

Return to Work table of costs

Effective 1 July 2020

Service	Descriptor	Insurer prior approval required ¹	Item number	Fee – GST not included ²
RTW Communication - 3 to 10 mins	Used by a provider who has received a referral from an insurer for the following return to work services: worksite assessment/evaluation, development of suitable duties program or updated program, functional capacity evaluation, vocational assessment, job seeking, job preparation, or job placement services. The provider is able to bill for communication between the provider, worker, insurer, treating allied health or medical providers to assist with faster and more effective rehabilitation and return to work for a specific worker including the monitoring of suitable duties programs, communication with relevant stakeholders about a worker's progress or issues related to an existing suitable duties program. Must be more than three (3) minutes. Consult list of exclusions before using. For WorkCover, service can only be provided by a return to work panel provider**	No	300210	\$31
RTW Communication - 11 to 20 mins	Used by a provider who has received a referral from an insurer for the following return to work services: worksite assessment/evaluation, development of suitable duties program or updated program, functional capacity evaluation, vocational assessment, job seeking, job preparation, or job placement services. The provider is able to bill for communication between the provider, worker, insurer, treating allied health or medical providers to assist with faster and more effective rehabilitation and return to work for a specific worker including the monitoring of suitable duties programs, communication with relevant stakeholders about a worker's progress or issues related to an existing suitable duties program. Must be more than 11 minutes. Consult list of exclusions before using. For WorkCover, service can only be provided by a return to work panel provider**	No	300211	\$62

Initial Suitable Duties Program (SDP)	Documentation of suitable duties for a worker, detailing specific information necessary for a safe and effective return to the workplace. For WorkCover, service can only be provided by a return to work panel provider**	Yes	300102	\$93
Updated Suitable Duties Program (SDP)	Documentation of an updated or further Suitable Duties Plan for a worker, detailing specific information necessary for a safe and effective return to the workplace. For WorkCover, service can only be provided by a return to work panel provider**	Yes	300084	\$62
Case Conference	Face-to-face or phone 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	\$186 ^ 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	\$62
Standard Report	A written report used for conveying relevant information about a worker's compensable injury where the case or treatment is 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	\$157
Comprehensive Report	A written report only used where the case and treatment is extremely complex. Hours to be negotiated with the insurer prior to providing the report.	At the request of the insurer	300090	\$186 ^ per hour
Travel - RTW	Only paid where the provider is required to leave their normal place of practice to provide a return to work service to a worker at their place of residence, rehabilitation facility, hospital or the workplace; for visits to multiple workers or facilities, divide the travel charge accordingly between workers assessed at each location. For WorkCover, service can only be provided by a return to work panel provider**	Yes	300091	\$134 ^ per hour
Workplace Evaluation/Assessment	Systematic process using the workplace to estimate work potential and work behaviour. Includes ergonomic assessments. For WorkCover, service can only be provided by a return to work panel provider**	At the request of the insurer	300158	\$186 ^ per hour
Functional Capacity Evaluation (FCE)	Systematic assessment using a series of standardised tests and work specific simulation activities to assess a worker's functional capacity for work or potential to return to suitable work; includes assessment and report. For WorkCover, service can only be provided by a return to work panel provider**	At the request of the insurer	300160	\$186 ^ per hour

