WorkCover QUEENSLAND

Mental Health Services Table of Costs

Effective 1 July 2023

WorkCover QUEENSLAND

This Mental Health Services Table of Costs includes the following services:

- Psychology (including neuropsychological services)
- Rehabilitation Counselling and Social Work
- Counselling and Psychotherapy
- Mental Health Occupational Therapy
- Mental Health Social Work

PROVIDER TYPE	MINIMUM QUALIFICATIONS
Psychologists	All psychology services performed must be provided by a psychologist who: – has a full general registration as a psychologist under the Psychology Board of Australia **or** – has a provisional registration as a psychologist under the Psychology Board of Australia; and is completing a period of supervised practice or internship to be eligible for full general registration. https://psychology.org.au/
Rehabilitation Support and Adjustment to Injury Counselling (Rehabilitation Counsellors and Social Workers)	Specific professional groups, referred to as 'registered persons' under s223(a) of the Act, are qualified to deliver rehabilitation services. Other 'non-registered' professional groups are also able to provide specific rehabilitation services within this table of costs. These 'non-registered approved providers' require insurer approval and are outlined in the service conditions of each item. Services may be provided by: – A person with a tertiary qualification in an accredited rehabilitation counselling course or other recognised behaviour science degree and a full member of the Australian Society of Rehabilitation Counsellors (ASORC) https://www.asorc.org.au/ – A person with a tertiary qualification in an accredited rehabilitation counselling course or other recognised behaviour science degree and a full member of the Rehabilitation Counselling Association of Australasia (RCAA) https://rcaa.org.au/ – A social worker with a tertiary degree in social work.
Counsellors and Psychotherapists	All counselling and psychotherapy services performed must be provided by a counsellor or psychotherapist who has the appropriate qualifications and is either a full clinical member of the Psychotherapy and Counselling Federation of Australia (PACFA) https://www.pacfa.org.au/ or a level 3 or 4 member of the Australian Counsellors Association (ACA) https://www.theaca.net.au/. Further details on these requirements can be found on the Australian Register of Counsellors and Psychotherapists (ARCAP) https://www.arcapregister.com.au/
Mental Health Occupational Therapists	Mental Health Occupational Therapy services must be undertaken by an Occupational Therapist that is: – Registered with the Australian Health Practitioners Authority (AHPA); and – Endorsed under the OTA Mental Health Endorsement Program https://otaus.com.au/membership/ota-member-programs/mental-health-endorsement A mental health endorsed occupational therapist undertaking an independent clinical assessment must have a minimum of:

	– Two years' FTE experience in the provision of mental health occupational therapy services and relevant clinical experience related to the injury type For more information please visit https://otaus.com.au/practice-support/areas-of-practice/mental-health
Neuropsychologists	All Neuropsychologists must have full general registration as a psychologist; and completed a minimum of six (6) years full-time university training^ including postgraduate study in a recognised clinical neuropsychology training program, plus further supervised experience; or must have an Approved Area of Practice endorsed by AHPRA. https://psychology.org.au/ (^ Minimum 3 years undergraduate degree plus 1-year honours program; and master's degree in clinical neuropsychology (2 years minimum) or equivalent. Please check with insurer for further details.)
Accredited Mental Health Social Workers	Social work is a four-year, or two-year masters qualifying, tertiary-qualified profession recognised nationally and internationally. Building on this tertiary qualified foundation is the opportunity to gain a further credential in mental health demonstrating expertise through evidenced practice experience. Social workers who are members of the AASW and who have met certain criteria in mental health settings can seek accredited status as an Accredited Mental Health Social Worker (AMHSW), which was introduced prior to 2008. The AASW is an Accrediting Authority recognised by the Federal Government. The accreditation indicates that the practitioner is a highly skilled mental health clinician in assessment, treatment planning, complex case formulation, and the delivery of evidence-based therapeutic interventions across formative and life stages in collaboration with clients. https://www.aasw.asn.au/

