WorkCover QUEENSLAND

Private Hospital Services Table of Costs

Effective 1 December 2022

WorkCover QUEENSLAND

Contents

Private Hospital Services Table of Costs

How to use this table of costs

This table of costs contains information on services and maximum fees that apply to private hospitals that provide services to workers who are managed under the Queensland workers' compensation scheme.

All services and fees in this schedule are effective 1 December 2022.

Invoicing and service provision is actively monitored to ensure services are invoiced in accordance with this fee schedule and that services are reasonable for the work injury and payable under the *Workers' Compensation and Rehabilitation Act 2003*.

This schedule contains the following:

1. Same day accommodation including:
    a. Accident and emergency attendance and
    b. Cast technician
2. Overnight accommodation
3. Theatre fees
4. Special access robotics
5. Prostheses
6. Provision of health records
7. Assistive Devices/Independent Living Aids
8. Hospital in the Home (HITH)
9. Rehabilitation in the Home (RITH)
10. Mental health programs
11. Rehabilitation programs
12. Pain management programs
13. Alcohol and other drugs programs
14. Haematology and oncology.

If you have any questions, please contact the relevant workers' compensation insurer. Contact details for the relevant self-insurer can be found on our website.

Annual review

This table of costs will have a pricing review undertaken annually, effective on the anniversary date of this document i.e., 1 December.

Insurer liability - accepted injuries only

The relevant workers' compensation insurer will only fund treatment in relation to accepted injuries. If you are unsure what injuries have been accepted, please contact the relevant insurer for clarification.

Prior approval for any elective hospitalisation **must** be obtained from the insurer **prior** to the patient admission.

Working electronically

When working with WorkCover Queensland we encourage you to submit invoices electronically via Provider Connect; business to business software integration or via the document submission portal on our website. This will ensure:

- a significant reduction in invoice administration
- improved invoice tracking capability
- faster payments.

Other workers' compensation insurers may have alternative arrangements for invoicing. Please contact the relevant insurer to confirm. Contact details for the relevant self-insurer can be found on our website.

GST

Rates within this document do **not** include GST. Check with the Australian Taxation Office or your tax advisor if GST is applicable.

Fee schedule

Effective 1 December 2022, the insurer will pay up to a maximum amount for the categories of services contained within this document. This fee schedule applies to treatment or services provided at a private hospital or at any rehabilitation centre conducted by such hospital.

Same-day accommodation (daily)

Stand-alone day surgery facilities will be paid using the same-day services table.

Prior approval for any elective hospitalisation must be obtained from the insurer prior to the patient admission.

Accident and emergency (A&E) attendance for the immediate treatment of a work-related injury is not considered to be an elective hospitalisation. However, payment of expenses associated with an A&E attendance will only be paid where there is an accepted claim for the relevant injury treated.

ITEM NO.	CATEGORY	DESCRIPTION[1]	GST EXCLUSIVE AMOUNT
400501	Band 1	Gastrointestinal endoscopies, certain minor surgical items, and nonsurgical procedures (as per the current rules) that do not normally require anaesthetic.	$496
400502	Band 2	Procedures (other than Band 1) carried out under local anaesthetic, no sedation.	$556
400503	Band 3	Procedures (other than Band 1) carried out under general or regional anaesthesia or intravenous sedation. Theatre time less than 1 hour.	$599
400504	Band 4	Procedures (other than Band 1) carried out under general or regional anaesthesia or intravenous sedation. Theatre time 1 hour or more.	$667
400500	Day Surgery Type C	Procedures that do not normally require hospital treatment. Type C procedures are defined by the relevant MBS items (Part 3 Clause 8).	$450
400599	A&E (non-admitted)	Only to be used for an accident and emergency attendance where the patient is **not admitted**. Not be used in conjunction with any other banded rate. Can be used for community/outreach services for a non-admitted patient.	$207

Cast Technician

Only to be used when a cast technician provides a service where the patient is **not admitted**. Can **only** be used on combination with 400599 – A&E (non-admitted). Services provided whilst the worker is an inpatient are not billable. A cast technician fee and associated incidental charges can only be billed if the treating technician holds a Certificate IV in Cast Technology (HLT41412 or HLT41407), only if issued prior to 13 June 2017 or a Diploma of Orthopaedic Technology (HLT57821).

[1] Private Health Insurance (Benefit Requirement) Rules 2011 – Schedule 3 – Same day accommodation

ITEM NO.	DESCRIPTION	GST EXCLUSIVE AMOUNT
400505	Cast Technician – Consultation	$101
400506	Cast Technician – Incidentals	
	- Short Arm	$46
	- Long Arm	$93
	- Short Leg	$54
	- Long Leg	$160

Additional costs during admission

All specialist consultations, allied health services or diagnostic (including pathology) investigations completed during a same-day admission are to be invoiced as per the relevant table of costs by the relevant service provider. This is inclusive of accident and emergency attendance where the patient is not admitted. Further information regarding the scheduled fees payable on a workers' compensation claim can be found on our website.

