

Allied Health Services Tables of Costs

Effective 1 August 2025

Rules for use

The Allied Health Services Tables of Costs set out the maximum fees payable by the insurer for applicable Allied Health services. These tables of costs apply to all work-related injury or condition claims whether insured through WorkCover Queensland or a self-insured employer. The maximum fees in this schedule, Allied Health Services, and those listed in the individual Allied Health disciplines below, apply to services provided on or after 1 August 2025:

- [Chinese Medicine](#)
- [Chiropractic Services](#)
- [Dental Services](#)
- [Exercise Physiology Services](#)
- [Hand Therapy Services](#)
- [Nursing Services](#)
- [Occupational Therapy Services](#)
- [Osteopathy Services](#)
- [Physiotherapy Services](#)
- [Podiatry Services](#)
- [Return to Work Services](#)
- [Speech Pathology Services](#)
- [Support Services](#)
- [Mental Health Services](#)

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

Please note: a worker's compensation claim must have been accepted by the insurer for the injury or condition being treated for services to be payable. If the application for compensation is pending or has been rejected, the responsibility for payment for any services provided is a matter between the provider and the worker (or the employer, where services have been requested by a Rehabilitation and Return to Work Coordinator).

In instances of a psychiatric or psychological injury, [early psychological support services](#) can be paid during the prescribed period of the worker making a claim for psychiatric injury and ending on the day the insurer decides to allow or reject the claim.

Rehabilitation and return to work

Rehabilitation is defined under section 40 of the *Workers' Compensation and Rehabilitation Act 2003* (the Act) as follows:

40 Meaning of rehabilitation

1. Rehabilitation, of a worker, is a process designed to—
 - a) ensure the worker's earliest possible return to work; or
 - b) maximise the worker's independent functioning.
2. Rehabilitation includes—
 - a) Necessary and reasonable—
 - i. Suitable duties programs; or
 - ii. Services provided by a registered person; or
 - iii. Services approved by an insurer; or
 - b) The provision of necessary and reasonable aids or equipment to the worker.

Primarily, the purpose of rehabilitation is to return the worker to their pre-injury duties and pre-injury employer. Sometimes this is not feasible because of the worker's injury and/or medical restrictions and the demands of the pre-injury duties. In this case, the secondary purpose of rehabilitation is to return the worker to other suitable duties with the pre-injury employer. If this is not possible, the worker may be offered suitable duties with a different employer (sometimes described as a host employer).

If the extent of an injury means return to work is inappropriate, the purpose of rehabilitation is then to maximise the worker's independent functioning.

Treatment standards and expectations

When treating a worker with a work-related injury or condition, the provider should, where appropriate:

- Deliver outcome-focused and goal-orientated services, which are focused on achieving maximum function and safely returning the worker to work.
- Goals should be SMART (S – Specific, M – Measurable, A – Attainable or assignable, R – Realistic, T – Time-related) measures.
- Consider biopsychosocial factors that may influence the injured worker’s return to work.
- Advise and liaise with the relevant treating practitioners and insurer.
- Keep detailed, appropriate, up-to-date treatment records and any relevant information obtained in the service delivery.
- Ensure that the worker has given their written authority prior to the exchange of information with third parties other than the referrer.
- Be accountable for the services provided, ensuring those services incurred for the work-related injury or condition are reasonable.
- Maintain practice competencies relevant to the provider’s profession and the delivery of services within the Queensland workers’ compensation environment.

Please Note: long-term maintenance therapy is generally not supported unless sustained improvement in function can be demonstrated.