Quick Reference Fees Guides

Psychology Services

ITEM NUMBER	DESCRIPTION (HIGH LEVEL)	INSURER PRIOR APPROVAL REQUIRED	FEE – GST NOT INCLUDED
400088	Initial Consultation – Psychology only	No	$250/hr (pro-rata)
400095	Subsequent Consultation – Psychology only	Yes (see table below)	$250/hr (pro-rata)
400184	Critical Incident Debriefing Sessions	Yes (see table below)	$250/hr (pro-rata)
300079	Communication – 3 to 10 mins	No	$35
300100	Communication – 11 to 20 mins	No	$70
300082	Case Conference	Yes (see table below)	$209/hr (pro-rata)
300086	Progress Report	At insurer request	$70
1000237	Standard Report – item code for psychology only	At insurer request	$177
1000238	Comprehensive Report- item code for psychology only	At insurer request	$209/hr (pro-rata)
300092	Travel – Treatment	Yes (see table below)	$155/hr (pro-rata)
300094	Incidental Expenses	Yes (see table below)	$80
400091	Neuropsychological Services	At insurer request	$250/hr (pro rata)

Counselling and Psychotherapy Services

ITEM NUMBER	DESCRIPTION (HIGH LEVEL)	INSURER PRIOR APPROVAL REQUIRED	FEE – GST NOT INCLUDED
400101 **1000243**	Initial Consultation – Counselling only Initial Consultation – Psychotherapy only	No	$185/hr (pro-rata)
400102 **1000244**	Subsequent Consultation – Counselling only Subsequent Consultation – Psychotherapy only	Yes (see table below)	$185/hr (pro-rata)

Mental Health Occupational Therapy Services

ITEM NUMBER	DESCRIPTION (HIGH LEVEL)	INSURER PRIOR APPROVAL REQUIRED	FEE – GST NOT INCLUDED
1000235	Initial Consultation	No	$209/hr (pro-rata)
1000236	Subsequent Consultation	Yes (see table below)	$209 (pro-rata)

Mental Health Social Work Services

ITEM NUMBER	DESCRIPTION (HIGH LEVEL)	INSURER PRIOR APPROVAL REQUIRED	FEE – GST NOT INCLUDED
1000241	Initial Consultation	No	$234/hr (pro-rata)
1000242	Subsequent Consultation	Yes (see table below)	$234 (pro-rata)

Rehabilitation Counsellor* and Social Work Services

ITEM NUMBER	DESCRIPTION (HIGH LEVEL)	INSURER PRIOR APPROVAL REQUIRED	FEE – GST NOT INCLUDED
300188	Adjustment Counselling – Initial Consultation	No	$234/hr (pro-rata)
300285	Adjustment Counselling – Subsequent Consultation	Yes (see table below)	$234/hr (pro-rata)

* Please note: Rehabilitation Counsellors can provide other vocational related services - please refer to the Return to Work Services Table of Costs for more details.

Common Item Numbers

ITEM NUMBER	DESCRIPTION (HIGH LEVEL)	INSURER PRIOR APPROVAL REQUIRED	FEE – GST NOT INCLUDED
300079	Communication – 3 to 10 mins	No	$35
300100	Communication – 11 to 20 mins	No	$70
300082	Case Conference	Yes (see table below)	$209/hr (pro-rata)

300086	Progress Report	At insurer request	$70
300088	Standard Report (Psychology item code 1000237)	At insurer request	$177
300090	Comprehensive Report (Psychology item code 1000238)	Yes (see table below)	$209/hr (pro-rata)
300092	Travel – Treatment	Yes (see table below)	$155/hr (pro-rata)

Table of Costs

Psychology Services

ITEM NUMBER/SERVICE	DESCRIPTION (HIGH LEVEL)	INSURER PRIOR APPROVAL REQUIRED	FEE – GST NOT INCLUDED
400088	Initial Consultation The initial consultation in the treatment of possible psychological, social, cognitive, emotional, and behavioural problems 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. The entire consultation must be one-on-one with the worker.	No	$250 per hour (charged pro-rata as a fraction of an hour)
400095	Subsequent Consultation A one-on-one subsequent consultation with the worker in the ongoing management and treatment of their work-related psychological issues. 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.	Yes	$250 per hour (charged pro-rata as a fraction of an hour)