Overnight accommodation (daily fee)

Approval for any elective hospitalisation must be obtained from the insurer prior to the patient admission.

The admission must be:

- required as a result of the work-related injury or illness
- reasonable, necessary, or appropriate in the circumstances
- clinically justified, safe and effective.

ITEM NO.	CATEGORY [2]	DESCRIPTION	GST EXCLUSIVE AMOUNT
400510	Advanced Surgical Patients	1-14 days	$1,185
400511		Over 14 days	$946
400512	General Surgical Patients	1-14 days	$1,062
400513		Over 14 days	$848
400514	Medical Patients	1-14 days	$1,027
400515		Over 14 days	$820
400586	Intensive Care Service [3]	Level A	$4,229
400587		Level B	$3,209
400588		Level C	$2,150
400598	Coronary Care Unit	per day rate	$2,600
400520	Clinically required private or single room (prior approval from insurer required*)		$71

In order for intensive care services to be billed the level of patient care must align to the Clinical Standard Capability Framework (CSCF) Intensive Care Services (Queensland Health), levels 4, 5 or 6.

[2] Private Health Insurance (Benefit Requirements) Rules 2011
[3] Clinical Standard Capability Framework (CSCF) Intensive Care Services (Queensland Health)

Request for private or single rooms

Private or single rooms are allocated based on **clinical need** and detailed clinical justification must be provided to the insurer for **prior approval**.

Where a worker requests a private or single room, the insurer will not be responsible for or accept any additional fee or surcharge.

Additional costs during admission

All specialist consultations, allied health services or diagnostic (including pathology) investigations completed during an overnight admission are to be invoiced as per the relevant table of costs by the relevant service provider. Further information regarding the scheduled fees payable on a workers' compensation claim can be found on our website.

Theatre fees

As per the National Procedure Banding List, services in this section will be determined in accordance with the National Procedure Banding List, current at the time of service.

In circumstances where the National Procedure Banding List does not specify a band, hospital providers should contact the relevant insurer regarding a procedure fee.

Further guidance on consumables can be found within this document under 'Explanatory Notes – Theatre fees'.

ITEM NO.	CATEGORY	GST EXCLUSIVE AMOUNT
400550	Band 1A	$415
400551	Band 1	$613
400552	Band 2	$900
400553	Band 3	$1,191
400554	Band 4	$1,504
400555	Band 5	$1,883
400556	Band 6	$2,313
400557	Band 7	$3,355
400558	Band 8	$4,280
400559	Band 9A	$4,545
400560	Band 9	$5,758
400561	Band 10	$6,854
400562	Band 11	$8,095
400563	Band 12	$9,674
400564	Band 13	$11,891

Multiple services

Where more than one service[4] is provided in a single theatre session, the theatre charge is:

a) 100% of the service with the highest theatre charge plus
b) 50% of the service with the next highest theatre charge plus
c) 25% of each of the other services provided.

Additional costs during admission

All specialist consultations, surgical assistant charges, allied health services or diagnostic (including pathology) investigations completed during a surgical admission are to be invoiced as per the relevant table of costs by the relevant service provider. Further information regarding the scheduled fees payable on a workers' compensation claim can be found on our website.

Special access robotic devices

Only in exceptional circumstances will additional fees be paid for special access robotic devices. Detailed clinical evidence (e.g., letter outlining the justification of use and applicable fees) from the hospital that the item is reasonably necessary for the appropriate management and treatment of the work-related injury will be required. **Prior approval** must be provided, in writing, by the insurer. In circumstances where the insurer has given prior approval for the billing of special access robotic devices, item code **400507** is to be used.

Exigent clinical circumstance

Where exigent clinical circumstances exist and special access robotic devices are required immediately to enable the provision of lifesaving treatment, prior approval from the insurer is **not required**. The insurer may request clinical justification to understand the need for the special access robotic device/s in these circumstances.

[4] Medical Benefits Schedule

Prostheses

ITEM NO.	CATEGORY	DESCRIPTION	GST EXCLUSIVE AMOUNT
400521	Prostheses	As per Department of Health benefit	
400522	Handling Fee	5% of prosthesis fee capped at $198 (per prosthetic device)	

All invoicing for prostheses needs to include the relevant Department of Health Prostheses List billing code.

For items which may be **removed** from the prostheses list as part of the staged federal Department of Health Prostheses List reforms, reimbursement for use of these items is subject to pre-approval from the insurer. The insurer may request clinical justification to understand the use of the removed item in these circumstances. The request must also be accompanied by a supplier quote/invoice.

Prostheses that are opened during procedures and not used will not be paid for unless there are **valid clinical circumstances** preventing successful implantation of such prostheses. All prostheses paid will need to be supported by the operation record and/or prosthetic stickers on the nurse's Intraoperative Report/Count Record/Implant Record or by a submission from the treating specialist detailing the clinical circumstances that prevented the successful implantation of the initial prosthesis.

Insurers may request a copy of the nurse's Intraoperative Report/Count Record/Implant Record relating to workers' compensation admissions from time to time.

