevant tests eg. pathology, diagnostic imaging and reports from specialists. Paid at $24 flat fee plus $1 per page.</td>
<td>No</td>
<td>300093</td>
<td>$24 plus $1 per page</td>
</tr>
<tr>
<td>Incidental Expenses</td>
<td>Reasonable charges for incidental items the worker takes with them up to $54.00 per claim without prior approval. Reasonable charges for supportive devices up to $193.00 per claim without prior approval. Hire of equipment to be negotiated with insurer.</td>
<td>Yes</td>
<td>300094</td>
<td>Incidental - $54 per claim Supportive - $190 per claim</td>
</tr>
<tr>
<td>Workplace Evaluation/Assessment</td>
<td>Systematic process using the workplace to estimate work potential and work behaviour. Includes ergonomic assessments. For WorkCover, service can only be provided by a return to work panel provider**</td>
<td>Yes</td>
<td>300158</td>
<td>$176 ^ per hour</td>
</tr>
<tr>
<td>Activities of Daily Living Assessment</td>
<td>A series of standardised tests and measures to assess a worker’s activities of daily living and mobility, including Modified Barthel Index assessments. Service includes assessment and report, noting that WorkCover’s template for Modified Barthel Index is to be used (for WorkCover claims).</td>
<td>At the request of the insurer</td>
<td>300159</td>
<td>$176 ^ per hour</td>
</tr>
<tr>
<td>Functional Capacity Evaluation (FCE)</td>
<td>Systematic assessment using a series of standardised tests and work specific simulation activities to assess a worker's functional capacity for work or potential to return to suitable work; includes assessment and report. For WorkCover, service can only be provided by a return to work panel provider**</td>
<td>Yes</td>
<td>300160</td>
<td>$176 ^ per hour</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Available</td>
<td>Code</td>
<td>Cost</td>
</tr>
<tr>
<td>----------------------------------------------</td>
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</tr>
<tr>
<td><strong>Driving Assessment</strong></td>
<td>Off-road and on-road driving assessments of cognitive, psychological and physical capacity to drive. Assessments conducted by qualified driving assessors. Service includes assessment and report. Driving instructor is also required for on-road assessment component and fees are paid separately.</td>
<td>At the request of the insurer</td>
<td>300161</td>
<td>$176^ per hour</td>
</tr>
<tr>
<td><strong>Return to Work Facilitation</strong></td>
<td>Communication with a worker and employer to establish an updated suitable duties program where no worksite assessment or job placement services are required or other service item code applies. Also used where there are significant barriers preventing a worker participating in a return to work program and the provider delivers strategies to overcome the barriers. Includes communication between the worker, employer and insurer (does not include general communication relating to a suitable duties program or job placement or where another code applies). For WorkCover, service can only be provided by a return to work panel provider**</td>
<td>Yes</td>
<td>300164</td>
<td>$176^ per hour</td>
</tr>
<tr>
<td><strong>Job seeking skills assessment initial</strong></td>
<td>Identify a worker's transferable skills and abilities for a new job/career or host placement; may involve the development of a vocational preparation action plan with the worker. For WorkCover, service can only be provided by a return to work panel provider**</td>
<td>Yes</td>
<td>300166</td>
<td>$176^ per hour</td>
</tr>
<tr>
<td><strong>Job Preparation Service</strong></td>
<td>Prepare the worker to find suitable employment. Services will be based on the needs of the worker and may include development of or updating a resume and/or cover letter, interview preparation skills and career counselling. For WorkCover, service can only be provided by a return to work panel provider**</td>
<td>Yes</td>
<td>300168</td>
<td>$176^ per hour</td>
</tr>
<tr>
<td>Service Description</td>
<td>Description</td>
<td>Conditions</td>
<td>Code</td>
<td>Hourly Rate</td>
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</tr>
<tr>
<td>Job Placement Services - New Employer</td>
<td>The process of sourcing and placing a worker in a host placement or for WorkCover also includes placing a worker in a Recover at Work program with a view to a durable return to work outcome. Also includes seeking new employment with/for the worker. Includes employer and worker liaison, job application and coaching. For WorkCover, service can only be provided by a return to work panel provider**</td>
<td>At the request of the insurer</td>
<td>300212</td>
<td>$176 ^ per hour</td>
</tr>
<tr>
<td>Job Placement Services - Work Hardening Program</td>
<td>The process of actively sourcing and placing a worker in a host placement or for WorkCover also includes placing a worker in a Recover at Work program where the worker has a job to return to. Includes employer and worker liaison, job application and coaching. For WorkCover, service can only be provided by a return to work panel provider**</td>
<td>At the request of the insurer</td>
<td>300213</td>
<td>$176 ^ per hour</td>
</tr>
<tr>
<td>Gym and Pool Entry Fees</td>
<td>Entry fee to the gymnasium or pool for treatment or assessment. Prior approval required before providing service.</td>
<td>Yes</td>
<td>300228</td>
<td>Usual facility fee</td>
</tr>
<tr>
<td>External Case Management</td>
<td>Includes an initial needs assessment and report; should outline a case management plan indicating goals of program, services required, timeframes and costs. Insurer request only.</td>
<td>At the request of the insurer</td>
<td>300295</td>
<td>$176 ^ per hour</td>
</tr>
</tbody>
</table>