	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. Max two (2) hours on any one day.		
400184	Critical Incident Debriefing Sessions A process where, following exposure to a critical incident, an individual or group of workers are debriefed by a psychologist to assist them to deal more effectively with their experience. Approval required after the first two (2) pre-approved sessions.	Yes	$250 per hour (charged as fraction of an hour)
400091	Neuropsychological Assessment An assessment to clarify the presence of possible acquired brain injury or brain dysfunction where possible psychological, social, cognitive, emotional, and behavioural problems are occurring after a work-related injury or condition (four to five (4-5) hours direct contact and test scoring time).	Yes	$250 per hour (charged as fraction of an hour)
400226	Independent Case Review An independent psychologist examination/assessment and report of a worker (not by the treating psychologist). Only provided following a request from the insurer. The review is requested by the insurer where progress of treatment and/or rehabilitation falls outside the plan or expected course of injury management.	At the request of the insurer	$250 per hour (charged pro-rata as a fraction of an hour)

	The examination/assessment and report provide the insurer with an assessment and recommendations for ongoing treatment and prognosis.		
300079	Communication - 3 to 10 mins 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.	No	$35
300100	Communication – 11 to 20 mins 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.	No	$70
300082	Case Conference **Prior approval is required before providing this 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	Yes	$209 per hour (charged pro-rata as a fraction of an hour)

	– worker – allied health provider; or – other.		
300086	Progress Report A written report providing a brief summary of the worker's progress towards recovery and return to work.	At the request of the insurer	$70
1000237	Standard Report (Item Code for Psychology only) 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.	At the request of the insurer	$177
1000238	Comprehensive Report (Item Code for Psychology only) 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.	At the request of the insurer	$209 per hour (charged pro-rata as a fraction of an hour)
300092	Travel - Treatment **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'.	Yes	$155 per hour (Charged pro-rata as a fraction of an hour)

	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.		
300093	Copies of Patient Records relating to claim Copies of patient records relating to the worker's compensation claim including file notes, results of relevant tests e.g., pathology, diagnostic imaging, and reports from specialists. Paid at $29 flat fee plus $1 per page.	At the request of the insurer	$29
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 **$80 in total** for incidental expenses and up to **$233 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.	Yes	$80/$233*

Counselling and Psychotherapy Services

ITEM NUMBER	DESCRIPTION (HIGH LEVEL)	INSURER PRIOR APPROVAL REQUIRED	FEE – GST NOT INCLUDED
400101 **1000243**	Initial Consultation Counselling Services Initial Consultation Psychotherapy Services	No	$185 per hour (charged pro-rata as a

	Undertaken where possible psychological, social, cognitive, emotional, and behavioural problems are occurring after a work-related incident or injury. The purpose of the assessment is to identify appropriate interventions/treatments to optimise rehabilitation outcomes (maximum 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 referrer, insurer, and other relevant parties. The entire consultation must be one-on-one with the worker.		fraction of an hour)
400102 **1000244**	Subsequent Consultation Counselling Services Subsequent Consultation Psychotherapy Services Ongoing management and treatment of work-related injury or condition of presenting psychological issues; intervention would be based on treatment formulated from the initial consultation. The first six (6) hours (including initial consultation) are pre-approved, 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. If additional treatment is required, the provider is required to submit a Provider Management Plan (PMP) when six (6) hours of consultations have been provided. The PMP should include a comprehensive treatment plan containing: – Expected functional gains, – Transition to self-care management; and – Treatment timeframes. The PMP form is available on the Workers' Compensation Regulator's website (www.worksafe.qld.gov.au). The insurer will not pay for the preparation or completion of a Provider Management Plan.	Yes	$185 per hour (charged pro-rata as a fraction of an hour)

	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 referrer) – any relevant information for the worker's rehabilitation to the insurer.		