Service conditions

Services provided to workers are subject to the following conditions:

- **Treatment consultations** – Where a claim has been accepted, the insurer will pay for the number of consultations pre-approved under the relevant Allied Health discipline Table of Costs. This includes the initial consultation.
- **Provider Management Plan** – Following the pre-approved consultations, a [Provider Management Plan \(PMP\)](#) must be provided to the insurer to advise of assessment outcome and before further treatment commences. More information is available on the WorkSafe [website](#) including a PMP form and approval process.
- **Approval for other services or consultations** – approval must be obtained for any service requiring prior approval from the insurer before commencing treatment. Approval requirements can be located within the relevant Allied Health discipline Table of Costs.
- **Payment of treatment** – the maximum fees payable are listed within this schedule, the Allied Health Table of Costs, and relevant Allied Health discipline’s Table of Costs. For information relating to qualification and professional standard requirements, treatment services and fees for individual allied health disciplines, please refer to the relevant Allied Health discipline Table of Costs.
- **Treatment period** – treatment will be deemed to have ended if there is no treatment for a period of two (2) calendar months. If further treatment is then required, the worker must obtain another referral from their treating medical provider and a PMP will need to be submitted prior to any services being delivered.
- **Post-operative treatment** – when a worker is referred for allied health treatment after a surgical procedure, a new set of pre-approved services in line with the relevant Allied Health discipline Table of Costs requirements will take effect (including initial consultation as required).
- **End of treatment** – all payments for treatment end 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 allied health professional if the worker has changed providers (not within the same practice). The new provider will be required to submit a PMP for further treatment outlining the number of consultations 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 invoicing purposes telehealth services do not have specific item numbers and should be invoiced in line with the current item numbers and descriptors in above each table of costs.
- The word ‘Telehealth’ must be noted in the comments section on any invoice submitted to the insurer when this service has been utilised.

General guidance on payment for services

It is an expectation of the insurer that the fees for services or treatment are to be reasonable and in line with this table of costs. Systems are in place to ensure compliance with invoicing and payment rules. Any non-compliant activities will be addressed with providers. Compliance actions may range from providing educational information to assist providers in understanding their responsibilities and the insurer’s expectations, to criminal penalties for fraud. The insurer also reserves the right to refer misconduct to the relevant professional body, council, or complaints commission.

The insurer will not pay for appointments where a worker fails to attend or cancels a scheduled appointment.

All invoices should be sent to the relevant insurer for payment. Check whether the worker is employed by a self-insured employer, or an employer insured by WorkCover Queensland. Self-insurers require separate tax invoices for services to individual workers.

Identify the appropriate item in the table of costs for services or treatment provided. The insurer will only consider payment for services or treatments for the work-related injury or condition, not other pre-existing conditions. Insurers will not pay for general communication such as receiving and reviewing referrals.

All hourly rates are to be charged at pro-rata where applicable e.g., for a 15-minute consultation/service charge one quarter (¼) of the hourly rate. All invoices must include the time taken for the service as well as the fee.

Fees listed in the table of costs do not include GST. The provider is responsible for incorporating any applicable GST on taxable services/supplies into the invoice. Refer to a taxation advisor or the Australian Taxation Office for assistance if required. Accounts for treatment must be sent to the insurer promptly, and within two (2) months after the treatment is completed. To ensure payment, the invoice must contain the following information:

- the words ‘Tax Invoice’ stated prominently
- practice details and Australian Business Number (ABN)
- invoice date
- worker’s name, residential address, and date of birth
- worker’s claim number (if known)
- worker’s employer name and place of business
- referring medical practitioner’s or nurse practitioner’s name
- date of each service
- item number/s and treatment fee
- a brief description of each service delivered, including areas treated
- the name of the provider who provided the service.

Changes across 2025-2026 Review

Across the 2025-2026 review of the Allied Health Services Tables of Costs, there were some key changes made to the structure and service design. The below table captures these changes with reference to the prior year publications:

