WorkCover QUEENSLAND

Support Services table of costs

Effective 1 July 2019

Service	Descriptor	Insurer prior approval required[1]	Item number	Fee – GST not included[2]
Ambulance Transport - Non QAS - Initial Transportation	Transport provided immediately after the injury is sustained.	No	300309	By negotiation
Ambulance Transport - Non QAS - Subsequent Transportation	Subsequent transport must be certified in writing by a doctor as necessary because of the worker's physical condition resulting from a compensable injury.	No	300310	By negotiation
Dietary Assessment	Consultation to evaluate dietary issues and objective tests to formulate an intervention plan focused on a return to work goal. Prior approval required before providing service.	Yes	300190	$111 ^ per session
Personal Care Assistance	Provided through an agency - includes services for injury/wound care, personal hygiene and grooming etc. where the worker is living at home and has been assessed as incapable (for physical, cognitive or emotional reasons) of undertaking these tasks and has no family or other social support network. Prior approval required before providing service. Day rate: $49.00/hour. Weekend rate: $71.00/hour.	Yes	300198	$49 ^ per hour Weekend - $71 ^ per hour
Diversional Therapy Program	Provided by a Diversional Therapist at a nursing home including therapeutic activities. Prior approval required before providing service.	Yes	300200	$44 ^ per hour

Domestic Assistance	Provided through an agency - includes cleaning, shopping and washing etc. where the worker is living at home and has been assessed as incapable (for physical, cognitive or emotional reasons) of undertaking these tasks and has no family or other social support network.	Yes	300201	$41 ^ per hour
Literacy Skills	Private tutoring by a qualified tutor to improve literacy skills for job placement prospects.	Yes	300202	Local TAFE fees
Communication	Direct communication between treating practitioners and insurer, employer, insurer referred allied health practitioner and doctors to assist with faster and more effective rehabilitation and return to work for a worker. Excludes communication of a general administrative nature or with a worker. Must be more than 3 minutes and is to be billed in 10 minute increments. Consult list of exclusions before using.	No	300079	$30 ^ per ten minute increment
Progress Report	A written report providing a brief summary of the worker's progress towards recovery and return to work.	At the request of the insurer	300086	$61

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

[1] Where prior approval is indicated the practitioner must seek approval from the insurer before providing services
[2] Rates do not include GST. Check with the Australian Taxation Office if GST should be included. See https://www.ato.gov.au/Business/GST/In-detail/Your-industry/GST-and-health/
^ Hourly rates are to be charged pro-rata

Service conditions

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

- **Assessment** – the practitioner is expected to assess the needs of the worker against the referral requirements and notify the insurer of the outcome and future treatment goals.
- **Provider management plan** – this form is available on the Workers' Compensation Regulator's website (www.worksafe.qld.gov.au) and is to be completed if treatment is required after any pre-approved sessions or any services where prior approval is required. An insurer may require the Provider management plan to be provided either verbally or in written format. (Check with each insurer as to their individual requirements). The insurer will not pay for the preparation or completion of a Provider management plan.
- **Approval for other services or sessions** – approval must be obtained for any service requiring prior approval from the insurer before commencing treatment.
- **Payment of treatment** – all fees payable are listed in the *Support services table of costs*. For services not outlined in the table of costs, prior approval from the insurer is required.
- **Treatment period** – treatment will be deemed to have ended if there is no treatment for a period of two (2) calendar months. After this a Provider management plan needs to be submitted for further treatment to be provided. (The worker must also obtain another referral).
- **End of treatment** – all payment for treatment ends where there is either no further medical certification, the presenting condition has been resolved, the insurer finalises/ceases the claim, the worker is not complying with treatment or the worker has achieved maximum function.
- **Change of provider** – the insurer will pay for another initial consultation by a new provider if the worker has changed providers (not within the same practice). The new provider will be required to submit a Provider management plan for further treatment outlining the number of sessions the worker has received previously.

Telehealth services

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

The following should be considered prior to delivering the service:

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

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

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

Ambulance transport (non-QAS) (Item code 300309, 300310)

Definition – under Section 219 of the *Workers' Compensation and Rehabilitation Act 2003*, ambulance transportation is defined as:

- transportation, irrespective of distance, first provided immediately after the injury is sustained. Transportation must be from the place where the injury is sustained to a place where appropriate medical treatment is available to seek the treatment.
- transportation, irrespective of distance, subsequently provided. There must be certification in writing by a doctor stating such transportation is necessary because of the worker's physical condition resulting from the injury.