Rehabilitation Counselling, Social Work and Mental Health Social Work Services

ITEM NUMBER	DESCRIPTION (HIGH LEVEL)	INSURER PRIOR APPROVAL REQUIRED	FEE – GST NOT INCLUDED
300188 **1000241**	Adjustment Counselling - Initial Consultation Rehabilitation Counselling and Social Work only Adjustment Counselling- Initial Consultation Mental Health Social Workers only Undertaken where possible to clarify the presence of possible adjustment to injury issues and set goals of therapy to optimise rehabilitation outcomes; performed where worker is displaying psychological, social, cognitive, emotional, and behavioural problems after a work-related incident or injury. The purpose of the consultation is to identify appropriate interventions/treatments to optimise rehabilitation outcomes. 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	No	$234 per hour (charged pro-rata as a fraction of an hour)

	Maximum one (1) hour.		
300285 **1000242**	Adjustment Counselling – Subsequent Consultation Rehabilitation Counselling and Social Work only Adjustment Counselling- Subsequent Consultation Mental Health Social Workers only Ongoing treatment of work-related components of presenting adjustment to injury conditions; intervention would be based on treatment formulated from the initial consultation (300188) The first six (6) hours (including initial consultation) are pre-approved, 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. If additional treatment is required, the provider is required to submit a Provider Management Plan (PMP) when six (6) hours of consultations have been provided. The PMP should include a comprehensive treatment plan containing: – Expected functional gains, – Transition to self-care management; and – Treatment timeframes. The PMP form is available on the Workers' Compensation Regulator's website (www.worksafe.qld.gov.au). The insurer will not pay for the preparation or completion of a Provider Management Plan. 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 referrer) – any relevant information for the worker's rehabilitation to the insurer. Maximum treatment time of one (1) hour per day	Yes	$234 per hour (charged pro-rata as a fraction of an hour)

Mental Health Occupational Therapy Services

ITEM NUMBER	DESCRIPTION (HIGH LEVEL)	INSURER PRIOR APPROVAL REQUIRED	FEE – GST NOT INCLUDED
1000235	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 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 – subjective and objective 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. – clinical assessment and reassessment including standardised tests and outcome measures	No	$209
1000236	Subsequent Consultation A one-on-one subsequent consultation in the treatment of work-related injuries or conditions. The first six (6) consultations (including initial consultation) are pre-approved, provided the injuries or conditions have 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.	Yes	$209

	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.		

Common Item Numbers

ITEM NUMBER	DESCRIPTION (HIGH LEVEL)	INSURER PRIOR APPROVAL REQUIRED	FEE – GST NOT INCLUDED
300079	Communication – 3 to 10 mins 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.	No	$35
300100	Communication – 11 to 20 mins 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.	No	$70

	The insurer may request evidence of communication at any time.		
300082	Case Conference **Prior approval required before providing this service.** Face-to-face or phone communication involving the provider, insurer and one or more of the following: – treating medical practitioner, specialist – employer or employee representative, – worker, – allied health providers; or – other.	Yes (see table below)	$209/hr (pro-rata)
300086	Progress Report A written report providing a brief summary of the worker's progress towards recovery and return to work.	At insurer request	$70
300088	Standard Report (Psychology only item code 1000237) 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.	At insurer request	$177
300090	Comprehensive Report (Psychology only item code 1000238) 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.	Yes (see table below)	$209/hr (pro-rata)
300092	Travel – Treatment **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:	Yes (see table below)	$155/hr (pro-rata)

	– 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.		
300093	Copies of Patient Records Relating to Claim Copies of patient records relating to the worker's compensation claim including file notes, results of relevant tests e.g., pathology, diagnostic imaging, and reports from specialists. Paid at $29 flat fee plus $1 per page.	At the request of the insurer	$29
300295	External Case Management Includes an initial needs assessment and report; should outline a case management plan indicating the goals of the program, services required, timeframes and costs.	At the request of the insurer	$209 per hour (charged pro-rata as a fraction of an hour)

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

Item Numbers – Descriptors

Consultations (Item numbers 400088, 400095, 400101,400102, 1000243, 1000244, 1000235,1000236)

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; psychologist-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) hours to complete for most services. The psychologist 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 compensable injury. 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).