	2024-2025	2025-2026
All tables	Supplementary services (such as communications and reports) were contained within the individual discipline's tables of costs.	All supplementary services and fees have been published within the Allied Health Services Table of Costs with the relevant individual discipline tables relating to treatment services only (with the exclusion of the Return to Work and Dental services Table of Costs).
	General guidance on the inclusion/exclusion criteria relating to communication billings for communication of a non-administrative nature (including case conferencing).	Communications can only be billed to the insurer where the insurer is involved in the communication. This includes communications of a non-administrative nature and case conferences: <ul style="list-style-type: none"> • 300079 • 300100 • 300082
All tables (excluding Mental Health Services and Exercise Physiology)	6 consultations pre-approved (including initial and subsequent consultations).	Pre-approved consultations from 6 sessions to 5 consultations (which includes initial and subsequent consultations) excluding mental health services and exercise physiology Exercise Physiology pre-approved consultations have been reduced from 6 sessions to 1 (inclusive of initial consultation). <u>Mental Health services remain at 6 pre-approved consultations</u>
Exercise Physiology and Physiotherapy	Maximum consultation length for subsequent Exercise Physiology and physiotherapy consultations of one (1) hour.	Change to the maximum consultation length for subsequent consultations for exercise physiology and physiotherapy (300187 and 100402 respectively) to a maximum of 45 minutes
	Pre-approval of 6 sessions (including initial and subsequent consultations) for Work Specific Functional Exercise programs (300186, 300187, 100314 and 100402).	A Provider Management Plan will be required for any subsequent consultations following the initial consultation for Work Specific Functional Exercise programs provided by an Exercise Physiologist or Physiotherapist
Mental Health Services	For psychologists, there were three primary reporting code types: <ul style="list-style-type: none"> • Progress Report • Standard Report • Comprehensive report 	Removal of Progress and Standard report types from psychological services. A new report type has been created called the Psychological Treatment Progress Report. Please refer to the Mental Health Services table of costs for further detail on service expectations.

Allied Health Supplementary Services

Quick reference table – Common Item Numbers

Item number	Description (High level)	Insurer prior approval required	Fee – GST not included ¹
300079	Communication – 3 to 10 mins	No	\$37
300100	Communication – 11 to 20 mins	No	\$75
300082	Case Conference	Yes (see table below)	\$223
300086	Progress Report (excluding psychology)	At the request of the insurer	\$75
300088	Standard Report (excluding psychology)	At the request of the insurer	\$189
300090	Comprehensive Report (excluding psychology)	At the request of the insurer	\$223/hr (pro-rata)
1000238	Comprehensive Report - (psychology only)	At the request of the insurer	\$223/hr (pro- rata)
300006	Psychological Treatment Progress Report- (psychology only)	At the request of the insurer	\$223/hr (pro-rata)
300092	Travel – Treatment	Yes (see table below)	\$165
300094	Incidental Expenses ²	Yes (see table below)	\$85
300228	Gym and Pool Entry Fees	Yes (see table below)	
300093	Copies of Patient Records relating to claim	At the request of the insurer	\$31

1. Rates do not include GST. Check with the [Australian Taxation Office](#) or your tax advisor if GST is applicable.

2. Incidental expenses specific to the Hand Therapy discipline are referenced in the [Hand Therapy Services Table of Costs](#)



You can click on the item numbers in the table to view details.

Item number / service	Description
<p>300079 Communication- 3 to 10 mins</p> <p>Insurer prior approval required No</p> <p>Fee – GST not included¹ \$37</p>	<p>Direct communication between the treating provider, insurer, employer, insurer-referred allied health providers, and doctors is essential for facilitating faster and more effective rehabilitation and return to work outcomes for workers. Communications must involve the insurer.</p> <p>This excludes communication with the worker of a general administrative nature, the exchange of non-specific information, and communication between or among internal and external medical or allied health providers - unless the communication specifically involves the insurer.</p> <p>Communication must last longer than three (3) minutes. Please refer to the exclusions listed below the table before using this item number.</p> <p>Treating providers are required to maintain a written record of the communication, including the date, time, and duration. The insurer may request evidence of communication at any time.</p>
<p>300100 Communication- 11 to 20 mins</p> <p>Insurer prior approval required No</p> <p>Fee – GST not included¹ \$75</p>	<p>Direct communication between the treating provider, insurer, employer, insurer-referred allied health providers, and doctors is essential for facilitating faster and more effective rehabilitation and return to work outcomes for workers. Communications must involve the insurer.</p> <p>This excludes communication with the worker of a general administrative nature, the exchange of non-specific information, and communication between or among internal and external medical or allied health providers -unless the communication specifically involves the insurer.</p> <p>Communication must last longer than ten (10) minutes. Please refer to the exclusions listed below in the table before using this item number.</p> <p>Treating providers are required to maintain a written record of the communication, including the date, time, and duration. The insurer may request evidence of communication at any time.</p>
<p>300082 Case Conference</p> <p>Insurer prior approval required Yes</p>	<p>Prior approval is required before providing this service.</p>