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.
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.
4. Hourly rates are to be charged pro-rata.
5. Insurer will only pay for the attendance of workers' compensation claimants.
Who can provide physiotherapy services to injured workers?

All physiotherapy services performed must be provided by a Physiotherapist who has a current registration with the Physiotherapy Board of Australia.

Service conditions

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

- **Referral** – all workers must have a current workers’ compensation certificate signed by a medical practitioner or nurse practitioner to cover any services provided
- **Assessment** – after the initial physical conditioning assessment a completed Provider management plan must be provided to the insurer to advise of assessment outcome
- **Postoperative physiotherapy treatment** – when a worker is referred for physiotherapy treatment after a surgical procedure, a new set of five (5) treatments will take effect
- **Provider management plan** – this form is available on the Workers’ Compensation Regulator’s website ([www.worksafe.qld.gov.au](http://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 Physiotherapy 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.

Consultations (Item code 100021)

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 Workers’ job
- **Objective (physical) assessment** – assess movement – for example active, passive, resisted, repeated, muscle tone, spasm, weakness, accessory movements, passive intervertebral movements. Assess overall work function level and any physical impairments preventing the Workers’ pain from resolving
- **Assessment results (prognosis formulation)** – provide a provisional prognosis for treatment, limitations to function and return to work progress
- **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 Workers’ 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 treatment goals, progress and expected outcomes with the worker. Provide advice on pacing, functional goals and methods to overcome barriers. Create appropriate functional exercise programs to be followed. Provide treatment modalities and/or therapeutic exercises according to therapy goals. May include appropriate gym, pool or home program modifications in line with progress
- **Clinical records** – record information in the Workers’ clinical records, including the purpose and results of procedures and tests
- **Communication (with the referrer)** – communicate any relevant information for the Workers’ rehabilitation to insurer. Acknowledge referral and liaise with the treating medical practitioner about treatment
Reassessment/program review (Item code 100555)

A reassessment/program review is a comprehensive assessment including:

- all components of the initial consultation
- a review of the Workers’ progress based on established objective measures
- a recommendation for future treatment and management strategies to assist the worker to return to work

A reassessment/program review may include referral recommendations to other practitioners, a change in therapy direction or a change on outcome direction requiring a new return to work goal.

The insurer’s prior approval is required before a reassessment/program review is undertaken by the Physiotherapist. A Provider management plan is to be completed and submitted to the insurer either verbally or in written format. (Check with the insurer for their individual requirements).

A reassessment/program review is 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

Complex physiotherapy assessment/intervention (Item codes 100406, 100407)

Only a small number of practitioners will treat conditions that will fall within this category. Clinical justification for the use of these item numbers should be supplied to the insurer.

These services will contain elements from the standard consultations, refer to consultation service descriptors.

Specialist hand therapy (Item code 100287)

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 five (5) pre-approved sessions rule applies
- Where a registered medical practitioner refers the worker, the practitioner (Physiotherapist) must obtain prior approval from the insurer by submitting a Provider management plan form before commencing treatment

Not all conditions or injuries occurring to the upper extremities require the input and expertise of a specialist hand therapist. In these circumstances use of the standard physiotherapy consultations codes are appropriate.

