WorkCover QUEENSLAND

Counselling and Psychotherapy Services Table of Costs

Effective 1 July 2022

Counselling and Psychotherapy Services Table of Costs

Quick reference table - Common Item Numbers

ITEM NUMBER	DESCRIPTION (HIGH LEVEL)	INSURER PRIOR APPROVAL REQUIRED	FEE – GST NOT INCLUDED
400101	Initial Consultation	No	$154/hr (pro-rata)
400102	Subsequent Consultation	Yes (see table below)	$154/hr (pro-rata)
300079	Communication – 3 to 10 minutes	No	$33
300100	Communication – 11 to 20 minutes	No	$66
300082	Case Conference	Yes (see table below)	$197/hr (pro-rata)
300086	Progress Report	At insurer request	$66
300088	Standard Report	At insurer request	$167
300090	Comprehensive Report	At insurer request	$197/hr (pro-rata)
300092	Travel – Treatment	Yes (see table below)	$140/hr (pro-rata)
300094	Incidental Expenses	Yes (see table below)	$75

ITEM NUMBER / SERVICE		DESCRIPTION
400101 Initial Consultation		A one-on-one initial consultation where possible psychological, social, cognitive, emotional, and behavioural problems are occurring after a work-related injury or condition. The purpose of the assessment is to identify appropriate interventions/treatments to optimise rehabilitation outcomes (maximum two (2) hours direct contact and test scoring time). Services to be conducted in accordance with the Clinical Framework for the Delivery of Health Services[2]. Initial consultation may include: – history taking – assessment – diagnostic formulation – treatment/service – tailored goal setting and treatment planning – setting expectations of recovery and return to work – clinical recording – communication with the insurer of any relevant information for the worker's rehabilitation.
Insurer prior approval required	No	
Fee – GST not included[1]	$154 per hour (charged pro-rata as a fraction of an hour)	
400102 Subsequent Consultation		A one-on-one subsequent consultation with the worker in their ongoing management and treatment. Intervention is based on treatment formulated in the initial consultation. The first six (6) hours (including initial consultation) are pre-approved, provided this condition has not previously been treated by an allied health provider, with a maximum of two (2) hours on any one day. If additional treatment is required, submit a Provider Management Plan[3] (PMP) within six (6) hours of consultations which includes a comprehensive treatment plan containing: – expected functional gains, – transition to self-care management; and – treatment timeframes. Services to be conducted in accordance with the Clinical Framework for the Delivery of Health Services[2]. Subsequent consultation may include: – ongoing assessment – intervention/treatment – setting expectations of recovery and return to work – clinical recording – communication with the insurer of any relevant information for the worker's rehabilitation.
Insurer prior approval required	Yes	
Fee – GST not included[1]	$154 per hour (charged pro-rata as a fraction of an hour)	

ITEM NUMBER / SERVICE	DESCRIPTION
300079 Communication - 3 to 10 mins **Insurer prior approval required** No **Fee – GST not included**[1] $33	Direct communication between treating provider and insurer, employer, insurer referred allied health provider and doctors to assist with faster and more effective rehabilitation and return to work for a worker. Excludes communication with a worker, and of a general administrative nature or conveying non-specific information. Must be more than three (3) minutes. Refer to details below the tables for a list of exclusions before using this item number. Treating providers are expected to keep a written record of the details of communication including date, time, and duration. The insurer may request evidence of communication at any time.
300100 Communication - 11 to 20 mins **Insurer prior approval required** No **Fee – GST not included**[1] $66	Direct communication between treating provider and insurer, employer, insurer referred allied health provider and doctors to assist with faster and more effective rehabilitation and return to work for a worker. Excludes communication with a worker, and of a general administrative nature or conveying non-specific information. Must be more than ten (10) minutes. Refer to details below the tables for a list of exclusions before using this item number. Treating providers are expected to keep a written record of the details of communication including date, time, and duration. The insurer may request evidence of communication at any time.
300082 Case Conference **Insurer prior approval required** Yes **Fee – GST not include**[1] $197 per hour (charged pro-rata as a fraction of an hour)	**Prior approval is required before providing the service.** Face-to-face or phone communication involving the treating provider, insurer and one or more of the following: – treating medical practitioner or specialist – employer or employee representative – worker – allied health providers; or – other.
300086 Progress Report **Insurer prior approval required** At the request of the insurer **Fee – GST not included**[1] $66	A written report providing a brief summary of the worker's progress towards recovery and return to work.