<p>Fee – GST not included¹ \$223 per hour (charged pro-rata as a fraction of an hour)</p>	<p>Face-to-face or phone communication involving the treating provider, insurer and one or more of the following:</p> <ul style="list-style-type: none"> • treating medical practitioner or specialist, • employer or employee representative • worker • allied health provider; or • other. <p>Communication must involve the insurer.</p>
<p>300086 Progress Report</p> <p>Insurer prior approval required At the request of the insurer</p> <p>Fee – GST not included¹ \$75</p>	<p>A written report providing a brief summary of the workers' progress towards recovery and return to work.</p>
<p>300088 Standard Report</p> <p>Insurer prior approval required At the request of the insurer</p> <p>Fee – GST not included¹ \$189</p>	<p>A written report that conveys relevant information relating to a worker's recovery and return to work including functional and return to work status, treatment plan, interventions to date, any changes in prognosis along with the reasons for those changes, barriers, recommendations, goals, and timeframes. Also includes responses to a limited number of questions raised by an insurer.</p>
<p>300090 Comprehensive Report</p> <p>Insurer prior approval required At the request of the insurer</p> <p>Fee – GST not included¹ \$223 per hour (charged pro-rata as a fraction of an hour)</p>	<p>A written report that conveys all the information included in a standard report however would only be relevant where questions raised by the insurer are extensive.</p> <p>Maximum billable time: 3 to 5 hours</p>
<p>1000238 Comprehensive Report- psychologists only</p> <p>Insurer prior approval required At the request of the insurer</p>	<p>A comprehensive psychological report prepared to assess diagnostic clarification, workplace functioning, or educational needs.</p> <p>Maximum billable hours: 3-5 hours.</p>

<p>Fee – GST not included¹ \$223 per hour pro-rata Maximum billable hours: 3-5 hours</p>	<p>Reports must be provided within 10 business days of the insurer’s request.</p> <p>This report is only to be prepared at the request of the insurer.</p>
<p>300006 Psychological Treatment Progress Report- psychologists only</p> <p>Insurer prior approval required At the request of the insurer</p> <p>Fee – GST not included¹ \$223 per hour pro-rata Maximum billable hours: 1.5 hours</p>	<p>This report is for cases where the insurer has requested specific information and/or where the insurer has requested specific information and/or a limited set of questions.</p> <p>Reports must be submitted within 10 business days of the request.</p> <p>Maximum billable time: 1.5 hours.</p> <p>This report is only to be prepared at the request of the insurer.</p>
<p>300092 Travel</p> <p>Insurer prior approval required Yes</p> <p>Fee – GST not included¹ \$165 per hour pro-rata</p>	<p>Prior approval is required for travel of more than one (1) hour.</p> <p>Travel charges are applicable when the provider is required to leave their ‘normal place of practice’ to treat a worker at a:</p> <ul style="list-style-type: none"> • rehabilitation facility • hospital • workplace • their place of residence • community-based setting. <p>Travel is not payable where:</p> <ul style="list-style-type: none"> • the travel is between clinics or facilities owned and/or operated by the provider or their employer • the travel is for services delivered at an ‘external facility’ where treatment at these external facilities is a regular part of that providers approach and there exists a contractual arrangement and/or agreement to use that ‘external facility’. <p>Please note: If a provider or their employer has multiple clinics, travel must be calculated from the providers closest normal place of practice to the site being attended. Where multiple workers are being treated in the same visit to a facility, or in the same geographical area on the same day, travel must be divided evenly between those workers.</p>
<p>300094 Incidental Expenses</p> <p>Insurer prior approval required Yes</p>	<p>Reasonable charges for incidental items required by the worker to assist in their recovery and which they take home with them following their treatment. Pharmacy items and consumables used by a provider during a consultation are not included. For further clarification refer to the information provided below the tables.</p>

Fee – GST not included¹ \$85 / \$249*

* Payment will be made up to **\$85 in total** for incidental expenses and up to **\$249 in total** for supportive devices, per claim (not per consultation), without prior approval. Approval from the insurer must be obtained for items exceeding the pre-approved value.