Vocational Assessment and Report*	Assessment of realistic vocational options in the current job market for a worker using integrated clinical and standardised assessment procedures and instruments; includes assessment and report. For WorkCover, service can only be provided by a return to work panel provider**	At the request of the insurer	300162	\$186 ^ per hour
Return to Work Facilitation	Communication with a worker and employer to establish an updated suitable duties program where no worksite assessment or job placement services are required or other service item code applies. Also used where there are significant barriers preventing a worker participating in a return to work program and the provider delivers strategies to overcome the barriers. Includes communication between the worker, employer and insurer (does not include general communication relating to a suitable duties program or job placement or where another code applies). May include face-to-face or electronic file reviews for the insurer. For WorkCover, service can only be provided by a return to work panel provider**	Yes	300164	\$186 ^ per hour
Job Seeking Skills Assessment - Initial*	Identify a worker's transferable skills and abilities for a new job/career or host placement; may involve the development of a vocational preparation action plan with the worker. For WorkCover, service can only be provided by a return to work panel provider**	Yes	300166	\$186 ^ per hour
Job Preparation Services*	Prepare the worker to find suitable employment. Services will be based on the needs of the worker and may include development of or updating a resume and/or cover letter, interview preparation skills and career counselling. For WorkCover, service can only be provided by a return to work panel provider**	Yes	300168	\$186 ^ per hour
Job Placement Services - New Employer*	The process of actively sourcing and placing a worker in a host placement or for WorkCover also includes placing a worker in a Recover at Work program with a view to a durable return to work outcome. Also includes seeking new employment with/for the worker. Includes employer and worker liaison, job application and coaching. For WorkCover, service can only be provided by a return to work panel provider**	Yes	300212	\$186 ^ per hour

Job Placement Services - Work Hardening Program*	The process of actively sourcing and placing a worker in a host placement or for WorkCover also includes placing a worker in a Recover at Work program where the worker has a job to return to. Includes employer and worker liaison, job application and coaching. For WorkCover, service can only be provided by a return to work panel provider**	Yes	300213	\$186 ^ per hour
External Case Management*	Includes an initial needs assessment and report; should outline a case management plan indicating the goals of the program, services required, timeframes and costs. Insurer request only.	At the request of the insurer	300295	\$186 ^ per hour

* Must be able to provide proof that they have the appropriate skills and demonstrated experience in the area of external case management, vocational assessment, job seeking, preparation and placement services to a level acceptable to the insurer.

** For services provided outside of Queensland, WorkCover may refer to a non-return to work service panel provider.

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

¹ Where prior approval is indicated the practitioner must seek approval from the insurer before providing services.

² Rates do not include GST. Check with the Australian Taxation Office if GST should be included.

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

^ Hourly rates are to be charged pro-rata.

Insurer will only pay for the attendance of workers' compensation claimants.

Who can provide occupational rehabilitation services to injured workers?

The following table is a summary of professionals and the services they are able to provide.

Provider	Workplace evaluation/ assessment	Functional Capacity Evaluation	Return to work facilitation	Suitable Duties Plan	Monitoring suitable duties	Vocational assessment	Job seeking	Job preparation	Job placement services
Accredited Exercise Physiologist (A person who is an Accredited Exercise Physiologist – AEP with Exercise and Sports Science Australia – ESSA)	✓	✓	✓	✓	✓	x	✓*	✓*	✓*
Occupational Therapist (A person registered as an occupational therapist with the Occupational Therapy Board of Australia)	✓	✓	✓	✓	✓	✓*	✓*	✓*	✓*
Physiotherapist (A person registered as a physiotherapist with the Physiotherapy Board of Australia)	✓	✓	✓	✓	✓	x	✓*	✓*	✓*
Psychologist (A person registered as a psychologist with the Psychology Board of Australia)	✓	x	✓	✓	✓	✓*	✓*	✓*	✓*
Rehabilitation Counsellor (A person with a tertiary qualification in an accredited rehabilitation counselling course or other recognised behaviour science degree and a full member of the Australian Society of Rehabilitation Counsellors – ASORC or Rehabilitation Counselling Association of Australasia – RCAA)	✓	x	✓	✓	✓	✓*	✓*	✓*	✓*
Social Worker (A person with a tertiary degree in social work)	x	x	✓	✓	✓	✓*	✓*	✓*	✓*
Vocational Placement Provider (Those wishing to provide job preparation, seeking and placement services. The provider must be able to provide proof that they are appropriately skilled to assist the worker to prepare for employment.)	x	x	x	x	x	x	✓*	✓*	✓*

The table below provides an overview of who is approved to deliver supplementary services within this table of costs.

