WorkCover QUEENSLAND

Specialist supplementary services table of costs
Effective 1 April 2020

Service	Descriptor	Insurer prior approval required[1]	Item number	Fee – GST not included[2]
Communication				
Case conference	Relating to rehabilitation or treatment options	Yes	100159	$575.00 ^ per hour
Telecommunications – less than 10 mins	Telephone, secure e-mail, facsimile relating to rehabilitation or treatment options	No	100161	$95.00
Telecommunications – 11 to 20 mins	Telephone, secure e-mail, facsimile relating to rehabilitation or treatment options	No	100163	$190.00
Medical reports (see pages 3-6 for report conditions)				
Phone & fax report	Immediate	No	100801	$220.00
Completed form (2-3 questions)	Received by insurer within 10 working days Received by insurer after 10 working days	No	100808 100814	$138.00 $68.00
Comprehensive report	Received by insurer within 10 working days Received by insurer after 10 working days	At the request of the insurer	100150 100151	$688.00 $344.00
Progress report	Received by insurer within 10 working days Received by insurer after 10 working days		100806 100807	$415.00 $207.00
Short report	Received by insurer within 10 working days Received by insurer after 10 working days		100810 100811	$138.00 $68.00
ILO report	Received by insurer within 10 working days Received by insurer after 10 working days		100818 100819	$136.00 $67.00
Permanent Impairment (PI) Assessment	Received by insurer within 10 working days Received by insurer after 10 working days or if payment requested prior to supply of report	Yes	100802 100803	$825.00 $412.00
Independent Medical Examination (IME) report	Received by insurer within 10 working days Received by insurer after 10 working days or if payment requested prior to supply of report	At the request of the insurer	100211 100212	$688.00 $344.00
Complex Case Review	Specialist report based on review of medical information	At the request of the insurer	100815	$553.00 ^ per hour
Pre-consultation reading time (for PI & IME assessment and report)	Additional reading time: more than 30 minutes	Yes	100805	$536.00 ^ per hour
Consultations associated with a report	Consultant physician – initial consultation Consultant physician – subsequent consultation	No	100300 100301	$345.00 $158.00
	Specialist – initial consultation Specialist – subsequent consultation		100279 100293	$182.00 $97.00
	Psychiatrist – consultation between 45-75 mins Psychiatrist – consultation more than 75 mins		100296 100302	$430.00 $522.00
Telehealth consultations associated with a report	Psychiatrist – telehealth consultation between 45-75 mins Psychiatrist – telehealth consultation more than 75 mins	Yes	100369 100370	$430.00 $522.00
Interpreter	Additional fee for examination and report conducted with the assistance of an interpreter	No	100816	$182.00
Non-attendance / cancellation fee (for IME or PI assessment only)	Consultant physician – less than 48 hours (excluding non-working days) notice	No	100303	$345.00
	Specialist – less than 48 hours (excluding non-working days) notice		100304	$182.00
	Psychiatrist – less than 48 hours (excluding non-working days) notice		100305	$430.00

Service	Descriptor	Insurer prior approval required[1]	Item number	Fee – GST not included[2]
Ancillary Services				
Workplace Assessment	Relating to rehabilitation or treatment options	Yes	100157	$551.00 ^ per hour
Travel	Vehicle cost Travelling time per hour	No Yes	100809 100800	$0.78 / km $275.00 ^ per hour
Patient records	Application fee for the provision of patient records relating to the workers compensation claim including file notes; results of relevant tests	No No	100511 100514	$70.00 plus $0.32 per page
Specialist MRI Services meeting the service level standards				
Specialist MRI	MBS item codes 63491, 63494	No	100501	$90.00
Specialist MRI	MBS item codes 63010, 63040, 63334	No	100502	$672.00
Specialist MRI	MBS item codes 63043, 63151, 63154, 63161 - 63170, 63179 - 63185, 63461	No	100503	$717.00
Specialist MRI	MBS item codes 63301, 63304, 63307	No	100504	$762.00
Specialist MRI	MBS item codes 63001 - 63007, 63046 – 63073, 63322, 63340, 63361, 63391, 63401, 63404, 63416, 63425, 63428, 63440	No	100505	$806.00
Specialist MRI	MBS item codes 63201, 63204, 63219 – 63243, 63385, 63388	No	100506	$869.00
Specialist MRI	MBS item codes 63101, 63111, 63114, 63125, 63128, 63131, 63271 - 63280	No	100507	$986.00
Specialist MRI	MBS item codes 63173, 63176, 63325, 63328, 63331, 63337	No	100508	$717.00
Specialist MRI	MBS item codes 63464, 63467, 63487	No	100509	$1380.00
Specialist MRI	MBS item code 63473	No	100510	$1254.00

