

Nursing table of costs
Effective 1 July 2018

Service	Descriptor	Insurer prior approval required ¹	Item number	Fee – GST not included ²
General Medical Procedures	Payable where a patient is seen by an advanced practice registered nurse (i.e. nurse practitioner or rural and isolated practice nurse) and performs straightforward medical procedures that would normally be payable as part of a doctor's MBS attendance fee i.e. suturing a wound or removal of a superficial foreign body. This also includes outpatient care in hospitals.	No	300081	\$39 ^ per procedure
Home Nursing Services by a Registered Nurse	Prior insurer approval is required. Home nursing services such as dressing of wounds and assistance with daily care. The insurer will not pay for home nursing service in excess of four (4) weeks without a treating medical practitioner review. NB: must be referred by a medical practitioner. Day & evening rate:\$72.00 Weekend rate: \$92.00	Yes	300014	Day and evening - \$72 ^ per hour Weekend - \$92 ^ per hour
Public Hospital Emergency Nurse Services	To be billed where a worker receives primary emergency services provided by nursing staff only. This code is used if the care is of an emergency nature only and the hospital is not considered to have a recognised emergency department as per the Public Health services table of costs.	No	300087	\$120 ^ per day
Assisting Doctor in Minor Surgery	This item will be payable only if the procedure attracts a MBS assistance fee and there is no other doctor available to assist.	No	300089	\$39 ^ per procedure

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 patient. 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
Case Conference	Face-to-face or telephone communication involving the treating provider, insurer and one or more of the following: treating medical practitioner, specialist, employer or employee representative, worker, allied health providers or other.	Yes	300082	\$180 ^ per hour
Progress Report	A written report providing a brief summary of the worker's progress towards recovery and return to work.	At the request of the insurer	300086	\$60
Standard Report	A written report used for conveying relevant information about a worker's compensable injury where the case or treatment are not extremely complex or where responses to a limited number of questions have been requested by the insurer.	At the request of the insurer	300088	\$152
Comprehensive Report	A written report only used where the case and treatment are extremely complex. Hours to be negotiated with the insurer prior to providing the report.	At the request of the insurer	300090	\$180 ^ per hour
Travel - Treatment	Only paid where the provider is required to leave their normal place of practice to provide a service to a worker at their place of residence, rehabilitation facility, hospital or the workplace; for visits to multiple workers or facilities, divide the travel charge accordingly between workers assessed/treated at each location.	Yes	300092	\$134 ^ per hour
Copies of Patient Records relating to claim	Copies of patient records relating to the workers' compensation claim including file notes; results of relevant tests eg. pathology, diagnostic imaging and reports from specialists. Paid at \$25 flat fee plus \$1 per page.	No	300093	\$25 plus \$1 per page

Incidental Expenses	Reasonable charges for incidental items the worker takes with them up to \$56.00 per claim without prior approval. Reasonable charges for supportive devices up to \$196.00 per claim without prior approval. Hire of equipment to be negotiated with insurer.	Yes	300094	Incidental - \$56 per claim Supportive - \$196 per claim
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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/Consultation--Business/In-detail/Health/Publications/>

3 If costs exceed pre-approved levels, or the hire equipment is required the practitioner must submit a *Request for incidental expenses, supportive devices or equipment hire* form detailing items and cost to the insurer available from www.worksafe.qld.gov.au

^ Hourly rates are to be charged pro-rata

Who can provide nursing services to injured workers?

All nursing services performed must be provided by a nurse who has a current registration with the Nursing and Midwifery Board of Australia.

Service conditions

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

- **Treatment** – the insurer will not pay for nursing services for any period in excess of four (4) weeks without a treating medical practitioner review
- **Prior approval** – approval must be obtained for any service requiring prior approval from the insurer before commencing treatment
- **Services not covered in this table of costs** – there may be other expenses not covered in this table of costs. The insurer will fund reasonable and appropriate expenses and the practitioner will need to negotiate these expenses directly with the insurer
- **Payment of treatment** – all fees payable are listed in the *Nursing services table of costs*. For services not outlined in the table of costs, prior approval from the insurer is required
- **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

Queensland Health advise that public patients deemed to have an invalid claim for workers' compensation are entitled to revert to public patient status in accordance with the provisions of the Australian Health Care Agreement.