Hire of equipment to be negotiated with insurer.

All expenses must be itemised on the invoice.

Please note: This item number is not to be used for admission fees to external facilities such as gyms and pools.

[300228](#) Gym and Pool Entry Fees

Insurer prior approval required Yes

Fee – GST not included¹ -

Prior approval is required before providing this service. The insurer may request justification and will consider seeking a second opinion if more than **three (3) months**² facility membership is requested per episode of care.

Entry fee for the worker to attend a gym or pool for assessment and treatment (up to a maximum three-month membership).

Entry fees will be paid for the worker, only where the facility is not owned or operated by the provider, their employer, or where either party contracts their services to the facility.

Entry fees will not be paid for providers.

A Provider Management Plan³ (PMP) is expected to be submitted for approval before any treatment commences. The PMP should include a comprehensive treatment plan containing:

- expected functional gains
- transition of care to self-management and
- treatment timeframes.

[300093](#) Copies of Patient Records Relating to Claim

Insurer prior approval required No

Fee – GST not included¹ \$31

Copies of patient records relating to the worker's compensation claim include file notes, results of relevant tests (e.g., pathology, diagnostic imaging, and reports from specialists).

Paid at \$31 flat fee plus \$1 per page.

Communication (Item numbers 300079, 300100)

- Used by treating providers for direct communication between the treating provider, insurer, employer, insurer-referred allied health providers, and doctors is essential for facilitating faster and more effective rehabilitation and return to work outcomes for workers.
- The communication must be relevant to the work-related injury or condition 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.
- This item may be used when sharing written or verbal feedback or recommendations with the insurer to help update a worker's Suitable Duties Plan (SDP), My Recovery Plan or Rehabilitation and Return to Work (RRTW) plan. This must follow discussion with the worker. Feedback or recommendations may relate to the worker's goals, diagnosis or treatment approach, capacity for work or return-to-work planning. The insurer uses this feedback to update the relevant plan where needed.

These items don't apply to:

- reading or reviewing the workers' SDP, My Recovery Plan or RRTW plan
- discussing the relevant plan with the worker during a consultation.

These activities form part of routine clinical care and are covered under consultation items in the relevant Table of Costs. Please check with the insurer for any specific requirements. For WorkCover Queensland, more information is available on the [My Recovery Plan](#) page.

Please note: Communications must involve the insurer.

Each phone call, fax/email preparation must be more than three (3) minutes in duration to be invoiced. 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 must be invoiced under the appropriate item number)
- 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 and
 - communication between or among internal and external medical or allied health providers, unless the communication specifically involves 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 where there are multiple parties involved with the same communication (phone 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 provider 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.

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Case Conference (Item number 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 travel to and from the venue).

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.

Please note: Communications must involve the insurer.

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Reports (Item numbers 300086, 300088, 300090)

Please note that Psychological Treatment Progress Report 300006 and Comprehensive Report- Psychology 1000238 are for Psychologists only.

A report should be provided only following a request from the insurer or where the provider 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 provider 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 accepted work-related injury or condition
- the report communicates the worker's progress or otherwise
- all reports are received by the insurer within ten (10) working days from when the provider received the request.

In general, reports delayed longer than three (3) weeks provide minimal benefit 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 the work-related injury
- claim number
- diagnosis
- date first seen
- period of time covered by the report
- referring medical practitioner
- contact details/signature and title of provider responsible for the report.

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

Progress report – a brief summary of a worker’s progress including return to work status, completion of goals, future recommendations, timeframes .

Standard report - conveys relevant information relating to a worker’s recovery and return to work including functional and return to work status, treatment plan, interventions to date, any changes in prognosis along with the reasons for those changes, barriers, recommendations, goals, and timeframes. Also includes responses to a limited number of questions raised by an insurer. A standard report should only be completed if the appropriate examination has been undertaken for the report to be completed.