Provider	Communication /consultation	Case conference	Progress report	Standard report	Comprehensive report	Travel	External Case Management
Accredited Exercise Physiologist (A person who is an Accredited Exercise Physiologist – AEP with Exercise and Sports Science Australia – ESSA)	✓	✓	✓	✓	✓	✓	✓*
Occupational Therapist (A person registered as an occupational therapist with the Occupational Therapy Board of Australia)	✓	✓	✓	✓	✓	✓	✓*
Physiotherapist (A person registered as a physiotherapist with the Physiotherapy Board of Australia)	✓	✓	✓	✓	✓	✓	✓*
Psychologist (A person registered as a psychologist with the Psychology Board of Australia)	✓	✓	✓	✓	✓	✓	✓*
Rehabilitation Counsellor (A person registered as a member of the Australian Society of Rehabilitation Counsellors – ASORC or Rehabilitation Counselling Association of Australasia – RCAA)	✓	✓	✓	✓	✓	✓	✓*
Social Worker (A person with a tertiary degree in social work)	✓	✓	✓	✓	✓	✓	✓*
Vocational Placement Provider (Those wishing to provide job preparation, seeking and placement services. The provider must be able to provide proof that they are appropriately skilled to assist the worker to prepare for employment.)	✓	x	✓	✓	✓	✓	x

Service conditions

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

- **Approval for other services or sessions** - approval must be obtained for any service requiring prior approval from the insurer before commencing treatment.
- **Treatment period** – services will be deemed to have ended if there is no treatment for a period of two (2) calendar months.
- **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 referred services have been provided, the worker is not complying with treatment or the worker has achieved maximum function.

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.

Return to Work Communication (Item Codes 300210, 300211)

Used by a provider who has **received a referral** from an insurer for the following return to work services: worksite assessment/evaluation, development of Suitable Duties Program or updated program, functional capacity evaluation, vocational assessment, job seeking, job preparation, or job placement services. The provider is able to bill for communication between the provider, insurer, treating allied health or medical providers to assist with faster and more effective rehabilitation and return to work for a specific worker, including the monitoring of Suitable Duties Programs, and communication with relevant stakeholders about a worker’s progress or issues related to an existing Suitable Duties Program. 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.

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

- relevance to the Suitable Duties Program
- assistance for the relevant parties to support and progress the worker’s program
- barriers limiting progress and strategies to address these

Where the information was not previously provided, phone calls between the practitioner and insurer relating to a new referral for the above listed return to work services can also be billed under this code if the referral goal, background, needs, barriers and directions for the referral are discussed in detail and the conversation is more than three (3) minutes in duration.

Communication includes phone calls, emails and facsimiles. Each call, fax/email preparation must be more than three (3) minutes in duration to be billable. Note: most communication would be of short duration and would only exceed 10 minutes in exceptional or unusual circumstances.

The insurer will not pay for:

- Normal consultation communication that forms part of the usual best practice of ongoing treatment (when not of an administrative nature this should be billed under the appropriate treatment code).
- Communication to and from a worker (where not administrative in nature this is billed under the appropriate referred item code).
- Communication with an employer (where not administrative in nature this is billed under the appropriate referred item code).
- Communication conveying non-specific information such as ‘worker progressing well’.
- Communication made or received from the insurer as part of a quality review process
- General administrative communication, for example:
 - Forwarding an attachment via email or fax e.g. forwarding a Suitable Duties Plan or report.
 - Leaving a message where the party phoned is unavailable.
 - Acknowledgement and/or acceptance/rejection of referrals from an insurer except as outlined above queries related to invoices
 - For approval/clarification of a Provider Management Plan or a Suitable Duties Plan by the insurer.

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

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

Suitable Duties Program and Updated Suitable Duties Program (Item Codes 300102, 300084)

The objectives of the Suitable Duties Program are to:

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

Prerequisite – where the practitioner is unfamiliar with the workplace, a workplace evaluation (300158) to assess the workplace and worker's needs may be a prerequisite to documenting the initial Suitable Duties Program. This would also include the time taken negotiating the program and any necessary consultation with the doctor and employer.

