

Osteopathy table of costs

Effective 1 July 2020

Service	Descriptor	Insurer prior approval required ¹	Item number	Fee – GST not included ²
Initial Consultation	First consultation with worker.	No	900021	\$89
Initial Consultation (Multiple Areas)	Two (2) or more entirely separate injuries/conditions are assessed and treated; treatment applied to one condition does not affect the symptoms of the other injury; must relate to the compensable injury; does not include a condition with referred pain to another area; requires workers' compensation certificate detailing each area/condition to be treated.	No	900313	\$132
Subsequent Consultation (Level A)	Selective review of treatment or exercise program where a standard consultation (Level B) is not required; may include brief or partial reassessment. The first five (5) sessions (including initial consultation) are pre-approved. Additional session/s require prior approval.	Yes	900108	\$59
Subsequent Consultation (Level B)	Standard treatment consultation - management of one area/condition only. The first five (5) sessions (including initial consultation) are pre-approved. Additional session/s require prior approval.	Yes	900006	\$78
Subsequent Consultation (Level C)	Two (2) entirely separate injuries/conditions treated; treatment applied to one (1) condition does not affect the symptoms of the other injury; does not include a condition with referred pain to another area. The first five (5) sessions (including initial consultation) are pre-approved. Additional session/s require prior approval.	Yes	900101	\$113

Subsequent Consultation (Level D)	More than two (2) entirely separate injuries/conditions are assessed and treated; treatment applied to one (1) condition does not affect the symptoms of the others; does not include a condition with referred pain to another area. The first five (5) sessions (including initial consultation) are pre-approved. Additional session/s require prior approval.	Yes	900102	\$150
Reassessment/Program Review	Indicated when the worker has been in active rehabilitation for six (6) weeks and further treatment is likely. Prior approval required before providing service.	Yes	900055	\$110
X-Ray - Cervical Spine	X-Ray - Cervical Spine. Must be clinically justifiable.	No	958100	\$184
X-Ray - Thoracic Spine	X-Ray - Thoracic Spine. Must be clinically justifiable.	No	958103	\$153
X-Ray - Lumbosacral Spine	X-Ray - Lumbosacral Spine. Must be clinically justifiable.	No	958106	\$213
X-Ray - Any Two Regions Of The Spine	X-Ray - Any two (2) regions of the spine. Must be clinically justifiable.	No	958112	\$269
X-Ray - Any Three Regions Of The Spine	X-Ray - Any three (3) regions of the spine. Must be clinically justifiable.	No	958115	\$369
Independent Case Review	Independent examination and report of a worker (not by the treating therapist). To be provided only following a request from the insurer.	At the request of the insurer	900226	\$232 ^ per hour
Communication - 3 to 10 mins	Direct communication between treating practitioners and insurer, employer, insurer referred allied health practitioner and doctors to assist with faster and more effective rehabilitation and return to work for a worker. Excludes communication of a general administrative nature or with a worker. Must be more than three (3) minutes. Consult list of exclusions before using.	No	300079	\$31

Communication - 11 to 20 mins	Direct communication between treating practitioners and insurer, employer, insurer referred allied health practitioner and doctors to assist with faster and more effective rehabilitation and return to work for a worker. Excludes communication of a general administrative nature or with a worker. Must be more than 11 minutes. Consult list of exclusions before using.	No	300100	\$62
Case Conference	Face-to-face or phone communication involving the treating provider, insurer and one (1) 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 - 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 worker's compensation claim including file notes, results of relevant tests e.g. 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 \$58 per claim without prior approval. Reasonable charges for supportive devices up to \$203 per claim without prior approval. Hire of equipment to be negotiated with insurer.	Yes	300094	Incidental - \$58 per claim Supportive - \$203 per claim
Gym and Pool Entry Fees	Entry fee to the gymnasium or pool for treatment or assessment. Prior approval required before providing service.	Yes	300228	Usual facility fee

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 www.ato.gov.au/Business/GST/In-detail/Your-industry/GST-and-health.

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 osteopathy services to injured workers?

All osteopathy services performed must be provided by an Osteopath who has a current registration with the Osteopathy Board of Australia.

Service conditions

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

- **Treatment sessions** – where the claim has been accepted, the insurer will pay for a maximum of five (5) osteopathic sessions without prior approval. This includes the initial consultation. These five (5) sessions may not be undertaken concurrently with sessions requiring insurer approval.
- **Provider Management Plan** – this form is available on the Workers' Compensation Regulator's website (<https://www.worksafe.qld.gov.au/>) and is to be completed if treatment is required after any pre-approved sessions or any services where prior approval is required. An insurer may require the Provider Management Plan to be provided either verbally or in written format (check with each insurer as to their individual requirements). The insurer will not pay for the preparation or completion of a Provider Management Plan.
- **Approval for other services or sessions** – approval must be obtained for any service requiring prior approval from the insurer before commencing treatment.
- **Postoperative osteopathic treatment** – when a worker is referred for osteopathic treatment after a surgical procedure, a new set of five (5) treatments will take effect.
- **Payment of treatment** – all fees payable are listed in the Osteopathy services table of costs. For services not outlined in the table of costs, prior approval from the insurer is required.
- **Treatment period** – treatment will be deemed to have ended if there is no treatment for a period of two (2) calendar months. After this a Provider Management Plan needs to be submitted for further treatment to be provided (the worker must also obtain another referral).
- **End of treatment** – all payment for treatment ends where there is either no further medical certification, the presenting condition has been resolved, the insurer finalises/ceases the claim, the worker is not complying with treatment or the worker has achieved maximum function.
- **Change of provider** – the insurer will pay for another initial consultation by a new provider if the worker has changed providers (not within the same practice). The new provider will be required to submit a Provider Management Plan for further treatment outlining the number of sessions the worker has received previously.