Also includes responses to a limited number of questions raised by an insurer.

Comprehensive report - conveys all the information included in a standard report however would only be relevant where questions raised by the insurer are extensive. **Maximum billable hours: 3–5 hrs.**

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Psychological Treatment Progress Report (Item number 300006 Psychologists only)

A psychological treatment progress report prepared to communicate relevant information regarding a worker’s work-related psychological injury or condition. This report is for cases where the insurer has requested specific information and/or a limited set of questions.

- Reports must be submitted within 10 business days of the request
- **Maximum billable time: 1.5 hours**
- This report is only to be prepared at the request of the insurer.

In general, reports delayed longer than three (3) weeks provide minimal benefit to the insurer and will not be paid for without prior approval from the insurer.

This is a written report requested by the insurer to assess the progress of treatment.

Your report should include the following:

- **Therapy Provided** - Briefly describe the psychological therapy or intervention delivered
- **Outcomes Achieved** - Include measurable outcomes and detail the progress made to date, supported by relevant outcome measures
- **Progress Toward Goals** - Clearly outline the worker’s goals and demonstrate how treatment has helped move toward achieving them
- **Recommendations** - Provide specific, evidence-based recommendations to support return to work (RTW) and self-management of the condition or any other treatment proposed with clear timeframes.

Please consider the following when preparing reports for the insurer:

- **Purpose** - Your report is a key information source for insurers, many of whom may not have a medical or allied health background.
- **Language** - Write in clear, plain English. Avoid complex clinical or medical terminology to ensure your recommendations and insights are easily understood.

- **Content Checklist:**

- Are your recommendations evidence-based and clearly stated?
- Is the treatment aligned with the worker's goals, recovery, and RRTW plans?
- Have you explained how treatment is progressing and how it supports the worker's recovery?
- Have you described how the worker's current psychological condition impacts their functional ability at home or work (e.g., social interactions, communication, self-care, financial or administrative tasks)?

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Psychologists Comprehensive report (Item number 1000238)

- At the request of the insurer.
- A comprehensive psychological report prepared to assess diagnostic clarification, workplace functioning, or educational needs.
- **Maximum billable hours: 3-5 hrs.**
- Reports must be provided within 10 business days of the insurer's request.
- In general, reports delayed longer than three (3) weeks provide minimal benefit to the insurer and will not be paid for without prior approval from the insurer.
- This report is only to be completed upon request.

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Travel – Treatment (Item number 300092)

Travel charges are applicable when the provider is required to leave their 'normal place of practice' to treat a worker at a:

- rehabilitation facility
- hospital
- workplace
- their place of residence, or
- community-based setting.

The travel must relate directly to service delivery for the work-related injury or condition*.

Travel can be charged when:

- it is appropriate to attend the worker somewhere other than the 'normal place of practice':
 - to assist in the provision of services or treatment - where the provider does not have the facilities at their practice
 - to attend a case conference*
- a worker is unable to attend the provider's 'normal place of practice' and they are treated at their home or in the community
- the travel relates directly to service delivery for the work-related injury or condition.

***Please note:** Check procedures and conditions of service to determine if prior approval is required from the insurer.

Travel is not payable where:

- the travel is between clinics or facilities owned and/or operated by the provider or their employer
- the travel is for services delivered at an 'external facility' where treatment at these 'external facilities' is a regular part of that providers approach and there exists a contractual arrangement and/or agreement to use that 'external facility'.

Payment of travel in relation to services delivered at 'external facilities' and there exists a contractual arrangement and/or agreement to use that 'external facility' will only be made in exceptional circumstances, to be considered on a case-by-case basis. The insurer's prior approval must be obtained in writing before delivering these services or incurring these costs. The insurer will not be liable for costs where prior approval was not obtained.

Approval is required for travel for more than one (1) hour.

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 i.e. when visiting multiple workers at the same workplace – the travel charge must be divided evenly between workers treated at that location; or when visiting multiple worksites in the same journey – the travel charge must be divided accordingly between workers involved and itemised separately.