Provision of health records (**at insurer request only**)

Patient health records refer to all records relating to the workers' compensation claim including file notes, results of relevant tests and operation notes.

ITEM NO.	DESCRIPTION	GST EXCLUSIVE AMOUNT
400591	Application fee for patient health records	$72
400594	Copying charge for patient health records – per page	$0.33

The insurer prefers the provision of patient health records in an electronic format. Hard copies of patient health records will only be accepted where records are not electronically maintained.

Patient health records are to be provided within **fourteen (14) days of request**.

Temporary assistive devices*

* Also referred to as temporary mobility aids or temporary independent living aids

ITEM NO.	CATEGORY	DESCRIPTION	GST EXCLUSIVE AMOUNT
400508	Temporary Assistive Device	Includes but not limited to the hire of crutches, braces, wheelchairs, toilet seats	Reasonable relevant hire charge

All invoicing for the hire/supply of temporary assistive devices needs to include specifics of the item and the hire term.

Only temporary assistive devices provided at **discharge** may be charged separately and must be billed using item code **400508**. The insurer will only fund temporary assistive devices provided at discharge that relate to the hospital admission.

Hospital in the Home (HITH)

Hospital in the Home (HITH) services are to be billed as per the relevant Medical and/or Allied Health Table of Costs. All of the relevant Table of Costs can be located here.

Rehabilitation in the Home (RITH)

Rehabilitation in the Home (RITH) services are to be billed as per the relevant Medical and/or Allied Health Table of Costs. All of the relevant Table of Costs can be located here.

Mental health programs (daily fee)

Approval for any elective hospitalisation must be obtained from the insurer prior to the patient admission. Requests must be made using the 'Request for Specialised Program' form (FM303).

ITEM NO.	CATEGORY	DESCRIPTION	GST EXCLUSIVE AMOUNT
400565	Inpatient admission	Inpatient admission for mental health program (per day)	$982 Requires insurer pre-approval
400567	Day patient	Full day patient (at least 4.5hrs duration) for mental health program (per day)	$700 Requires insurer pre-approval
400509		Half (1/2) day (at least 2.5hrs duration) patient for mental health program (per day)	$400 Requires insurer pre-approval

Inpatient admission – service provision

Specialised overnight admitted patient mental health care (also referred to as specialised psychiatric care) takes place within a designated mental health ward/unit, which is staffed by a health professional with specialist mental health qualifications or training, and have as their principal function, the treatment and care of patients affected by mental illness[5].

The program is managed by a multi-disciplinary team including a medical director and consultant psychiatrist (i.e., Fellow of the Royal Australian and New Zealand College of Psychiatrists). They are defined programs with targeted service provision. Specific outcome goals are to be clearly defined and measured during admission. The program includes physiotherapy, occupational therapy, clinical psychology, group education sessions, graded gym sessions, relaxation sessions, case conferences, and discharge planning.

Additional costs during admission

All specialist consultations or diagnostic (including pathology) investigations completed during an inpatient admission are to be invoiced as per the relevant table of costs by the relevant service provider. Further information regarding the scheduled fees payable on a workers' compensation claim can be found on our website.

Mental health treatments

Electroconvulsive Therapy (ECT)

Any ECT service delivered is to be invoiced as per:

- item number **14224** referenced within the Medical Items Table of Costs,
- the appropriate banded rate reflecting the level of sedation required to administer the ECT treatment (e.g., less than 1 hour or greater than 1 hour), and
- the appropriate accommodation charge (for overnight admissions only).

ECT is to be administered as per the recommended Queensland Health guideline.

[5] Australian Institute of Health and Welfare - Mental health services in Australia

Repetitive Transcranial Magnetic Stimulation (rTMS)

Any rTMS service delivered is to be invoiced as per:

- either of the following item numbers referenced within the Medical Items Table of Costs:
  - **14216**
  - **14217**
  - **14219**
  - **14220**
- the appropriate banded rate reflecting the level of sedation required to administer the rTMS treatment, and
- the appropriate accommodation charge (for overnight admissions only).

Day patient – service provision

A day patient program is usually available to provide ongoing support and care to patients after discharge from treatment as inpatients or in circumstances where an inpatient admission has not been possible/available. It is managed by a multi-disciplinary team of healthcare professionals and is ***tailored*** to the individual needs of the patient. It can include specialised therapy modules including cognitive behavioural therapy, relaxation, coping skills, and anxiety management. A day patient program should include a gradual return to work focus.

Patient outcome data

Insurers may request a copy of the patient outcome data relating to workers' compensation admissions for mental health programs from time to time.

Rehabilitation programs (daily fee)

Approval for any elective hospitalisation must be obtained from the insurer prior to the patient admission. Requests must be made using the 'Request for Specialised Program' form (FM303).