Specialist MRI Services must meet the following service level standards

1. The patient must be referred by a specialist.
2. Services are to be provided in DIAS-accredited diagnostic imaging practices.
3. Appointments within 3 working days (unless it is clinically not appropriate or additional services/preparation is required) from receiving a valid request for a workers' compensation patient with an open claim.
4. The report shall be comprehensive and will address all information requested by the referrer, required by the procedure and necessary for the interpretation of the results – see *RANZCR Standards of Practice for Clinical Radiology, V11, 5.5.1 Interpretation and Reporting the Result*.
5. The report shall be provided within 24 hours of the service, except in circumstances where additional radiology services or further clinical information is required.
6. If the provider, using their clinical judgement, determines that further scans are required, prior approval will be sought from the insurer.
7. Where the radiologist needs to clarify a referral, contact will be made with the referring practitioner.
8. Where the referring practitioner requires it, an electronic version of the report will be available
9. Radiologists to submit invoices and a copy of the report through electronic channels, if available.
10. Imaging examinations will be provided by radiologists who are registered as specialists in Diagnostic Radiology with AHPRA. 'Specialist MRI' services will be provided by radiologists who are registered with RANZCR as an MRI Radiologist and who participate in the MRI Quality and Accreditation Program which includes MRI specific CPD requirements – see *RANZCR, Standards of Practice for Clinical Radiology, V11, 13.2.4 CPD – MRI Radiologist*

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.
^ Hourly rates are to be charged pro-rata e.g. $47.92 per 5 mins

Service conditions

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

- **Approval for other services** – approval must be obtained for any service requiring prior approval from the insurer.
- **Payment**
  - All fees payable are listed in the *Supplementary services table of costs*. For services not outlined in the table of costs, prior approval from the insurer is required
  - Accounts for treatment must be sent to the insurer promptly, and within two (2) months after the treatment is completed.

Fees listed in the *Specialists - Supplementary services table of costs* have not included GST. The practitioner is responsible for incorporating any applicable GST on taxable services/supplies into the invoice. Refer to a taxation advisor or the Australian Taxation Office for assistance if required.

Item number descriptions and conditions

Item number	Descriptor
100159	**Case conference** Face-to-face or telephone communication involving the treating doctor, insurer and one or more of the following: GP, specialist, employer or employee representative, worker, allied health provider or other. **Prior approval is required by the insurer.**

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.

Communication

Item number	Descriptor
100161	**Communication** - **less than 10 mins** Communication between doctors and stakeholders (insurer, employer and rehabilitation providers) relating to rehabilitation, treatment or return to work options for the worker. Does not include calls of a general administrative nature or if party is unavailable.
100163	**Communication** - **11 mins to 20 mins** Communication between doctors and stakeholders (insurer, employer and rehabilitation providers) relating to rehabilitation, treatment or return to work options for the worker. Does not include calls of a general administrative nature or if party is unavailable.

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.

This item can be used for **approval of documents** provided by other health professionals and/or insurer e.g. suitable duties program transmitted by facsimile, secure email or submitted using online services.

All invoices must include names of involved parties and reasons for contact. Item will only be paid once regardless of multiple recipients to email/fax.

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

Valid communication – relates to treatment or rehabilitation of a specific worker involving any of the parties listed:

- the insurer
- the worker's treating medical practitioner/specialist
- the worker's allied health/rehabilitation provider
- the worker's employer.

Exclusions – the insurer will not pay for the following calls/emails/faxes:

- where the party phoned is unavailable
- to and from the worker
- about the referral e.g. acceptance and basic acknowledgement of accepting referrals
- of a general administrative nature
- made during the duration of a billable service—these are considered part of the consultation
- conveying non-specific information such as 'worker progressing well'
- provision of reports by faxing, secure email or online services (these are included in the report cost).