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 Workers’ 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 to be able to charge this item number.

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 runs parallel to splinting
- knowledge of post-surgical care, including specific operative procedures and rehabilitation protocols.
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 examples of evaluations and treatments provided by specialised hand therapists include:

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

Therapeutic exercise services (Item codes 100314, 100402)

The insurer will not pay for an initial and subsequent consultation on the same day unless in exceptional circumstances, as approved by the insurer.

The objective of these interventions is to ensure a smooth and safe transition from one-on-one treatment to a conditioning program. Where the injury has been significant, the worker may need the supervision of the treating practitioner when commencing a physical conditioning program.

Exercise programs developed by Physiotherapists should be:

- aimed at increasing the Workers’ capacity and orientated towards a return to suitable and sustainable employment. Insurers do not pay for aquatic/gym physiotherapy programs that are only focused on improving a Workers’ general level of health and fitness
- outcome-focused—the practitioner must be able to demonstrate that the worker has achieved an increase in work capacity and a decrease in clinical treatment
- aimed at maximising function

Gym/aquatic/pilates sessions:

- an individual session requires one-on-one contact between the therapist and the worker and
- the practitioner must be in the gym/pool with the worker during an individual session.

Group sessions (Item codes 100106, 100171)

The insurer will only pay for the attendance of workers’ compensation claimants in a group exercise/education session.

The objective of any exercise rehabilitation or education program is to ensure that injured workers achieve the best practicable levels of physical recovery along with assisting the worker to understand their injury and the process of rehabilitation.

Exercise programs developed by Physiotherapists should be:

- aimed at increasing the Workers’ capacity and orientated towards a return to suitable and sustainable employment—workers’ compensation insurers do not pay for gym/aquatic/pilates physiotherapy programs that are only focused on improving a Workers’ general level of health and fitness
- outcome-focused—the practitioner must be able to demonstrate that the worker has achieved an increase in work capacity and a decrease in clinical treatment
- aimed at maximising function

Education programs developed by Physiotherapists should:

- aim to increase the Workers’ 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 100226)

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 physiotherapy treatment
- propose a recommended course of physiotherapy management
- make recommendations for strategic planning to progress the case. Recommendations should relate to treatment goals and steps to achieve those goals, which will assist in a safe and durable return to work
- provide a professional opinion on the Workers’ prognosis where this is unclear from the current physiotherapy program
- provide an opinion and/or recommendation on the other criteria as determined by the insurer

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 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.

Return to work Communication (Item codes 300210, 300211)

Used by a provider who has received a referral from an insurer for the following return to work services: worksite assessment/evaluation, development of suitable duties program or updated program, functional capacity evaluation, vocational assessment, job seeking, job preparation, or job placement services. The provider is able to bill for communication between the provider, insurer, treating allied health or medical providers to assist with faster and more effective rehabilitation and return to work 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.

Where the information was not previously provided, phone calls between the practitioner and insurer relating to a new referral for the above listed return to work services can also be billed under this code if the referral goal, background, needs, barriers and directions for the referral are discussed in detail and the conversation is more than three (3) minutes in duration.
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 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 to and from a worker (where not administrative in nature this is billed under the appropriate referred item code)
- communication with an employer (where not administrative in nature this is billed under the appropriate referred item 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
  - Acknowledgement and/or acceptance/rejection of referrals from an insurer except as outlined above
  - 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.

**Suitable duties program and updated suitable duties program (Item codes 300102, 300084)**

The objectives of the suitable duties program are to:

- document agreed work tasks which are medically suitable for the worker to commence a graduated return to normal work duties
- ensure all parties involved understand that the program’s requirement is to achieve a safe and effective return to the workplace

**Prerequisite** – where the practitioner is unfamiliar with the workplace, a workplace evaluation (300158) to assess the workplace and Workers’ needs may be a prerequisite to documenting the initial suitable duties program. This would also include the time taken negotiating the program and any necessary consultation with the doctor and employer.

**Mandatory requirements** – Before a worker can participate in a suitable duties program, the treating medical practitioner must provide a medical certificate approving suitable duties or have provided a signed approval of the program.