All insurers must pay the cost of transportation provided by services other than the Queensland Ambulance Service e.g. the Royal Flying Doctor Service.

Note: insurers are not required to pay for Queensland Ambulance Services (QAS) transportation—payment is covered under a worker's compensation grant.

Dietary consultation (Item code 300190)

Services must be provided by a person with a tertiary degree in dietetics.

A consultation may include all or some of the following elements:

- **Subjective (history) reporting** – consider major symptoms and lifestyle dysfunction; current and past history and treatment; aggravating and relieving factors; general health, medication and risk factors.
- **Objective assessment** – where appropriate, use standardised outcome measurements to provide a baseline prior to commencing treatment.
- **Assessment results (prognosis formulation)** – provide provisional prognosis for treatment, limitations to function and progress for return to work • **Treatment (intervention)** – formulate and discuss the treatment goals and expected outcomes with the worker; goal setting; strategies to improve return to work with the worker. Advise the worker on self-management strategies.
- **Reassessment (subjective and objective)** – evaluate the progress of the worker using outcome measures that are relevant, reliable and sensitive. Compare against the baseline measures. Identify factors compromising outcomes.
- **Clinical records** – record information in the worker's clinical records, including the purpose and results of procedures and tests.
- **Communication (with the referrer)** – communicate any relevant information for the worker's rehabilitation to the insurer. Acknowledge referral and liaise with the treating medical practitioner about treatment.

Diversional therapy (item code 300200)

Services must be provided by a person with a minimum of an Associate Diploma in diversional therapy. (The service should only be used under the supervision of an Occupational Therapist, who has recommended therapeutic activities as part of the overall treatment program).

Domestic assistance (Item code 300201)

Services must be provided by a person who is provided through an agency.

This is restricted to where the worker:

- is living at home
- was assessed by an Occupational Therapist as incapable of undertaking these tasks
- has no family or other social support network

Note: weekend and public holiday rates may be negotiated with the insurer.

Tutoring (Item code 300202)

Item number	Descriptor
300202	**Literacy skills** Private tutoring by a qualified tutor to improve literacy skills for job placement prospects. **Prior approval is required by the insurer**

Program should be limited to achieving a base level of competency—four (4) to six (6) weeks. Typically literacy services are provided through the local TAFE or appropriately qualified private literacy services.

Communication (Item codes 300079)

Used by **treating practitioners** for direct communication between a practitioner and any of the following: insurer, employer and/or treating medical or insurer appointed allied health provider to provide detailed information to facilitate faster, safer and more effective rehabilitation and return to work program for a specific worker. The communication should be **relevant** to the compensable injury and assist the insurer and other involved parties to resolve barriers and/or agree to strategies or intervention/s proposed. Communication includes phone calls, emails and facsimiles.

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

The insurer will not pay for:

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

Supporting documentation is required for all invoices that include communication. Invoices must include the reason for contact, names of involved parties and will only be paid once, regardless of the number of recipients of the call/email/fax. Line items on an invoice will be declined if the comments on the invoice indicate that the communication was for reasons that are specifically excluded.

If part of the conversation would be excluded, the practitioner can still invoice the insurer for the communication if the rest of the conversation is valid. The comments on the invoice should reflect the valid communication. Providing comments on an invoice that indicates that the communication was specifically excluded could lead to that line item being declined by the insurer.

Reports (Item code 300086, 300088, 300090)

A report should be provided only following a request from the insurer or where the practitioner has spoken with the insurer and both parties agree that the worker's status should be documented. Generally, a report will not be required where the information has previously been provided to the insurer.

The practitioner should ensure:

- the report intent is clarified with the referrer
- reports address the specific questions posed by the insurer
- all reports relate to the worker's status for the compensable injury
- the report communicates the worker's progress or otherwise
- all reports are received by the insurer within ten (10) working days from when the practitioner received request

In general, reports delayed longer than three (3) weeks are of little use to the insurer and will not be paid for without prior approval from the insurer.

All reports include:

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

Clinical reports

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

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

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

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

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.