ITEM NUMBER / SERVICE		DESCRIPTION
300088 Standard Report **Insurer prior approval required** **Fee – GST not included**[1]	 At the request of the insurer $167	A written report used for conveying relevant information about a worker's work-related 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.
300090 Comprehensive Report **Insurer prior approval required** **Fee – GST not included**[1]	 At the request of the insurer $197 per hour (charged pro-rata as a fraction of an hour)	A written report only used where the case and treatment are extremely complex. Hours to be negotiated with the insurer prior to providing the report.
300092 Travel - Treatment **Insurer prior approval required** **Fee – GST not included**[1]	 Yes $140 per hour (charged pro-rata as a fraction of an hour)	**Prior approval is required for travel of more than one (1) hour.** 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. 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'. **Please note:** If a provider or their employer have 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.

ITEM NUMBER / SERVICE		DESCRIPTION
300093 Copies of Patient Records relating to claim		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 $27 flat fee plus $1 per page.
Insurer prior approval required	No	
Fee – GST not included[1]	$27	
300094 Incidental Expenses		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. * Payment will be made up to **$75 in total** for incidental expenses and up to **$220 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.
Insurer prior approval required	Yes	
Fee – GST not included[1]	$75/$220*	
300295 External Case Management		This service includes an initial needs assessment and report which must outline a case management plan indicating the goals of the program, services required, timeframes and costs.
Insurer prior approval required	At the request of the insurer	
Fee – GST not included[1]	$197 per hour (charged pro-rata as a fraction of an hour)	

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

1. Rates do not include GST. Check with the Australian Taxation Office or your tax advisor if GST is applicable.
2. WorkCover Queensland encourages the adoption of the nationally recognised Clinical Framework for the Delivery of Health Services when treating a worker with a work-related injury or condition.
3. A Provider Management Plan (PMP) template is available on the Workers' Compensation Regulatory Services' website.

Who can provide counselling and psychotherapy services to workers?

All counselling and psychotherapy services must be provided by a counsellor or psychotherapist who is either a full clinical member of the Psychotherapy and Counselling Federation of Australia (PACFA), or a level 3 or level 4 member of the Australian Counsellors Association (ACA). Further details on these requirements can be found on the Australian Register of Counsellors and Psychotherapists (ARCAP).

Consultations (Item numbers 400101, 400102)

For an accepted claim, the insurer will pay the cost of an initial consultation, however not for an initial and subsequent consultation on the same day unless in exceptional circumstances, as approved by the insurer.

A provider cannot bill for multiple initial consultations or multiple subsequent consultations for the same claimant on the same day.

Consultations may include the following elements:

- **Assessment time (initial consultation)** – includes one-on-one time with the worker and where necessary their significant other; provider-administered tests and the scoring of the tests—self-administered tests are not included in the assessment time. Generally, an assessment will take up to two (2) to complete. The providers must obtain prior approval from the insurer for additional time if an assessment is likely to take longer than two (2) hours.
- **Subjective (history) assessment** – consider major symptoms and lifestyle dysfunction; current/past history and treatment; aggravating and relieving factors; general health; medication; risk factors and key functional requirements of the worker's job.
- **Objective (psychological) assessment** – assess using standardised outcome measurements to provide a base line prior to commencing treatment. The assessment should include psychological function, activity and participation and the impact of environmental and personal factors on recovery relevant to the worker's work-related injury or condition. 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. Actively promote self-management and empower the worker to play an active role in their rehabilitation.
- **Treatment (intervention)** – formulate and discuss the treatment goals, progress and expected outcomes with the worker. Provide advice on pacing, functional goals, and methods to overcome barriers.
- **Clinical recordings** – 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.