Medical reports

Generally there are two fees associated with written communication.
A full fee is payable if the form or report is received by the insurer within 10 working days.
A lesser fee is payable if the form or report is received by the insurer after 10 working days **or** if prepayment is requested.

- forms/reports must be received by insurer having being mailed/faxed/emailed/submitted using online services within the timeframe
- the 10 day timeframe begins from date of receipt of letter/request from insurer

Report essentials
All reports should contain the following information:

- worker's full name
- date of birth
- date of injury
- claim number
- diagnosis
- date first seen
- time period covered by the report
- contact details/signature and title of practitioner responsible for the report.

A report must be received by the insurer having been mailed/faxed/emailed/submitted using online services within the 10 day timeframe. This timeframe begins from date of receipt of the letter/request from the insurer or date of the initial consultation with the patient, whichever is the later.

Item number	Descriptor
100801	**Phone & fax report** Phone interview with insurer which includes the approval of the transcript faxed to the doctor by the insurer.

An insurer arranges a telephone interview with the doctor and during that conversation types up a transcript/report of the discussion and/or outcomes. The insurer will then fax the transcript to the doctor for their approval and signature before faxing back to the insurer.

Discussion should be brief and no longer than 20 mins. The fee for this report includes time spent in telecommunications.

Item number	Descriptor
100808	**Completed form received by the insurer within 10 working days** A form sent from the insurer by post/fax/email or online services
100814	**Completed form received by the insurer after 10 working days** A form sent from the insurer by post/fax/email or online services

The intent of this item is to obtain additional specific information for the management of the claim. Forms must be received by insurer having being mailed/faxed/emailed or submitted using online services within timeframe. The 10 day timeframe begins from date of receipt of letter/request from insurer. This item can be used for the development of a suitable duties plan or clarification of rehabilitation documentation and excludes the completion of Medical Certification per section 213(4) of the Workers' Compensation and Rehabilitation Act 2003.

Item number	Descriptor
100150 100151	**Comprehensive clinical report received by the insurer within 10 working days** **Comprehensive clinical report received by the insurer after 10 working days** See below for report expectations and descriptions. **At the request of the insurer only**
100806 100807	**Progress report received by the insurer within 10 working days** **Progress report received by the insurer after 10 working days** See below for report expectations and descriptions. **At the request of the insurer only**
100810 100811	**Short report received by the insurer within 10 working days** **Short report received by the insurer after 10 working days** See below for report expectations and descriptions. **At the request of the insurer only**
100818 100819	**ILO report received by the insurer within 10 working days** **ILO report received by the insurer after 10 working days** See below for report expectations and descriptions. **At the request of the insurer only**

Report types

Comprehensive:

- written response to insurer's request for further detailed information as outlined in a progress report
- information sought may include statement of attendance, diagnosis, investigations, prognosis, clarification of treatment and return to work goals
- may include clinical findings, summing-up and opinion helpful to insurer
- insurer questions may pertain phases of the claim e.g. establishment, ongoing management and return to work
- treating specialist opinion should be given outlining nature of the injury, capacity for work and advice on further management of case.

Progress:

- written response to insurer's request for specific information at a specific stage of the claim e.g. information about a specific line of treatment or progress for return to work
- only information subsequent to previous reports should be provided
- A progress report provides information on the worker's functional/psychosocial progress towards recovery and/or return to work (RTW). It is appropriate to use this report where the worker is progressing toward treatment/RTW goals or where minor changes to their program are required.
- A progress report may also be appropriate where the goals of a worker's program has altered or changed substantially, such that the original goal or treatment approach is no longer appropriate. This report would be used when re-examination of the worker is not a pre-requisite for the preparation of the report and the report is based on a transcription of existing clinical records, relates to the status of the claim and comprises a clinical/professional opinion, statement or response to specific questions.

Short:
- written responses to insurer's very limited number of questions (2 or 3) seeking further information about the worker's condition at a specific stage of the claim
- provides relevant information about the worker's compensable injury
- may be used for conveying brief information that relates to simple injuries.