ITEM NO.	CATEGORY	DESCRIPTION	GST EXCLUSIVE AMOUNT
400569	Inpatient admission	Inpatient admission for rehabilitation program (per day)	$992 Requires insurer pre-approval
400571	Day patient	Full day (at least 3hrs duration) patient for rehabilitation program (per day)	$700 Requires insurer pre-approval
400516		Half (1/2) day (at least 1.5hrs duration) patient for rehabilitation program (per day)	$400 Requires insurer pre-approval

Inpatient admission – service provision

Rehabilitation programs involve referral and assessment by the coordinator of the program. The assessment is undertaken by a rehabilitation physician (i.e., Fellow of the Australasian Faculty of Rehabilitation Medicine, The Royal Australasian College of Physicians). In addition, the rehabilitation physician will oversee the patient's participation in the program. They are defined programs with targeted service provision. Specific outcome goals are to be clearly defined and measured during admission. The program includes physiotherapy, aquatic therapy, occupational therapy, psychology (as appropriate), speech therapy (if relevant), case conferences, and discharge planning.

Additional costs during admission

All specialist consultations or diagnostic (including pathology) investigations completed during an inpatient admission are to be invoiced as per the relevant table of costs by the relevant service provider. Further information regarding the scheduled fees payable on a workers' compensation claim can be found on our website.

Day patient – service provision

A day patient program is usually available to provide ongoing support and care to patients after discharge from treatment as inpatients or in circumstances where an inpatient admission has not been possible/available. It is managed by a multi-disciplinary team of healthcare professionals and is ***tailored*** to the individual needs of the patient. It can include specialised therapy modules including physiotherapy, graded gym sessions, aquatic therapy, occupational therapy, psychology (as appropriate), case conferences, and a gradual return to work program.

Patient outcome data

Insurers may request a copy of the patient outcome data relating to workers' compensation admissions for rehabilitation programs from time to time.

Pain management programs (daily fee)

Approval for any elective hospitalisation must be obtained from the insurer prior to the patient admission. Requests must be made using the 'Request for Specialised Program' form (FM303).

ITEM NO.	CATEGORY	DESCRIPTION	GST EXCLUSIVE AMOUNT
400573	Inpatient admission	Inpatient admission for pain management program (per day)	$992 Requires insurer pre-approval
400575	Day patient	Full day (at least 3hrs duration) patient for pain management program (per day)	$700 Requires insurer pre-approval
400517		Half (1/2) day (at least 1.5hrs duration) patient for pain management program (per day)	$400 Requires insurer pre-approval

Inpatient admission – service provision

Pain programs involve referral and assessment by the coordinator of the program. The assessment is undertaken by a pain physician (i.e., Fellow of the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists). In addition, the pain physician will oversee the patient's participation in the program. They are defined programs with targeted service provision. Specific outcome goals are to be clearly defined and measured during admission. The program includes physiotherapy, aquatic therapy, occupational therapy, clinical psychology, group education sessions, graded gym sessions, relaxation sessions, case conferences, and discharge planning.

Additional costs during admission

All specialist consultations or diagnostic (including pathology) investigations completed during an inpatient admission are to be invoiced as per the relevant table of costs by the relevant service provider. Further information regarding the scheduled fees payable on a workers' compensation claim can be found on our website.

Day patient – Service provision

A day patient program is usually available to provide ongoing support and care to patients after discharge from treatment as inpatients or in circumstances where an inpatient admission has not been possible/available. It is managed by a multi-disciplinary team of healthcare professionals and is ***tailored*** to the individual needs of the patient. It can include specialised therapy modules including physiotherapy, aquatic therapy, occupational therapy, clinical psychology, group education sessions, graded gym sessions, relaxation sessions, case conferences, and a gradual return to work program.

Patient outcome data

Insurers may request a copy of the patient outcome data relating to workers' compensation admissions for pain management programs from time to time.

Alcohol and other drugs programs (AODs) (daily fee)

Approval for any elective hospitalisation must be obtained from the insurer prior to the patient admission. Requests must be made using the 'Request for Specialised Program' form (FM303).

ITEM NO.	CATEGORY	DESCRIPTION	GST EXCLUSIVE AMOUNT
400581	Inpatient admission	Inpatient admission for AODS program (per day)	$982 Requires insurer pre-approval
400583	Day patient	Full day (at least 4.5hrs duration) patient for AODS program (per day)	$700 Requires insurer pre-approval
400518		Half (1/2) day (at least 2.5hrs duration) patient for AODS program (per day)	$400 Requires insurer pre-approval

Inpatient admission – service provision

These programs provide the specialised treatment and care for patients with alcohol or drug dependency (including analgesics/narcotics/opiates and benzodiazepines). The program is managed by a multi-disciplinary team including a medical director and consultant psychiatrist or addiction specialist (i.e., Fellow of the Royal Australian and New Zealand College of Psychiatrists or Fellow of the Australasian Chapter of Addiction Medicine, Royal Australasian College of Physicians). Where required, the program involves the medically controlled, safe withdrawal of drugs or alcohol.

They are defined programs with targeted service provision. Specific outcome goals are to be clearly defined and measured during admission.

Additional costs during admission

All specialist consultations or diagnostic (including pathology) investigations completed during an inpatient admission are to be invoiced as per the relevant table of costs by the relevant service provider. Further information regarding the scheduled fees payable on a workers' compensation claim can be found on our website.

