Rehabilitation Counsellor, Social Worker and Vocational Placement Provider table of costs

Effective 1 July 2019

Service	Descriptor	Insurer prior approval required[1]	Item number	Fee – GST not included[2]
Adjustment Counselling - Initial Assessment	Assess worker to clarify the presence of possible adjustment to injury issues and set goals of therapy to optimise rehabilitation outcomes; performed where worker is displaying emotional/behavioural problems relating to changes in lifestyle after a work-related incident/accident. Maximum treatment of two (2) hours per day. Prior approval required before providing service.	Yes	300188	$183 ^ per hour
Adjustment Counselling - Subsequent Session	Ongoing treatment of compensable components of presenting adjustment to injury issues; intervention would be based on treatment formulated from the initial assessment. Maximum treatment of two (2) hours per day. Prior approval required before providing service.	Yes	300285	$183 ^ per hour
Communication	Direct communication between treating practitioners and insurer, employer, insurer referred allied health practitioner and doctors to assist with faster and more effective rehabilitation and return to work for a worker. Excludes communication of a general administrative nature or with a worker. Must be more than 3 minutes and is to be billed in 10 minute increments. Consult list of exclusions before using.	No	300079	$30 ^ per ten minute increment

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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	$183 ^ 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	$61
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	$154
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	$183 ^ 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
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	$183 ^ per hour

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 rehabilitation support services to injured workers?

Specific professional groups, referred to as 'registered persons' under Section 223(a) of the Act, are qualified to deliver return to work and vocational rehabilitation services. Other 'non-registered' professional groups are also able to provide specific rehabilitation services within this *Table of costs*. These 'non-registered approved providers' require insurer approval and are outlined in the service conditions of each item.

Service conditions

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

- **Assessment** – the practitioner is expected to assess the needs of the worker against the referral requirements and notify the insurer of the outcome and future treatment goals.
- **Provider management plan** – this form is available on the Workers' Compensation Regulator's website (www.worksafe.gld.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.
- **Treatment sessions** – where the claim has been accepted, the insurer will pay for a maximum of five (5) treatment sessions without prior approval. This includes the initial consultation. These five (5) sessions may not be undertaken concurrently with sessions requiring insurer approval.
- **Postoperative treatment** – when a worker is referred for 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 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.

Adjustment counselling (Item code 300188 and 300285)

Services may be provided by a Rehabilitation Counsellor who is a full member of the Australian Society of Rehabilitation Counsellors (ASORC) or Rehabilitation Counselling Association of Australasia - RCAA or a Social Worker with a tertiary degree in social work. (Where a psychologist provides adjustment counselling they should refer to the *Psychology table of costs* for the correct item number.)

Indicators for adjustment counselling include but are not limited to:

- Unhelpful coping strategies such as avoidance behaviours e.g. not undertaking physical programs for fear they may cause more hurt/harm
- Being stuck in one of the stages of grief reaction

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

- **Assessment time** – includes one-on-one time with the worker and scoring of tests; excludes time taken by the worker for self-administered tests. Generally an assessment will take up to two (2) hours to complete. If an assessment is likely to be greater then two (2) hours, the practitioner must obtain prior approval from the insurer for additional time.
- **Subjective (history) reporting** – consider of major symptoms and lifestyle dysfunction; current/past history and treatment; and relevant personal and family history.
- **Objective (psychosocial) assessment** – assess using standardised outcome measurements to provide a baseline prior to commencing treatment. The outcome measurement tools should be reliable, valid and sensitive to change.
- **Assessment results (prognosis formulation)** – provide a provisional prognosis for treatment, limitations to function and progress for return to work.
- **Reassessment (subjective and objective)** – evaluate the 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, and implement strategies to improve the worker's ability to return to work and normal functional activities.
- **Treatment (intervention)** – formulate and discuss the treatment goals, progress and expected outcomes; goal setting; strategies to improve return to work with the worker. Provide advice on homework to promote self-management strategies.
- **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.

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 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 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 worker's status should be documented. Generally, a report will not be required where the information has previously been provided to the insurer.

The practitioner should ensure:

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

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

All reports include:

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

Clinical reports

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

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

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

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

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 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.

External case management (Item code 300295)

External case management services would only be required in a very limited number of situations—for example 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.

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.