When transitioning between pre-approved and prior approved services, it is recommended that you contact the insurer for clarification on what (if any) restrictions may apply.

The insurer will not pay a fee for the completion of a Provider Management Plan (PMP).

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 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.

Service conditions

Services provided to workers are subject to the following conditions:

- **Assessment** – after the initial consultation (as per applicable item numbers) a Provider Management Plan (PMP) must be provided to the insurer to advise of assessment outcome and before any further treatment commences. More information is available on the Workers' Compensation Regulatory Services' website including a PMP form and approval process.
- **Therapy** – the first six (6) hours (including initial consultation), provided the work-related injury or condition has not previously been treated by an allied health provider, with a maximum of two (2) hours on any one day. For complex assessments, contact the insurer to discuss the case and to negotiate further hours if necessary. If additional treatment is required, the provider is required to submit a PMP when six (6) hours of consultations and have been provided.
- **Provider Management Plan (PMP)** – this form is available on the Workers' Compensation Regulatory Services' website and is to be completed if treatment is required after any pre-approved consultations or any services where prior approval is required. Check with each insurer as to their individual requirements.
- **Approval for other services or consultations** – approval must be obtained for any service requiring prior approval from the insurer before commencing treatment.

- **Payment of treatment** – the maximum fees payable are listed in the table of costs above. For services not outlined in the table of costs above, 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. 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.
- **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 provider 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.

Communication (Item numbers 300079, 300100)

Used by treating providers for direct communication between the insurer, employer, insurer referred allied health provider and doctors to assist with faster and more effective rehabilitation and return to work for a worker.

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.

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.

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.

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.

Reports (Item numbers 300086, 300088, 300090)

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 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 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, 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, 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 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.

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. Insurer 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 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 mins 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 have 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.

Patient Records (Item number 300093)

The fee is payable upon request from the insurer for copies of patient records relating to the workers compensation claim, including file notes and reports from specialists.

Paid at $27 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.

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.**

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 actually 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

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.

External Case Management (Item number 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 provider may be requested to provide case management for the entirety or for a portion of the worker's claim.

External case management may require the provider to co-ordinate equipment prescription, assistive technology and/or home modifications for the 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.

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.

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 worker has ongoing or predicted impairment and/or medical restrictions, and the demands of the pre-injury duties are beyond the worker's capabilities, the primary purpose of rehabilitation becomes to permanently return the worker to other suitable duties with the pre-injury employer. If this is not feasible, the worker may be returned to work on other suitable duties with a different 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.
- 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.

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

General guidance on payment for services

The insurer's objective under section 5 of the *Workers' Compensation and Rehabilitation Act 2003* (the Act) is to ensure that workers receive timely treatment and rehabilitation to assist with their return to work. This table of costs sets out the maximum fees payable by the insurer for the applicable services. This table of costs applies to all work-related injury or condition claims whether insured through WorkCover Queensland or a self-insured employer. The maximum fees in this schedule apply to services provided on or after 1 July 2022. The related injury or condition may have been sustained before, on or after this date.

The purpose of the services outlined in this table of costs is 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.

The insurer expects the fees for services 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 worker's compensation claim must have been accepted by the insurer for the injury or condition being treated. With prior approval from the insurer, a patient can access early psychological support services in relation to a primary and/or secondary work-related psychological injury or condition while the claim is being assessed. Please contact the insurer for further clarification regarding early psychological support services.

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.

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.

Self-insurers require separate tax invoices for services to individual workers. WorkCover Queensland will accept invoicing for more than one worker on a single invoice.

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.

Further 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.

More information for service providers is available on our website together with the current list of self-insured employers. If you require further information, call us on 1300 362 128.

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