ILO:
- Chest x-ray review and associated ILO report.
- Performed in accordance with ILO Classification Guidelines by a single qualified (NIOSH accredited) B-reader

Assessment of Permanent Impairment (PI)

Item number	Descriptor
100802 100803	**Permanent Impairment (PI) Assessment –** **Permanent Impairment (PI) report received by the insurer within 10 working days** **Permanent Impairment (PI) report received by the insurer after 10 working days** A thorough written response to the insurer's request for examination and report assessing permanent impairment (PI) using: For Injuries on or after 15 October 2013: • *Guidelines for Evaluation of Permanent Impairment (GEPI), 2nd Edition:* • *American Medical Association Guides 5th Edition* (AMA5); and • in the approved form (form available at www.workcoverqld.com.au) For Injuries before 15 October 2013: • *American Medical Association Guides 4th Edition* • the *Table of injuries schedule* 2 *(Workers' Compensation and Rehabilitation Regulation 2003 s92)* • using the endorsed template for reporting PI (template available at www.worksafe.qld.gov.au). **At the request of the insurer only**

A report for permanent impairment (PI) is requested by an insurer in order to finalise a claim. For injuries on or after 15 October 2013, the PI assessment is required to be done in accordance with GEPI (2nd Edition) and AMA5. WorkCover Queensland has created a template to assist doctors to complete the assessment in accordance with GEPI which can be found at workcoverqld.com.au. If the report does not comply with the approved form, the insurer may request further details before payment is processed.

For injuries before 15 October 2013, the PI assessment is required to be undertaken using AMA4 and the Table of injuries. The regulator has created a template for clear, concise reporting of all appropriate aspects of assessing PI and strongly recommends that doctors adhere to this format. Further information about assessing PI as well as the template can be found at the www.worksafe.qld.gov.au.

When reporting for PI, doctors are able to charge the following:
- a consultation fee
- the PI report fee
- a fee for file reading time **after** 30 mins (any reading time up to 30 mins is included in the PI report fee).

N.B. If the injury is not stable and stationary, the doctors can charge the following:
- a consultation fee
- the IME report fee (see 100211 or 100212)
- a fee for file reading time **after** 30 mins (any reading time up to 30 mins is included in the IME report fee).

Independent Medical Examination (IME) report

Item number	Descriptor
100211	**Independent Medical Examination (IME) report received by the insurer within 10 working days** A written response to the insurer's request for an independent medical examination and report. **At the request of the insurer only**
100212	**Independent Medical Examination (IME) report received by the insurer after 10 working days** A written response to the insurer's request for an independent examination and report **At the request of the insurer only**

An Independent Medical Examination (IME) is a report requested by the insurer for a patient that has not previously been a patient of that doctor.

When reporting for IME's doctors are able to charge the following:
- a consultation fee
- the IME report fee
- a fee for file reading time **after** 30 mins (any reading time up to 30 mins is included in the IME report fee).

The report should contain:
- medical summary of case
- clinical findings
- medical opinion on aspects of the case as requested by insurer.

The insurers may ask the following questions:
- claim details e.g. establishment, ongoing management and return to work
- statement of attendance
- history diagnosis
- investigations
- prognosis
- clarification of treatment
- return to work goals.

Treating specialist opinion should be given outlining:
- nature of the injury
- capacity for work
- advice on further management of case.

N.B. If the requested IME report includes a PI assessment it should be paid at the applicable PI rate e.g. item numbers 100802 or 100803.

Item number	Descriptor
100805	**Pre-consultation reading time (association with a PI report)** Additional reading time that is for more than 30 mins **Prior approval is required by the insurer.**

The pre-reading item number is for reading time that is longer than 30 mins. The reading time covers reading of material provided by the insurer and reading in preparation for a consultation for an Independent Medical Examination (IME) or a Permanent Impairment (PI) assessment. Administrative tasks such as printing of claim documentation is excluded.

Reading of up to 30 mins is included in the report fee.

Complex Case Review

Item number	Descriptor
100815	**Review of File.** Provide advice and guidance of an injured worker's claim for complex and unusual medical conditions by a review of the medical information available. **At the request of the Insurer.**

Consultations associated with a report

Item number	Descriptor
100300 100301	**Consultant Physician – initial consultation** **Consultant Physician – subsequent consultation** Consultation(s) specifically for IME or PI appointments.
100279 100293	**Specialist – initial consultation** **Specialist – subsequent consultation** Consultation(s) specifically for IME or PI appointments.
100296 100302	**Psychiatrist – consultation between 45-75 mins** **Psychiatrist – consultation more than 75 mins** Consultation(s) specifically for IME or appointments.