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.

Case Conference (Item code 300082)

The objectives of a case conference are to plan, implement, manage or review treatment options and/or rehabilitation plans and should result in an agreed direction for managing the Workers' return to work.

The case conference must be authorised by the insurer prior to being provided and would typically be for a maximum of one hour (this excludes travelling to venue and return).

A case conference may be requested by:

- a treating medical practitioner
- the worker or their representative/s
- the insurer
- an employer
- an allied health provider

Reports (Item code 300086, 300088, 300090)

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

The practitioner should ensure:

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

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

All reports include:

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

Clinical reports

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

- **Progress report** – a brief summary of a Workers' progress including RTW status, completion of goals, future recommendations and timeframes
- **Standard report** – conveys relevant information relating to a Workers' recovery and return to work where the case or treatment **are not** extremely complex. Includes functional and RTW status, treatment plan, interventions to date, any changes in prognosis along with the reasons for those changes, barriers, recommendations and goals and timeframes. Also includes responses to a limited number of questions

raised by an insurer. A standard report would not be appropriate if further examination of the worker was required in order for the report to be completed

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

Travel – Treatment (Item code 300092)

Travel should only be charged when:

- it is appropriate to attend the worker somewhere other than the normal place of practice - for example:
 - to assist therapy* - where the practitioner does not have the facilities at their practice
 - to attend a case conference*
- a worker is unable to attend the practitioner's normal place of practice and they are treated at their home. In this case, the treating medical practitioner must certify the worker as unfit for travel
- the travel relates directly to service delivery for the Workers' compensable injury

*Note: Please check procedures and conditions of service to determine if prior approval is required from the insurer. Approval is required for travel in excess of one (1) hour return trip. Prior approval is not required where the total travel time will exceed one (1) hour but the time can be apportioned (divided) between a number of workers for the same trip and equates to one (1) hour or less per worker.

Travel may not be charged when:

- travelling between one site or another if the practitioner's business consists of multiple practice sites
- the practitioner conducts regular sessional visits to particular hospitals, medical specialist rooms or other sessional rooms/facilities
- visiting multiple workers in the same workplace – the travel charge should be divided evenly between workers treated at that location
- visiting multiple worksites in the same journey – the travel charge should be divided accordingly between workers involved and itemised separately

Patient records (Item code 300093)

The fee is payable upon request from the insurer for copies of patient records relating to the workers compensation claim. If the copies of records are to exceed 50 pages the practitioner is required to seek approval from the insurer before finalising the request.

Incidental expenses (Item code 300094)

The values specified in this *table of costs* for incidental expenses and supportive devices are per claim and not per consultation. Contact the insurer for further clarification of what qualifies as an incidental expense.

For items exceeding the pre-approved values listed in this *table of costs* practitioners should discuss the request with the insurer. Approval must be obtained by contacting the insurer and submitting a *Request for incidental expenses, supportive devices* form available at www.worksafe.com.au. All items must be itemised on invoices.

Reasonable expenses

Items considered to be reasonable incidental expenses are those that the worker actually takes with them – including bandages, elastic stockings, tape, crutches, therapy putty, theraband, grippers, hand weights, audio tapes/CD, education booklets, and disposable wound management kits (such as those containing scissors, gloves, dressings, etc.). Tape may only be charged where a significant quantity is used.

Items considered reasonable supportive device expenses – including splinting material, prefabricated splints, and braces – must be shown to be necessary items for successful treatment of the compensable injury.

The insurer will not pay for:

- items regarded as consumables used during the course of treatment – including towels, pillowcases, antiseptics, gels, tissues, disposable electrodes, bradflex tubing, and small non-slip matting
- items/procedures that are undertaken in the course of normally doing business – including autoclaving/sterilisation of equipment, and laundry

Hire/loan items

Prior approval must be obtained from the insurer for payments for hire or loan of items e.g. biofeedback monitors. The insurer will determine the reasonable cost and period for hire or loan and is not liable for the deposit, maintenance, repair or loss of the hire equipment.

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.