Day patient – service provision

A day patient program is usually available to provide ongoing support and care to patients after discharge from treatment as inpatients or in circumstances where an inpatient admission has not been possible/available. It is managed by a multi-disciplinary team of healthcare professionals and is ***tailored*** to the individual needs of the patient. It can include specialised therapy modules including cognitive behavioural therapy, relaxation, coping skills, and (if relevant) post treatment medication management.

Patient outcome data

Insurers may request a copy of the patient outcome data relating to workers' compensation admissions for alcohol and other drug (AODs) programs from time to time.

Haematology and oncology

Approval for any elective hospitalisation must be obtained from the insurer prior to the patient admission.

Any haematology or oncology service delivered is to be invoiced as per:

1. the relevant PBS rate for the agent or drug must be billed using item no. **400595**,
2. where an infusion pump is used for the delivery of the agent or drug, a fee of $76 will be paid and must be billed using item no. **400597.** Infusion pumps are not considered to be a disposable or consumable, they are considered for the purposes of this document to be an approved device,
3. the relevant item code within the Medical Items Table of Costs for the parenteral chemotherapy,
4. the appropriate accommodation charge as relevant from the table below:

CATEGORY	DESCRIPTION
Same Day Accommodation	Same day accommodation for the administering of haematology or oncology services. To billed at **Band 2 Same Day accommodation rate**.
Overnight Accommodation	Overnight accommodation for the administering of haematology or oncology services. To billed at the **relevant overnight accommodation rate** dependent on clinical care needs.

5. any other patient care costs (not referenced in items 1-4 above) for workers undergoing haematology/oncology treatments, which may include (but are not limited to) scalp cooling treatments, oncology maintenance services, patient education sessions must be billed using item no. **400600.**

The treatment protocol is to be dictated by the relevant specialist team in relation to the accepted work-related injury.

Where a high cost, non-PBS drug is required to treat the work-related injury, a pharmacy estimate must be provided to the insurer for prior approval.

Agents or drugs include:

- alkylating agents,
- nitrosoureas,
- anti-metabolites,
- plant alkaloids,
- anti-tumour antibiotics,
- hormonal agents,
- biological response modifiers.

Additional costs during admission

All specialist consultations or diagnostic (including pathology) investigations completed during an inpatient admission are to be invoiced as per the relevant table of costs by the relevant service provider. Further information regarding the scheduled fees payable on a workers' compensation claim can be found on our website.

Explanatory notes

Health literacy for patients

Health literacy is about how:

- a worker *accesses* the relevant information about their health and healthcare
- a worker *understands* information about their health and healthcare, and
- they *use* the information to make *informed decisions* about their healthcare.

WorkCover embraces to Australian Commission on Safety and Quality in Health Care position on Health Literacy and the National Safety and Quality Health Service (NSQHS) Standards.

WorkCover expect all providers who deliver services to Queensland workers' to:

- make it easy for the worker to know where to go, what to do and how to find what is needed to improve their health and wellbeing, including information about their diagnosis, prognosis, processes, likely outcomes of possible tests and treatments and how prevent further injuries or illnesses
- make it easy for the worker to make better decisions about their health, wellbeing, and health care
- make it easy for the worker to manage their own health care, including treatment and medications
- help the worker to contribute to more effective decision-making and action about their own health care
- work in partnership with the worker so the worker can made informed and effective decisions
- help the worker reduce the risk of harm to themselves by providing thorough information that they can understand.[6]

Supporting resources in relation to health literacy can be found on the Australian Commission on Safety and Quality in Health Care website.

Theatre fees

The theatre fees include the costs of consumables and disposable items.

Provision of high cost surgical, consumable, and disposable items during an admission requires pre-approval by the insurer. The insurer will not unreasonably withhold approval during an emergency, where the item is clinically required.

Only in exceptional circumstances will additional fees be paid for high cost surgical, consumable, and disposable items on provision of clinical evidence (e.g., letter outlining the justification of use) from the hospital that the item is reasonably necessary for the appropriate management and treatment of the work-related injury.

It should be noted that a number of MBS item numbers have items excluded on the National Procedure Banding List, for example: including but not limited to disposables, robotic consumables, the stent receiver device, the therapeutic substance, and the cost of the implant.

Exigent clinical circumstance

Where exigent clinical circumstances exist and a high cost surgical, consumable, and disposable is required immediately to enable the provision of lifesaving treatment, prior approval from the insurer is **not required**.

[6] 3.4 What are the benefits of health literacy? https://www.safetyandquality.gov.au/sites/default/files/migrated/Health-Literacy-Taking-action-to-improve-safety-and-quality.pdf

The insurer may request clinical justification to understand the need for the provision of the high cost surgical, consumable, or disposable in these circumstances.

Pharmacy

Accommodation fees also **include** the cost of PBS pharmaceutical items provided during the admission. The insurer will only fund non-PBS pharmaceutical items where no PBS equivalent exists.

Provision of high-cost drugs during an admission requires pre-approval by the insurer. The insurer will require provision of clinical evidence (e.g., letter outlining the justification of use) from the hospital that the high-cost drug is reasonably necessary for the appropriate management and treatment of the work-related injury.