All consultation descriptions and conditions of service are outlined in the MBS under the following item numbers:

100300 is equivalent to MBS item 110
100301 is equivalent to MBS item 116
100279 is equivalent to MBS item 104
100293 is equivalent to MBS item 105
100296 is equivalent to MBS item 306
100302 is equivalent to MBS item 308

To be eligible for recognition as a **specialist**, you should:

• be registered with the AHPRA to practise as a specialist in the relevant specialty or hold Fellowship and status as a Fellow of the relevant Australasian Specialist Medical College in the specialty. Recognition can only be granted for those medical specialties listed in Schedule 4 of the Health Insurance Regulations.

To be eligible for recognition as a **consultant physician**, you should:

• be registered with the AHPRA to practise as a specialist in a sub-speciality of general medicine, psychiatry or rehabilitation medicine. Recognised sub-specialties general medicine are listed in Schedule 4 of the Health Insurance Regulations, or
• hold Fellowship of the Royal Australasian College of Physicians or Fellowship of the Royal Australian and New Zealand College of Psychiatrists and have status as a Fellow of the relevant College in relation to the specialty.

Schedule 4 of the Health Insurance Regulations is available at www.comlaw.gov.au

Telehealth consultations associated with a report

Item number	Descriptor
100369 100370	**Psychiatrist – telehealth consultation between 45-75 mins** **Psychiatrist – telehealth consultation more than 75 mins** Consultation(s) specifically for IME appointments.

Telehealth consultation that complies with the same MBS rules outlined in item codes 369 and 370 (see para A48 of explanatory notes in this category). The conditions of service are detailed in para A48 of explanatory notes in the telepsychiatry category.

Providers are to comply with the International Telecommunications Union Standards which cover all types of videoconferencing.

Interpreter associated with preparing a report

Item number	Descriptor
100816	**Interpreter** Additional fee for examination and report conducted with the assistance of an interpreter

This fee is payable in addition to the above consultation fees when additional time is required to conduct the examination and report due to the additional assistance of an interpreter.

Non-attendance / cancellation fee

Item number	Descriptor
100303	**Consultant Physician – less than 48 hours (excluding non-working days) notice** Non-attendance and/or cancellation for insurer arranged appointments for IME or PI assessment. **Insurer must be notified of non-attendance and/or cancellation.**
100304	**Specialist – less than 48 hours (excluding non-working days) notice** Non-attendance and/or cancellation for insurer arranged appointments for IME or PI assessment. **Insurer must be notified of non-attendance and/or cancellation.**
100305	**Psychiatrist – less than 48 hours (excluding non-working days) notice** Non-attendance and/or cancellation for insurer arranged appointments for IME or PI assessment. **Insurer must be notified of non-attendance and/or cancellation.**

Fee payable only:

- when insurer-arranged appointment for Independent Medical Examination (IME) or Permanent Impairment (PI) assessment is cancelled or not kept
- when insurer or injured worker does not provide notice of cancellation or fails to attend a prescheduled appointment inside the timeframe above (excluding weekends and public holidays).

Ancillary services

Item number	Descriptor
100157	**Workplace assessment** Assessment relating to rehabilitation or treatment options that involves a work site visit.

Workplace assessment involves attending the workplace to assess aspects of the injured worker's job or environment. Item can be used in connection with the planning and/or implementation of a rehabilitation plan.

Item number	Descriptor
100809 100800	**Travel** **Vehicle cost – rate per km travelled** **Travelling time per hour** Travel time will only be paid where the medical practitioner is required to leave their normal place of practice to provide a service to a worker at their place of residence or the workplace. **Prior approval is required by the insurer if more than 1 hour return trip.**

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.

Exclusions

Travel may not be charged when:

- travelling between one site or another if the practitioner' 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.