**Initial suitable duties program** – should be drawn up after:

- completing an initial workplace evaluation (300158) where appropriate
- the Workers’ estimated work potential and work behaviours have been defined
- appropriate duties have been negotiated with the employer or their representative

Each program should contain the following:

- goals or objectives of the overall program
- documentation of specific tasks and duties to be performed by worker
- days and hours to be worked
- key reviewing and reporting requirements during the program
- any restrictions or limitations
- recommendations for upgrading the program
- start, completion and review dates for the program
Updated suitable duties programs – it is not mandatory to conduct a subsequent workplace evaluation with each update to the suitable duties program. Updated programs should:

- progressively build tolerances from the initial program
- reflect changes in work duties, and to days and hours worked
- detail new reporting requirements
- identify new or changed restrictions or limitations
- show start and completion dates for program

Complex suitable duties programs – in a small number of cases where the suitable duties program is likely to be involved and complex, the practitioner must negotiate additional time with the insurer first.

For WorkCover, service can only be provided by a return to work services panel provider.

Monitoring Suitable Duties Program (Item codes 300084, 300101)

Communication with relevant stakeholders (worker, insurer, employer, the Workers’ treating medical practitioner and/or the Workers’ allied health provider) about a specific Workers’ progress or issues related to an existing suitable duties program where shared understanding is important. The communication should be relevant to the compensable injury and program and assist the insurer and employer to support the return to work process.

When monitoring suitable duties, the practitioner must address the following elements:

- relevance to the suitable duties program
- assistance for the relevant parties to support and progress the Workers’ program
- barriers limiting progress and strategies to address these

Each call, fax/email preparation must be more than three (3) minutes in duration to be billable. 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.

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 to and from a worker (where not administrative in nature this is billed under the appropriate referred item code)
- communication with an employer (where not administrative in nature this is billed under the appropriate referred item 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
  - Acknowledgement and/or acceptance/rejection of referrals from an insurer except as outlined above
  - queries related to invoices
  - for approval/clarification of a Provider Management Plan or a Suitable Duties Plan by the insurer

For WorkCover, service can only be provided by a return to work services panel provider.

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 Workers’ 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 Workers’ 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 Workers’ status for the compensable injury
- the report communicates the Workers’ 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:
- Workers’ 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 Workers’ progress including RTW status, completion of goals, future recommendations and timeframes

- **Standard report** – conveys relevant information relating to a Workers’ 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

Return to work reports

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

- **Progress report** – a brief summary of a Workers’ progress including RTW status, completion of goals and future recommendations

- **Standard report** – conveys relevant information relating to a Workers’ 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. Also includes details of the barriers to RTW, more detailed information on the assessment criteria performed and strategies recommended to address barriers. A comprehensive report may be appropriate if further examination of the worker was required in order for the report to be completed or for a Vocational Assessment Report or Functional Capacity Evaluation Report, or where there are multiple extremely complex psychosocial issues to be addressed as part of the RTW process.

**Travel – Return To Work (Item code 300091)**

Used by a provider who has **received a referral** from an insurer for the following return to work services: worksite assessment/evaluation, development of suitable duties program or updated program, functional capacity evaluation, vocational assessment, job seeking, job preparation, or job placement services.

The provider should only charge for return to work travel when:

- it is appropriate to attend the worker somewhere other than the normal place of practice - for example:
  - to attend a case conference*
  - to perform a workplace assessment*
- a worker is unable to attend the practitioners normal place of practice and they are treated at their home. In this case, the treating medical practitioner must certify the worker as unfit for travel
- the travel relates directly to service delivery for the Workers’ 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

For WorkCover Queensland, service can only be provided by a return to work services panel provider.

**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 Workers’ 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.com.au. All items must be itemised on invoices.

Reasonable expenses

Items considered to be reasonable incidental expenses are those that the worker actually takes with them – including bandages, elastic stockings, tape, crutches, 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.