High-cost drugs do not have a formal definition in Australia. For the purposes of this table of costs, high costs drugs have been defined as those that are not:

- listed under the Pharmaceutical Benefits Scheme;
- funded through the s100 program (Section 100 of the *National Health Act 1953*) and the Life Saving Drugs Program (LSDP).

Only pharmaceutical items provided at discharge may be charged separately and must be billed using item code **400596**. The insurer will only fund discharge medication that relates to the hospital admission.

Exigent clinical circumstance

Where exigent clinical circumstances exist and a high-cost drug is required immediately to enable the provision of lifesaving treatment, prior approval from the insurer is **not required**. The insurer may request clinical justification to understand the need for the provision of the high-cost drug in these circumstances.

Account and invoicing standards

If applicable, the insurer will pay to the provider an amount on account of the provider's GST liability in addition to the GST exclusive fee. Suppliers must provide the insurer with a tax invoice where the amounts are subject to GST.

For queries regarding whether the services you provide to a worker are taxable (that is, subject to GST) please contact the Australian Taxation Office and/or your tax advisor.

Appropriate tax invoices for private hospital patients are to be submitted to insurers (or if relevant, workers). Invoices must include the following **minimum** information:

- hospital name and address, provider details (i.e., treating practitioner) – name, Medicare provider number (if applicable) and/or insurer provider number (if known)
- invoice number and invoice date
- Australian Business Number (ABN)
- worker's surname and given name(s)
- date of birth (if known)
- claim number (if known)
- brief description of the injury to which the services relate
- employer name (if known)
- bank account details for electronic funds transfer (EFT)
- each service itemised separately in accordance with this fee schedule including:
  For surgical procedures
  - date of service

- service item number and service description (including ICD10 code, surgery commencement and completion times)
- theatre band corresponding to the service item number and description
- charge for the service in accordance with this fee schedule
- each taxable sale must display the total charge and GST applicable
- where the invoice contains both taxable and non-taxable supplies that the taxable must be listed with the GST and total applicable for each individual supply
- a copy of the relevant operation note must accompany the surgery invoice.

For non-surgical inpatient admissions

- date of service including admission
- service item number and service description
- charge for the service in accordance with this fee schedule
- each taxable sale must display the total charge and GST applicable
- where the invoice contains both taxable and non-taxable supplies that the taxable must be listed with the GST and total applicable for each individual supply.

It is important to note that some insurers may require additional information such as discharge dates on their invoices.

Invoices that do not meet these standards may be returned to the provider for amendment.

Invoices are to be submitted within **two months** after completion of the treatment as per section 213(2) of the *Workers' Compensation and Rehabilitation Act 2003*.

Invoices received more than two months after completion of the treatment may not be paid unless in exceptional circumstances.

Insurers are unable to pay on 'account rendered' or statement invoices. Payment will be made, where appropriate, on an original invoice or duplicate/copy of the original.

Payment for services, including reports, will not be made in advance.

Where payment is outstanding

Please contact the insurer if:

- the claim has been accepted,
- prior approval for the hospitalisation was obtained, and
- the payment is outstanding (if greater than two months after completion of the treatment).

If the claim has not been accepted, responsibility for payment of accounts rests with the worker.

Additional information

The insurer may request additional information as evidence of the service provided and invoiced.

Quality assurance

Insurers may request a copy of the performance metrics relating to workers' compensation admissions from time to time.

The criteria for the performance metrics will be developed in consultation with the relevant private hospitals.

The objective of WorkCover Queensland or a self-insured employer under section 5 of the *Workers' Compensation and Rehabilitation Act 2003* is to ensure that workers receive timely treatment and rehabilitation to assist with their return to work.

This table of costs sets out the maximum fees payable by the insurer for the applicable services. This fee schedule applies to all work injury claims whether insured through WorkCover Queensland or a self-insured employer. The maximum fees in this schedule apply to services provided on or after 1 December 2022. The related injury may have been sustained before, on or after this date.

The purpose of the services in this fee schedule are to enable injured workers to receive timely and quality medical and rehabilitation services to maximise the worker's independent functioning and facilitate their return to work as soon as it is safe to do so. WorkCover Queensland or the self-insurer will periodically review a worker's treatment and services to ensure they remain reasonable having regard to the accepted work injury.

WorkCover Queensland expects the provision of services to be consistent with this fee schedule and to be reasonable. Systems are in place for monitoring compliance with invoicing and payment rules. Non-compliance with expected service provisions will be addressed with providers. Compliance actions may range from providing educational information to assist providers in understanding the expectations, to criminal penalties for fraud. WorkCover Queensland also reserves the right to refer misconduct to the relevant professional body, council, or complaints commission.