Item number	Descriptor
100511	**Patient Records** Application fee for the provision of patient records relating to the workers compensation claim including file notes; results of relevant tests eg. Pathology, diagnostic imaging and reports
100514	**Patient Records** Processing fee per page of records provided

The fee is payable upon request from the insurer for copies of patient records relating to the workers' compensation claim.

Specialist MRI services

Item number	Descriptor
100501	**Specialist MRI** MBS item codes 63491, 63494
100502	**Specialist MRI** MBS item codes 63010, 63040, 63334
100503	**Specialist MRI** MBS item codes 63043, 63151, 63154, 63161 - 63170, 63179 - 63185, 63461
100504	**Specialist MRI** MBS item codes 63301, 63304, 63307
100505	**Specialist MRI** MBS item codes 63001 - 63007, 63046 – 63073, 63322, 63340, 63361, 63391, 63401, 63404, 63416, 63425, 63428, 63440
100506	**Specialist MRI** MBS item codes 63201, 63204, 63219 – 63243, 63385, 63388
100507	**Specialist MRI** MBS item codes 63101, 63111, 63114, 63125, 63128, 63131, 63271 - 63280
100508	**Specialist MRI** MBS item codes 63173, 63176, 63325, 63328, 63331, 63337
100509	**Specialist MRI** MBS item codes 63464, 63467, 63487
100510	**Specialist MRI** MBS item code 63473

Radiologists who meet the following service level standards will be able to bill at these rates:

1. Appointments within 3 working days (unless it is clinically not appropriate or additional services are required) from receiving a valid request for a workers' compensation patient with an open claim.
   - Workers' compensation patients to be examined within three working days of the imaging provider receiving a valid request which is already pre-approved for payment by the insurer.
   - Some patients may not be accommodated within three working days, such as some interventional procedures which require additional expertise and access to operating suites. Patients requesting these services will be given priority by providers, and accommodated within a maximum seven days.
   - Services will be delayed where it is clinically appropriate to do so.
2. The report shall be comprehensive and address mechanism of injury (if provided on the referral), pre-existing conditions and all information requested by the referrer, required by the procedure and necessary for the interpretation of the results – see *RANZCR Standards of Practice for Clinical Radiology, V11, 5.5.1 Interpretation and Reporting the Result.*
3. If the Provider, using their clinical judgement, determines that further scans are required, prior approval will be sought from the insurer.
4. Where the radiologist needs to clarify a referral, contact will be made with the referring practitioner.
5. Where the referring practitioner requires it, an electronic version of the report will be available.
   - The current standard of care for diagnostic imaging in Queensland is delivery of images and the report to the referrer by electronic transfer.
   - NOTE: To ensure consistent service delivery the imaging provider maintains a record of the referring clinician's report and image delivery preference. When patients are referred on for tertiary care/assessment the clinician may need to contact the provider to obtain reports/images in their preferred format.
   - To accommodate the needs of specific referrers and treating specialists for workers' compensation patients, providers to make available any or all of the following image formats on request:
     - CD-ROM, web delivery in JPEG or DICOM format, film or other hard copy.
   - To accommodate the needs of specific referrers for WQ patients, providers to make available any or all of the following report formats on request:
     - Fax, electronic delivery, paper.
   - Providers commit to deliver images and reports to referrers and treating specialists promptly upon request:
     - For digital formats, to be delivered within two working days of the examination unless additional work is required, such as consultation with another radiologist or comparison with earlier images. When urgent/same day delivery is necessary it should be pre-arranged with the provided.
     - For hard copy formats, delivery time will depend on the means of delivery.
6. Radiologists to submit invoices and a copy of the report through electronic channels.
7. Payee can only be a provider of radiological services.
8. Imaging examinations will be provided by radiologists who are registered as specialists in Diagnostic Radiology with AHPRA. 'Specialist MRI' services will be provided by radiologists who are registered with RANZCR as an MRI Radiologist and who participate in the MRI Quality and Accreditation Program which includes MRI specific CPD requirements – see *RANZCR, Standards of Practice for Clinical Radiology, V11, 13.2.4 CPD – MRI Radiologist*

Assistance

Contact the relevant insurer for claim related information such as:

- payment of invoices and account inquiries
- claim numbers/status
- rehabilitation status.

For general advice about the tables of costs visit www.worksafe.qld.gov.au or call 1300 362 128.