Workplace evaluation/assessment services (Item code 300158)

Attendance at the Workers' workplace or prospective workplace to provide one or all of the following:
- an overview of the workplace and availability of suitable duties
- suitable duties identification and/or program negotiation with relevant parties
- a job analysis to isolate specific difficulties with job performance, recommend possible solutions and determine the most effective way of performing specified duties
- advice on workplace design, modification or provision of aids and appliances if required to assist in a sustainable return to work
- assisting the Workers' supervisor and co-workers to understand recommended work restrictions and safe work methods
- workplace setup evaluation
- work practice review and/or modification
- ergonomic assessment
- job redesign

Fee is charged at an hourly rate with the number of hours negotiated with the insurer prior to providing the service. This item does not include a mandatory report. Providers who specifically believe a report should be provided for their particular client they are encouraged to discuss those reasons with the individual insurer.

Communication with the worker or employer regarding this service (when not of an administrative nature) is billed under this code.

For WorkCover, service can only be provided by a return to work services panel provider.
Activities of daily living assessment services (Item code 300159)

Activities of Daily Living (ADLs) is a series of standardised tests used to measure a Workers’ activities of daily living and mobility, including Modified Barthel Index. The Modified Barthel Index assessments can only be done by qualified practitioners. Please note that WorkCover Queensland’s template for the Modified Barthel Index is to be used for WorkCover Queensland claims.

Fee is charged at an hourly rate with the number of hours negotiated with the insurer prior to providing the service. This service includes the assessment and mandatory report. Generally, an assessment (including report) will take one (1) to two (2) hours. The practitioner must obtain prior approval from the insurer for assessments greater than two (2) hours.

Functional capacity evaluation services (Item code 300160)

A Functional Capacity Evaluation (FCE) is used to obtain information about a Workers’ functional abilities that is not available through other means. Wherever possible, the FCE should reflect a Workers’ capacity for the physical activities of jobs that are potentially available to the worker.

The objectives of the FCE are to:
- determine a Workers’ abilities over a range of physical demands to assist their functional recovery
- assess the Workers’ functional capacity
- determine a Workers’ ability to work
- determine a Workers’ job-specific rehabilitation needs
- document a Workers’ progress before, during or after rehabilitation

Generally, an assessment (including report) will take two (2) to four (4) hours to complete. The practitioner must obtain prior approval from the insurer for assessments greater than four (4) hours.

This assessment/consultation may not be feasible if there is/are:
- unstable medical conditions
- recent surgery
- substantial psychiatric or behavioural issues
- non-compensable medical co-morbidities excluding the worker from work activities
- communication barriers or concerns that prevent instructions being understood and reactions being interpreted during a functional capacity evaluation
- a recent functional capacity evaluation

Consider the following when completing a FCE:
- **Purpose** – prior to assessment, the provider or the referrer should clearly define the FCE purpose which will assist in determining the level of assessment and time required to establish functional abilities
- **Work Capacity Certificate** – the provider must assess the worker within the limitations outlined on their current Work Capacity Certificate. Where the current certificate places limitations on the worker that will limit the value of an FCE, this should be discussed with the medical practitioner to obtain an appropriate clearance to conduct the assessment
- **Referral details** – all relevant information should be supplied by the requestor including medical reports, current Work Capacity Certificate, a job analysis, rehabilitation progress reports, previous functional and vocational assessments and relevant medical investigations
- **Informed consent** – the worker must be informed of the purpose and requirements of the assessment, their obligations, any risk factors and safety obligations, and the provider should obtain the Workers’ written authority prior to the assessment and for the exchange of information
- **Subjective (history)** – gather relevant information including but not limited to medical history; rehabilitation progress; workplace information; and the Workers’ own perception of their abilities
- **Objective measures** – the assessment should consider the Workers’ functional abilities to perform the physical demands of the proposed job and determine their capacity to undertake these demands. The examination should include but not be limited to neuro-musculoskeletal examination; basic measures of range of motion and muscle strength as well as baseline physical abilities—lifting, standing, walking, climbing—relevant to the worker
- **Safety** – the main focus for undertaking a FCE should be the prevention of further injury. Functional abilities should be the Workers’ maximum ability using safe body mechanics. If the worker consistently demonstrates poor or unsafe body mechanics, the provider needs to use professional judgment about whether or not the FCE should be continued
For WorkCover Queensland, service can only be provided by a return to work services panel provider.

