WorkCover QUEENSLAND

Chiropractic Services Table of Costs

Effective 1 July 2021

Chiropractic Services Table of Costs

ITEM NUMBER / SERVICE	DESCRIPTION
500021 Initial Consultation **Insurer prior approval required** No **Fee – GST not included**[1] $90	A one-on-one initial consultation in the treatment of a work-related injury or condition, or the first consultation in a new episode of care for the same work-related injury or condition. Services to be conducted in accordance with the Clinical Framework for the Delivery of Health Services[2]. Initial consultation may include: – subjective assessment – objective assessment – 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.
500313 Initial Consultation - multiple injuries or conditions **Insurer prior approval required** No **Fee – GST not included**[1] $134	A one-on-one initial consultation in the treatment of two or more entirely separate work-related injuries or conditions, or the first consultation in a new episode of care for the same two or more entirely separate work-related injuries or conditions. **Please note**: – this does not include an injury or condition with referred pain to another area, and – a workers' compensation certificate detailing each work-related injury or condition to be treated is required. Services to be conducted in accordance with the Clinical Framework for the Delivery of Health Services[2]. Initial consultation may include: – subjective assessment – objective assessment – 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.

ITEM NUMBER / SERVICE	DESCRIPTION
500006 Subsequent Consultation **Insurer prior approval required** Yes **Fee – GST not included**[2] $80	A one-on-one subsequent consultation in the treatment of one work-related injury or condition only. The first five (5) consultations (including initial consultation) are pre-approved, provided the injury or condition has not previously been treated by an allied health provider. If additional treatment is required, submit a Provider Management Plan[3] (PMP) by the 6th subsequent treatment consultation. The PMP should include a comprehensive treatment plan containing: – expected functional gains, – transition of care to self-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 (subjective and objective) – 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.
500102 Subsequent Consultation - multiple injuries or conditions **Insurer prior approval required** Yes **Fee – GST not included**[1] $153	A one-on-one subsequent consultation with the worker in the treatment of two or more entirely separate work-related injuries or conditions. The first five (5) consultations (including initial consultation) are pre-approved, provided the injury or condition has not previously been treated by an allied health provider. If additional treatment is required, submit a Provider Management Plan[3] (PMP) by the 6th subsequent treatment consultation. The PMP should include a comprehensive treatment plan containing: – expected functional gains, – transition of care to self-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 (subjective and objective) – 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.

ITEM NUMBER / SERVICE	DESCRIPTION
500055 Reassessment or Program Review **Insurer prior approval required** Yes **Fee – GST not included**[1] $111	A comprehensive assessment used when: – the worker has been in active rehabilitation for at least six weeks and further treatment is likely; and/or – there are new clinical findings that might affect ongoing treatment; and/or – there is a rapid change in worker's status and/or – there is no response to current therapeutic interventions. It should include: – all components of initial consultation – a review of the worker's progress based on established objective measures – a recommendation for future treatment and management strategies to assist the worker to return to work. It may include referral recommendations to other providers, a change in therapy or outcome direction requiring a new return to work goal. Following reassessment submit a Provider Management Plan[3] (PMP) with an updated comprehensive treatment plan containing: – expected functional gains, – transition of care to self-management; and – treatment timeframes.
558100 X-Ray - Cervical Spine **Insurer prior approval required** No **Fee – GST not included**[1] $187	X-Ray - Cervical Spine. Must be clinically justifiable.
558103 X-Ray - Thoracic Spine **Insurer prior approval required** No **Fee – GST not included**[1] $155	X-Ray - Thoracic Spine. Must be clinically justifiable.

ITEM NUMBER / SERVICE	DESCRIPTION
558106 X-Ray - Lumbosacral Spine **Insurer prior approval required** No **Fee – GST not included**[1] $217	X-Ray - Lumbosacral Spine. Must be clinically justifiable.
558112 X-Ray - Any Two Regions of the Spine **Insurer prior approval required** No **Fee – GST not included**[1] $273	X-Ray - Any two regions of the spine. Must be clinically justifiable.
558115 X-Ray - Any Three Regions of the Spine **Insurer prior approval required** No **Fee – GST not included**[1] $375	X-Ray - Any three regions of the spine. Must be clinically justifiable.
500226 Independent Case Review **Insurer prior approval required** At the request of the insurer **Fee – GST not included**[1] $236 per hour (charged pro-rata as a fraction of an hour)	An independent chiropractic examination and report on a worker and is not carried out by the treating chiropractor. The review is requested by the insurer where progress of treatment and/or rehabilitation falls outside the plan or expected course of injury management. The examination and report provide the insurer with an assessment and recommendations for ongoing treatment and prognosis.