Examples of visiting multiple workers might include:

Provider travels from their normal place of practice to an external gym facility to see three (3) workers in succession at this facility (outbound travel time = 30mins); provider then returns to their normal place of practice (inbound travel time = 30mins)

In this example, travel time to and from the external gym facility should be charged on each worker’s claims but divided in three (3) i.e., each worker’s claim should be charged for 10 mins outbound and 10 mins inbound travel time.

Provider travels from their normal place of practice to external gym facility to see one worker (outbound travel time = 30 mins); then on to another external gym facility to see another worker (outbound travel time = 15 mins) and then returns to normal place of practice (inbound travel time = 20mins)

In this example, only travel time to the first external gym facility should be charged on the first worker’s claim, i.e., 30 minutes only. Travel time to the second gym facility and then back to the normal place of practice should be charged on the second worker’s claim i.e., 15 mins outbound and 20 mins inbound travel time.

Providers must only charge for travel time that is actually incurred.

Travel must be calculated from the providers closest ‘normal place of practice’ to the site being attended.

If a provider or their employer has multiple clinics, travel must be calculated from the providers closest ‘normal place of practice’ to the site being attended.

All accounts must include the total time spent travelling, departure and destination locations and the distance travelled.

Definition for ‘**Normal place of practice**’:

Normal place of practice means the facility or premises from which the provider regularly operates their practice for the delivery of treatment services. It also includes external facilities where services may be delivered on a regular basis or as a contracted service, such as a hospital, gym, or pool. If the provider attends an external facility and there exists a contractual arrangement and/or agreement to use that external facility, this will still be seen to be part of the normal place of practice.

Definition for ‘**External facility**’:

External facility means an external facility such as a gym or pool, where the facility is not owned or operated by the treatment provider or where the provider does not contract their services to and/or have an agreement with the facility.

Please note: Where the provider’s ‘normal place of practice’ is solely mobile, travel approval will be considered on a case-by-case basis, considering the worker’s individual circumstances, including their capacity to travel, geographic location, and the availability of suitably qualified alternative providers. Approval will only be given where travel is deemed necessary and reasonable and supports treatment access and timely service delivery.

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Incidental Expenses (Item number 300094)

Please note: The values specified in this table of costs for incidental expenses are **total per claim and not per consultation**. **Incidental and Dressing Pack items relating to the provision of Hand Therapy Services are located within the Hand Therapy Services Table of Costs.**

Reasonable fees are payable for incidental expenses required by the worker resulting from the work-related injury or condition, that the worker takes with them.

Pharmacy items and consumables used by a provider during a consultation are not included.

Hire of equipment to be negotiated with insurer. 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, providers must discuss the request with the insurer.

All items must be itemised on invoices.

Please note: This item number is not to be used for admission fees to external facilities such as gyms and pools.

Reasonable expenses

Items considered to be reasonable incidental expenses are those that the worker takes with them – including bandages, elastic stockings, tape, crutches, theraputty, 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 include splinting material, prefabricated splints, and braces.

All items must be shown to be necessary items for successful treatment of the work-related injury or condition.

The insurer will not pay for:

- items regarded as consumables used in 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.

Please note: Incidental expenses/consumables that relate to wound care and dressings can be considered as reasonable expenses. These may include:

- Forceps
- Scissors
- Saline
- Dressing packs
- Suture cutters
- Gauze swabs.

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Gym and Pool Entry Fees (Item number 300228)

Insurer approval must be obtained prior to undertaking the service.

This includes entry fees for the worker to attend a gym or pool for assessment and treatment (up to a maximum 3-month membership).

The insurer will not pay an entrance fee where the facility is owned or operated by the provider, their employer, or where either party contracts their services to the facility. Exceptions to this may be approved by the insurer where unusual circumstances apply. Entry fees will not be paid for providers.

The insurer may request justification for use of this item number from the requesting provider and may also consider seeking a second opinion if more than 3 month's membership is requested (per episode of care).

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Patient Records (Item number 300093)

The fee is payable upon request from the insurer for 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 \$31 flat fee plus \$1 per page.

If the copies of records are to exceed 50 pages, the provider is required to seek approval from the insurer before finalising the request.

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