**Driving Assessments (Item code 300161)**

Driving assessments are required to determine if the work-related medical condition/s will impact the Workers’ fitness to drive for a private and/or commercial vehicle. Assessments can only be conducted by a suitably trained and qualified occupational therapist or physiotherapist. Assessments take into consideration the Workers’ restrictions and can include interview, vision screening, cognitive testing, and examination of functional abilities including strength, motor skills and reaction time. The Workers’ ability to judge the traffic situation, make safe decisions and handle the vehicle form part of the on road assessment.

The outcome of the driving assessment may indicate that a worker is fit or unfit to drive, or that specialist equipment or modifications are required.

The fee is charged at an hourly rate (pro-rata) with the number of hours negotiated with the insurer prior to providing the report. Service includes assessment and report. If a driving instructor is also required for the on-road assessment component, fees will be paid separately.

**Return to work facilitation (Item code 300164)**

Return to work facilitation should assist the worker to return to the workplace where there are significant barriers preventing smooth return to work and includes:

- identifying strategies to overcome the barriers to return to work through discussion with the worker and significant others in the workplace
- developing a plan to address barriers
- documenting a Workers’ progress and outcome
- Worker and Employer liaison

Also includes communication with a worker and/or employer where an updated suitable duties program is required and a worksite assessment or job placement services are not required.

Excludes general communication relating to return to work services, or communication relating to worksite assessment, Job placement services, Job preparation services or Job seeking skills assessments.

For WorkCover, service can only be provided by a return to work services panel provider.

**Job seeking skills assessment (item code 300166)**

A job seeking skills assessment is used to identify a Workers’ transferable skills to enable realistic work goals to be set for the worker. The assessment may also identify possible barriers to return to work. Generally the initial consultation will take between one (1) and two (2) hours, based on direct contact time with the worker (there may be cases where longer than two (2) hours of direct contact with the worker is required for assessment.) The time is to be negotiated with the insurer prior to delivery.

Communication with the worker regarding this service (when not of an administrative nature) is billed under this code.

The Fee is charged at an hourly rate (pro-rata) with the number of hours negotiated with the insurer.

For WorkCover, service can only be provided by a return to work services panel provider.
Job preparation services (Item code 300168)

Provides workers with the skills and tools to find a job. For example:
- development of a current resume or cover letter
- presentation skills for interview e.g. appropriate dress, social skills, voice projection
- interview preparation—how to answer interview questions, selling your skills in an interview and role playing
- guidance on how to search for employment (excluding services covered under Job placement services)
- counselling to address barriers to achieve new vocational goals and set realistic and achievable work goals in the current job market and within the limitations of the system

Communication with the worker regarding this service (when not of an administrative nature) is billed under this code.

The Fee is charged at an hourly rate (pro-rata) with the number of hours negotiated with the insurer. For future provision of job preparation services the provider may be required to complete a Job seeking initial consultation report for approval by the insurer.

For WorkCover, service can only be provided by a return to work services panel provider.

Job placement service – New employer (Item code 300212)

Provides practical one-on-one assistance and support for a worker to source and facilitate suitable durable employment within their local job market. This service may include:
- Intensive job search activities with guidance
- Assistance applying for jobs (excluding resume and cover letter writing)
- Worker and Employer liaison (when not of an administrative nature)
- For WorkCover also includes placing a worker in a Recover at Work program with a view to a durable return to work outcome

There must be evidence of worker participation—for example a job search activity diary completed by the worker to demonstrate their commitment to the agreed job search goals.

The Fee is charged at an hourly rate (pro-rata) with the number of hours negotiated with the insurer.

For WorkCover, service can only be provided by a return to work services panel provider.

Job placement service – Work hardening (Item code 300213)

Provides practical one-on-one assistance and support to source and place a worker in a suitable temporary job placement matching their medical restrictions. This service would be appropriate where a worker is temporarily unable to return to their current employer due to their current medical restrictions. This service may include:
- Job search activities with guidance
- Worker and Employer liaison (when not of an administrative nature)
- For WorkCover also includes placing a worker in a Recover at Work program

There must be evidence of worker participation—for example a job search activity diary completed by the worker to demonstrate their commitment to the agreed job search goals.

The Fee is charged at an hourly rate (pro-rata) with the number of hours negotiated with the insurer.

For WorkCover, service can only be provided by a return to work services panel provider.

Gym and pool entry fees (Item code 300228)

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