WorkCover QUEENSLAND

Definitions

Accredited means assessed as being fully compliant with the *National Safety and Quality Health Service Standards* by a body approved by the Australian Commission on Safety and Quality in Health Care to assess health organisations against the *National Safety and Quality Health Service Standards*.

the Act means the *Workers' Compensation and Rehabilitation Act 2003.*

Acute patient means an admitted patient to an acute care facility:

(a) where a patient stays for the first 35 days of continuous hospitalisation, or
(b) where a patient has been in continuous hospital care for more than 35 days where an Acute Care Certificate, or an equivalent form devised by the hospital, has been completed and signed by a medical practitioner indicating the patient is to remain as an acute care patient for a specified period.

Admission means the formal administrative process of a private hospital or day surgery facility by which the hospital or facility commences the provision of treatment, care, accommodation, and other services to a patient.

Admitted patient means a patient who undergoes a hospital's admission process to receive treatment and/or care. This treatment and/or care can be provided over a period of time for extended admissions.

Advanced surgical patient is defined *Private Health Insurance (Benefit Requirements) Rules 2011 – Part 2 Type A Procedures* as amended from time to time.

Consumables refers to single use items standard to the procedure, excluding items on the Department of Health Prostheses List and items on the National Procedure Banding List identified as excluded from bands. Examples include but are not limited to disposables, robotic consumables, the stent receiver device, the therapeutic substance, and the cost of the implant.

Continuous period of hospitalisation for the purpose of counting days of hospital treatment, includes any two periods during which a patient was, or is, receiving hospital treatment as a patient at a hospital, whether or not the same hospital, where the periods are separated from each other by a period of not more than seven days during which the patient was not receiving hospital treatment as a patient at any hospital.

Cost of hospitalisation at private hospital is per section 217 of the *Workers' Compensation and Rehabilitation Act 2003*:

(1) The cost for which an insurer is liable for hospitalisation of a worker as an inpatient at a private hospital is the cost for the provision of the facility at a private hospital where a procedure is carried out.
(2) The insurer must pay the cost of hospitalisation, whether the hospitalisation is provided at one time or at different times.
(3) The insurer must pay the cost of hospitalisation that-
    (a) is published by WorkCover Queensland by gazette notice (namely the Private Hospital Services Table of Costs); or
    (b) if a cost of hospitalisation is not published – the cost lawfully charged by the hospital.

Day means a calendar day.

Day hospital means a facility as defined by Section 10 of the *Private Health Facilities Act 1999*.

(1) A day hospital is a facility at which day hospital health services are provided to persons who are admitted to, and discharged from, the facility on the same day, but does not include a facility operated by the state.
(2) However, a facility is not a day hospital merely because a day hospital health service is provided to a person at the facility if—
    (a) the service is provided to the person in an emergency; and
    (b) it would be unreasonable, having regard to the health and wellbeing of the person, to move the person to another facility to receive the health service.

Day hospital health service means any of the following health services (as defined by section 10(3) of the *Private Health Facilities Act 1999*):

(a) a diagnostic, surgical or other procedure performed by a medical practitioner involving—
    (i) the administration of a general, spinal, or epidural anaesthetic; or
    (ii) sedation, other than simple sedation;
(b) a diagnostic, surgical or other procedure—
    (i) performed by, or under the direction of, a medical practitioner; and
    (ii) involving a significant risk that a person on whom the procedure is performed may, because of cardiac, respiratory, or other complications arising from the performance of the procedure, require resuscitation; and
    (iii) prescribed under a regulation.

Discharge means the formal administrative process of a private hospital or day surgery facility by which the hospital or facility ceases the provision of treatment, care, accommodation, and other services to a patient.

Discharged means a person who has been a patient in a private hospital or day surgery facility, means that the person has undergone the formal discharge process of the hospital or facility.

Episodes of care, must be:

- required for the work-related injury or illness
- reasonable, necessary, or appropriate in the circumstances and
- is clinically justified, safe and effective

for the purposes of this schedule, includes (where applicable) the cost of the following:

(a) accommodation
(b) intensive care unit
(c) coronary care unit
(d) theatre
(e) common use theatre items (including consumable and disposable items)
(f) prostheses (including prostheses handling charge)
(g) pharmaceutical items directly related to the work-related injury or illness being treated. Discharge medications and any approved non-PBS medications are charged separately in accordance with this table of costs.

Exigent clinical circumstance means an emergency situation which requires immediate action to prevent danger to life.

Extent of liability for hospitalisation at private hospital is per section 216 of the *Workers' Compensation and Rehabilitation Act 2003*, an insurer's liability for the cost of hospitalisation of a worker at a private hospital extends only to the cost of the hospitalisation of the worker as an inpatient at a private hospital:

(a) for **non-elective hospitalisation** – for not more than four days; or
(b) for **non-elective hospitalisation** for more than four days – to the extent agreed to by the insurer under arrangements entered into between the insurer and the worker or someone for the worker *before* the hospitalisation or any extension of the hospitalisation; or
(c) for **elective hospitalisation** – to the extent agreed to by the insurer under arrangements (namely the Private Hospital Services Table of Costs) entered into between the insurer and the worker or someone for the worker *before* the hospitalisation.

GST means the goods and services tax payable under the GST law.

Health record means a record of the health information of an individual.