Telehealth services

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

The following should be considered prior to delivering the service:

- Providers must consider the appropriateness of this mode of service delivery for each worker on a case-by-case basis i.e. the principles and considerations of good clinical care continue to be essential in telehealth services.

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

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

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

Consultations (Item Codes 900006, 900021, 900101, 900102, 900108, 900313)

For an accepted claim, the insurer will pay the cost of an initial consultation and report when it has been requested by the treating medical practitioner or an accredited workplace/employer. The insurer will not pay for an initial and subsequent consultation on the same day unless in exceptional circumstances, as approved by the insurer.

Consultations may include the following elements:

- **Subjective (history) reporting** – consider major symptoms and lifestyle dysfunction; current/past history and treatment; pain, aggravating and relieving factors; general health; medication; risk factors and key functional requirements of the worker’s job.
- **Objective (physical) assessment** – assess movement – e.g. active, passive, resisted, repeated, muscle tone, spasm, weakness, accessory movements, passive intervertebral movements - pain by carrying out appropriate procedures and tests.
- **Assessment results (prognosis formulation)** – provide a provisional prognosis for treatment and limitations to function and progress for return to work.
- **Reassessment (subjective and objective)** – evaluate the physical progress of the worker using outcome measures for relevant, reliable and sensitive assessment. Compare against the baseline measures and treatment goals. Identify factors compromising treatment outcomes.
- **Treatment (intervention)** – formulate and discuss treatment goals, progress and expected outcomes with the worker. Provide treatment modalities and/or therapeutic exercises according to the goals of therapy. Advise on home care, including any exercise programs to be followed.
- **Clinical records** – record information in the worker’s clinical records, including the purpose and results of procedures and tests.
- **Communication (with the referrer)** – communicate any relevant information for the worker’s rehabilitation to insurer. Acknowledge referral and liaise with the treating medical practitioner about treatment.

Reassessment/Program Review (Item Code 900055)

A reassessment/program review is a comprehensive assessment including:

- all components of the initial consultation
- a review of the worker’s progress based on established objective measures
- a recommendation for future treatment and management strategies to assist the worker to return to work

A reassessment/program review may include referral recommendations to other practitioners, a change in therapy direction or a change on outcome direction requiring a new return to work goal.

The insurer’s prior approval is required before a reassessment/program review is undertaken by the osteopath. A Provider management plan is to be completed and submitted to the insurer either verbally or in written format. (Check with the insurer for their individual requirements).

A reassessment/program review is not required:

- during routine reassessments as part of each treatment session
- where the worker is already on a clear management plan and is progressing as expected
- following postoperative protocols
- where a rehabilitation program extends beyond the reassessment period
- where the treating medical practitioner assesses the worker and recommends continued or more specific treatment

X-Rays (Item Codes 958100, 958103, 958106, 958112)

All x-rays performed on injured workers must be clinically justifiable. Indications for x-ray must be clear and the results of such imaging will assist in the prognosis and management of the patient.

Written consent must be obtained from the worker after discussion of the nature of the recommended x-rays. In the case of minors or the mentally incompetent, consent must be obtained from a parent or legal guardian.

Routine x-ray screening of patients other than for exceptional circumstance is inappropriate. This includes serial or follow-up x-rays when the patient is making adequate clinical recovery. Exceptions include progressive pathology and fracture repair.

Independent Case Review (Item Code 900226)

An independent case review is only requested by the insurer. The payment for this service includes the assessment and report.

The purpose of an independent clinical assessment is to:

- assess and make recommendations regarding the appropriateness and necessity of current or proposed osteopathic treatment
- propose a recommended course of osteopathic management
- make recommendations for strategic planning to progress the case. Recommendations should relate to treatment goals and steps to achieve these goals, which will assist in a safe and durable return to work
- provide a professional opinion on the worker's prognosis where this is unclear from the current osteopathic program
- provide an opinion and/or recommendation on the other criteria as determined by the insurer

Communication (Item Codes 300079, 300100)

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. 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, e.g.:
 - 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 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.

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 – e.g.:
 - 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 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 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.qld.gov.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.

Gym and Pool Entry Fees (Item Code 300228)

The insurer will not pay an entrance fee if the practitioner owns or operates the gymnasium or pool. Exceptions to this may be approved by the insurer where unusual circumstances apply.

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.