ITEM NUMBER / SERVICE	DESCRIPTION
300079 Communication - 3 to 10 mins **Insurer prior approval required** No **Fee – GST not included**[1] $32	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] $63	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 included**[1] $189 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] $63	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 $160	A written report used for conveying relevant information about a worker's work-related injury or condition 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 $189 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 $134 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 (including a gym or pool) – hospital – workplace, or – their place of residence (worker must be certified unable to travel). **Please note:** 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. Travel is **not** payable where: – the provider does not have (or is employed by a business that does not have) a commercial place of business for the delivery of treatment services (e.g. mobile provider practice) – the travel is between clinics owned and/or operated by the provider or their employer – a provider or their employer have multiple clinics, travel is only payable from the clinic closest to the location of treatment.

ITEM NUMBER / SERVICE	DESCRIPTION
300093 Copies of Patient Records relating to claim **Insurer prior approval required** No **Fee – GST not included**[1] $26	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 $26 flat fee plus $1 per page.
300094 Incidental Expenses **Insurer prior approval required** Yes **Fee – GST not included**[1] $58	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 **$58 in total** for incidental expenses and up to **$203 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.

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. The insurer will not pay for the preparation or completion of a PMP.

Who can provide chiropractic services to workers?

All chiropractic services performed must be provided by a chiropractor who has a current registration with the Australian Health Practitioner Regulation Agency (AHPRA).

Consultations (Item numbers 500006, 500021, 500102, 500313)

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.

Consultations may include the following elements:

- **Subjective (history) assessment** – consider major symptoms and lifestyle dysfunction; current/past history and treatment; pain; aggravating and relieving factors; general health; medication; risk factors and key functional requirements of the worker's job.
- **Objective (physical) assessment** – assess movement – for example active, passive, resisted, repeated, muscle tone, spasm, weakness, accessory movements, passive intervertebral movements. Assess overall work function level and any physical impairments preventing the worker's pain from resolving.
- **Assessment results (prognosis formulation)** – provide a provisional prognosis for treatment, limitations to function and return to work progress.
- **Reassessment (subjective and objective)** – evaluate the physical progress of the worker using outcome measures for relevant, reliable, and sensitive assessment. Compare against the baseline measures and treatment goals. Identify factors compromising treatment outcomes and implement strategies to improve the worker's ability to return to work and normal functional activities. Actively promote self-management (such as ongoing exercise programs) 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 treatment modalities according to the goals of therapy.
- **Clinical recording** – record information in the worker's clinical records, including the purpose and results of procedures and tests.
- **Communication (with the insurer)** – communicate any relevant information for the worker's rehabilitation to the insurer. Acknowledge referral and liaise with the treating medical practitioner about treatment.

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.

'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 injured workers are subject to the following conditions:

- **Treatment consultations** – where the claim has been accepted, the insurer will pay for a maximum of five (5) chiropractic consultations without prior approval provided the injury has not previously been treated by an allied health provider. This includes the initial consultation. These five (5) consultations may not be undertaken concurrently with consultations requiring insurer approval.
- **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. The insurer will not pay for the preparation or completion of a PMP.
- **Approval for other services or consultations** – approval must be obtained for any service requiring prior approval from the insurer before commencing treatment.
- **Postoperative chiropractic treatment** – when a worker is referred for chiropractic treatment after a surgical procedure, a new set of five (5) treatments will take effect.
- **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 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 chiropractor if the worker has changed providers (not within the same practice). The new chiropractor will be required to submit a PMP for further treatment outlining the number of consultations the worker has received previously.

Reassessment/Program Review (Item number 500055)

This reassessment or program review is indicated when:

- the worker has been in active rehabilitation for at least six weeks; and further treatment is likely; and/or
- there are new clinical findings that might affect ongoing treatment; and/or
- there is a rapid change in the worker's status and/or
- there is no response to current therapeutic interventions.

A reassessment/program review is a comprehensive assessment including:

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

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

The insurer's prior approval is required before a reassessment/program review is undertaken. The chiropractor is expected to submit a PMP following the reassessment. Check with each insurer as to their individual requirements in relation to the PMP).

A reassessment/program review is not required:

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

X-Rays (Item numbers 558100, 558103, 558106, 558112, 558115)

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

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

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

Independent Case Review (Item number 500226)

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

The purpose of an independent clinical assessment is to:

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

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 is only paid where the provider is required to leave their normal place of practice to provide a service to a worker at a:

- rehabilitation facility (including a gym or pool)
- hospital
- workplace,
- the worker's place of residence (where a worker is certified unable to travel).

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. In this case, the treating medical practitioner must certify the worker as unfit for travel
- 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.

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.

Travel may not be charged when:

- the provider conducts regular consultations visits to particular hospitals, medical specialist rooms or other consultation rooms/facilities
- the provider does not have (or is employed by a business that does not have) a commercial place of business for the delivery of treatment services (e.g. mobile practice)

- the travel is between clinics owned and/or operated by the provider or their employer
- when a provider or their employer have multiple clinics, travel is only payable from the clinic closest to the location of treatment.

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, results of relevant tests e.g. pathology, diagnostic imaging, and reports from specialists.

Paid at $26 flat fee plus $1 per page.

If the copies of records are to exceed 50 pages the chiropractor 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. This item number does not apply to external facility fees.

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.

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.

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 2021. 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. 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).

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.

WorkCover
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worksafe.qld.gov.au