Health information has the same meaning as in the *Information Privacy Act 2009* and means information about an individual containing the following

(a) personal information about the individual that includes any of the following-
    (i) the individual's health at any time;
    (ii) a disability of the individual at any time;
    (iii) the individual's expressed wishes about the future provision of health services to the individual;
    (iv) a health service that has been provided, or that is to be provider, to the individual; or
    (v) personal information about the individual collected for the purpose of providing, or in providing, a health service; or
    (vi) personal information about the individual collected in connection with the donation, or intended donation, by the individual of any of the individual's body parts, organs or body substances.

Health service is defined in section 7 of *the Private Health Facilities Act 1999* and means a service provided to a person for maintaining, improving, or restoring the person's health and wellbeing.

High-cost drugs do not have a formal definition in Australia. For the purposes of this table of costs, high costs drugs have been defined as those that are:

- not listed under the Pharmaceutical Benefits Scheme;
- funded through the s100 program (Section 100 of the *National Health Act 1953)* and the Life Saving Drugs Program (LSDP).

Inpatient in relation to a private hospital means an admitted patient who, following a clinical decision, requires or is expected to require overnight treatment for a minimum of one night.

Insurer means the employer's workers' compensation insurer.

Intensive care services are outlined within the Clinical Standard Capability Framework (CSCF) Intensive Care Services module published by the Queensland Department of Health.

Item has the same meaning as in subsection 3(1) of the *Health Insurance Act 1973*.

Length of stay (LOS), in relation to an admitted patient in a private hospital, means the number of days between the day of admission of the patient to the hospital and the day of discharge of the patient from the hospital – (a) counting the day of admission as one day, and (b) excluding the day of discharge (unless it is also the day of admission).

Non-admitted patient means a patient who does not undergo a hospital's formal admission process. There are three categories of non-admitted patient:

1. emergency department patient;
2. day patient; and
3. other non-admitted patient (treated by hospital employees off the hospital site – includes community/outreach services).

Private health facility is defined in section 8 of the *Private Health Facilities Act 1999* and is:

(a) a private hospital; or
(b) a day hospital.

Private hospital is defined in section 9 of the *Private Health Facilities Act 1999* and:

(1) is a facility at which health services are provided to persons who are discharged from the facility on a day other than the day on which the persons were admitted to the facility.
(2) However, a private hospital does not include the following—
    (a) a hospital operated by the state;
    (b) a nursing home, hostel, or other facility at which accommodation, and nursing or personal care, is provided to persons who, because of infirmity, illness, disease, incapacity, or disability, have a permanent need for nursing or personal care.

The *Private Health Insurance (Benefit Requirements) Rules 2011* also define a private hospital as a hospital in respect of which there is in force a statement under subsection 121-5(8) of the Act that the hospital is a private hospital.

Note: Section 15 of the *Private Health Insurance (Transitional Provisions and Consequential Amendments) Act 2007* deals with the status of certain hospitals for which a declaration had been made before the commencement of the Act.

Prostheses are an artificial device to replace or augment a missing or impaired part of the body.

Relevant service provider means the actual provider delivering the service.

Same day in relation to a service, means a service that is provided on a single calendar day.

Same day patient means an admitted patient who is admitted and discharged on the same day.

Fees for same day patients in a registered day facility are calculated as follows: Maximum fee = theatre fee (or banded rate where relevant and applicable) plus same day accommodation fee as per this schedule.

Simple sedation means the administration of one or more drugs to a person, that depress the person's central nervous system, to allow a procedure to be performed on the person by a medical practitioner in a way that—

(a) allows communication with the person to be maintained while the procedure is being performed; and
(b) makes loss of the person's consciousness unlikely.

Surgical patient is defined in the *Private Health Insurance (Benefit Requirements) Rules 2011* as amended from time to time.

Type A procedure is defined in the *Private Health Insurance (Benefit Requirements) Rules 2011* and means:

(a) a procedure specified in clauses 3 to 9 of Schedule 1; or
(b) a certified Type B procedure; or
(c) a certified overnight Type C procedure.

A copy of the certificate is not required to be provided to WorkCover Queensland. However, it should be noted self-insurers may request this document.

Type B procedure is defined in the *Private Health Insurance (Benefit Requirements) Rules 2011* and means:

(a) a procedure specified in clauses 3 to 7 of Schedule 3 other than a certified Type B procedure; or
(b) a certified overnight Type C procedure.

A copy of the certificate is not required to be provided to WorkCover Queensland. However, it should be noted self-insurers may request this document.

Type C procedure is defined in the *Private Health Insurance (Benefit Requirements) Rules 2011* and means a procedure specified in clause 8 of Schedule 3 other than a certified Type C procedure.

A copy of the certificate is not required to be provided to WorkCover Queensland. However, it should be noted self-insurers may request this document.

Temporary assistive devices *(also known as mobility aids or independent living aids)* include wheelchairs, walkers, canes, crutches, toilet seats provided at discharge to help a worker safely mobilise while in the acute recovery phase.

Further information (including forms) can be found at www.worksafe.qld.gov.au.

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