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

Initial Suitable Duties Program – should be drawn up after:

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

Each program should contain the following:

- goals or objectives of the overall program
- documentation of specific tasks and duties to be performed by worker
- days and hours to be worked
- key reviewing and reporting requirements during the program
- any restrictions or limitations
- recommendations for upgrading the program
- start, completion and review dates for the program

Updated Suitable Duties Programs – it is not mandatory to conduct a subsequent workplace evaluation with each update to the Suitable Duties Program. Updated programs should:

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

Complex Suitable Duties Programs – in a small number of cases where the Suitable Duties Program is likely to be involved and complex, the practitioner must negotiate additional time with the insurer first.

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

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 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 (1) 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 Codes 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 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 return to work 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 return to work status, treatment plan, interventions to date, any changes in prognosis along with the reasons for those changes, barriers, recommendations and goals and timeframes. Also includes responses to a limited number of questions raised by an insurer. A standard report would not be appropriate if further examination of the worker was required in order for the report to be completed.
- **Comprehensive report** – conveys all the information included in a standard report however would only be relevant where the case or treatment are **extremely complex** or the questions raised by the insurer are extensive. A standard report would be appropriate if further examination of the worker was required in order for the report to be completed for example a neuropsychological report or multi-trauma patient.

Return to Work Reports

Insurers may request a progress return to work report, a standard return to work report or a comprehensive return to work report.

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

- **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 return to work status, treatment plan, interventions to date, any changes in prognosis along with the reasons for those changes, barriers, recommendations and goals and timeframes. Also includes responses to a limited number of questions raised by an insurer. A standard report would not be appropriate if further examination of the worker was required in order for the report to be completed.
- **Comprehensive report** – conveys all the information included in a standard report however would only be relevant where the case or treatment are **extremely complex** or the questions raised by the insurer are extensive. Also includes details of the barriers to return to work, more detailed information on the assessment criteria performed and strategies recommended to address barriers. A comprehensive report may be appropriate if further examination of the worker was required in order for the report to be completed or for a vocational assessment report or functional capacity evaluation report, or where there are multiple extremely complex psychosocial issues to be addressed as part of the return to work process.

Travel – Return to Work (Item Code 300091)

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

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

- it is appropriate to attend the worker somewhere other than the normal place of practice – for example:
 - to attend a case conference*
 - to perform a workplace assessment*
- a worker is unable to attend the practitioners normal place of practice and they are treated at their home. In this case, the treating medical practitioner must certify the worker as unfit for travel
- the travel relates directly to service delivery for the worker’s 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 (1) site or another if the practitioner’s business consists of multiple practice sites
- the practitioner conducts regular sessional visits to particular hospitals, medical specialist rooms or other sessional rooms/facilities
- visiting multiple workers in the same workplace – the travel charge should be divided evenly between workers treated at that location
- visiting multiple worksites in the same journey – the travel charge should be divided accordingly between workers involved and itemised separately

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

Workplace Evaluation/Assessment Services (Item Code 300158)

Attendance at the worker’s workplace or prospective workplace to provide one or all of the following:

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

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

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

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

Functional Capacity Evaluation Services (Item Code 300160)

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

The objectives of the FCE are to:

- determine a worker's abilities over a range of physical demands to assist their functional recovery
- assess the worker's functional capacity
- determine a worker's ability to work
- determine a worker's job-specific rehabilitation needs
- document a worker's progress before, during or after rehabilitation

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

This assessment/consultation may not be feasible if there is/are:

- unstable medical conditions
- recent surgery
- substantial psychiatric or behavioural issues
- non-compensable medical co-morbidities excluding the worker from work activities
- communication barriers or concerns that prevent instructions being understood and reactions being interpreted during a functional capacity evaluation
- a recent functional capacity evaluation

Consider the following when completing a FCE:

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

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

Vocational Assessment and Report (Item Code 300162)

Vocational assessments evaluate the worker's actual and potential ability, cognitive skills, aptitudes and competencies, and relate these to available and realistic job options, recognising all relevant background information. Generally an assessment (including report) will take two (2) to five (5) hours to complete. This timeframe is based on direct contact time with the worker, test scoring and report writing. The provider must obtain prior approval from the insurer if an assessment is likely to be greater than five (5) hours. Fee is charged at an hourly rate with the number of hours negotiated with the insurer prior to providing the service.

A vocational assessment may be appropriate where:

- the worker cannot return to their pre-injury work and there are no suitable duties or alternative career/job options with their current employer, and
- the worker needs assistance to identify sustainable alternative work options suited to their functional abilities and skills and the current job market

This assessment/consultation may not be feasible if there is/are:

- physical capacity for work is unclear
- unstable medical conditions
- recent surgery
- substantial psychiatric or behavioural issues
- non-compensable medical co-morbidities which exclude the worker from work activities
- communicating barriers or concerns that prevent instructions being understood and reactions being interpreted during a vocational assessment

Components of the vocational assessment include:

- **Purpose** – the provider must tailor vocational assessments to the specific needs of the worker and referring party.
- **Referral details** – all relevant information should be supplied by the requestor including medical reports, current medical certificate, a job analysis, rehabilitation progress reports, previous functional and vocational assessments and relevant medical investigations.
- **Informed consent** – the provider must inform the worker of the purpose and requirements of the assessment, and their obligations, and obtain the worker's written authority prior to the assessment.
- **Subjective (history)** – includes education and work history to identify transferable skills and educational restrictions.
- **Objective assessment** – a dynamic process in which the provider makes professional, vocational judgments based on data gathered during the evaluation. The assessment should include but not be restricted to the worker's cognitive skills, aptitude, personality and vocational interests/preferences that are relevant to the worker and the current job market.
- **Recommendations** – should include possible work goals that are realistic and achievable; and where necessary, strategies to achieve such goals.

The fee is charged at an hourly rate (pro-rata) with the number of hours negotiated with the insurer prior to providing the report.

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

Return to Work Facilitation (Item Code 300164)

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

- identifying strategies to overcome the barriers to return to work through discussion with the worker and significant others in the workplace
- developing a plan to address barriers
- documenting a worker's progress and outcome
- worker and employer liaison

Also includes communication with a worker and/or employer where an updated Suitable Duties Program is required and a worksite assessment or job placement services are not required.

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

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

Job Seeking Skills Assessment (Item Code 300166)

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

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

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

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

Job Preparation Services (Item Code 300168)

Provides workers with the skills and tools to find a job. For example:

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

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

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

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

Job Placement Service – New Employer (Item Code 300212)

Provides practical one-on-one assistance and support for a worker to source and facilitate suitable durable employment within their local job market. This service may include:

- intensive job search activities with guidance
- assistance applying for jobs (excluding resume and cover letter writing)
- worker and employer liaison (when not of an administrative nature)
- For WorkCover also includes placing a worker in a Recover at Work program with a view to a durable return to work outcome

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

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

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

Job Placement Service – Work Hardening (Item Code 300213)

Provides practical one-on-one assistance and support to source and place a worker in a suitable temporary job placement matching their medical restrictions. This service would be appropriate where a worker is temporarily unable to return to their current employer due to their current medical restrictions. This service may include:

- job search activities with guidance
- worker and employer liaison (when not of an administrative nature)
- for WorkCover also includes placing a worker in a Recover at Work program

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

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

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

External Case Management (Item Code 300295)

External case management services would only be required in a very limited number of situations e.g. interstate cases or very serious/catastrophic injuries where the insurer requires specialised skills of the provider. The insurer will determine the needs on a case-by-case basis. A practitioner may be requested to provide case management for the entirety or for a portion of the injured workers claim.

External case management may require the practitioner to co-ordinate equipment prescription, assistive technology and/or home modifications for the injured worker. It also requires the development of non-medical strategies in consultation with the employer, worker, treating medical practitioner, allied health professional and insurer to assist the worker's return to the workplace, in keeping with their level of functional recovery.

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

Services must be provided by a person who has the appropriate skills and demonstrated experience in this area to a level acceptable to the insurer.

Assistance

Contact the relevant insurer for claim related information such as:

- payment of invoices and account inquiries
- claim numbers/status
- rehabilitation status
- approval of Provider Management Plans

For a current list of insurers and for more information on the table of costs, visit www.worksafe.qld.gov.au or call 1300 362 128.