Adjustment Counselling – Rehabilitation Counsellors and Social Work (Item numbers 300188, 300285) and Mental Health Social Workers (item numbers 1000241 and 1000242)

Indicators for adjustment counselling include but are not limited to:
- unhelpful coping strategies such as avoidance behaviours e.g., not undertaking physical programs for fear, they may cause more hurt/harm
- being stuck in one of the stages of grief reaction.

Consultations may include the following elements:
- **Initial assessment time** – includes one-on-one time with the worker and scoring of tests; excludes time taken by the worker for self-administered tests. An initial assessment allowed up to one (1) hour to complete. If an assessment is likely to be greater than one (1) hour, the provider must obtain prior approval from the insurer for additional time.
- **Subjective (history) assessment** – consider of 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 (psychosocial) assessment** – assess using standardised outcome measurements to provide a baseline prior to commencing treatment. The outcome measurement tools should be reliable, valid, and sensitive to change.
- **Assessment results (prognosis formulation)** – provide a provisional prognosis for treatment, limitations to function and progress for return to work.
- **Reassessment (subjective and objective)** – evaluate the progress of the worker using outcome measures for relevant, reliable, and sensitive assessment. Compare against the baseline measures and treatment goals. Identify factors compromising treatment outcomes and implement strategies to improve the worker's ability to return to work and normal functional activities.
- **Treatment (intervention)** – formulate and discuss the treatment goals, progress and expected outcomes; goal setting; strategies to improve return to work with the worker. Provide advice on homework to promote self-management strategies.
- **Clinical records** – record information in the worker's clinical records, including the purpose and results of procedures and tests.
- **Communication (with the referrer)** – communicate any relevant information for the worker's rehabilitation to insurer. Acknowledge referral and liaise with the treating medical practitioner about treatment.

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).

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.

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 – the provider is expected to assess the needs of the worker against the referral requirements and notify the insurer of the outcome and future treatment goals.
- Provider Management Plan (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 sessions – 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 practitioner if the worker has changed providers (not within the same practice). The new practitioner will be required to submit a PMP for further treatment outlining the number of consultations the worker has received previously.

Critical Incident Debriefing Sessions (Item number 400184)

Critical incident debriefing is a process whereby an individual or a group debriefing is conducted by a psychologist to assist persons involved to deal more effectively with their experiences. Debriefing is likely to occur up to 48 hours after a traumatic incident. During the debrief participants are encouraged to speak freely about the experience, given reassurance and provided with strategies for coping with the work-related injury.

Mandatory requirements of critical incident debriefing sessions:

Following a critical incident, the employer may initiate debriefing sessions. Approval required after the first two (2) pre-approved sessions. Please contact the insurer for further clarification (for WorkCover Queensland claims refer to the Mental Injuries Treatment Guidelines). A Provider Management Plan must be submitted if ongoing therapy is required beyond the two (2) sessions.

Neuropsychological Assessment (Item number 400091)

A neuropsychological assessment may be appropriate where the worker presents with a range of problems related to brain dysfunction that impact on their ability to remain or return to work. Areas for assessment may include, but are not limited to:

- memory problems

- concentration problems
- attention difficulties
- problems thinking clearly and logically
- problems making important decisions
- language and learning difficulties.

Assessment time* – includes one-on-one time with the worker and where necessary their significant other; Neuropsychologist-administered tests and the scoring of the tests—self-administered tests are not included in the assessment time. Generally, assessments will take up to four (4) to five (5) hours for neuropsychology.

For additional time the Neuropsychologist must obtain prior approval from the insurer. Assessment time does not include the report.
(*Note: if the worker is unable to undertake all assessment requirements in one session the time can be broken up over multiple days.)

An assessment may include all or some of the following elements:
- **Subjective (history) reporting** – consider major symptoms and lifestyle dysfunction; current/past history; aggravating and relieving factors; general health; medication and risk factors; and where appropriate, behavioural information from significant others about the worker's present functioning.
- **Objective assessment** – assess face-to-face using standardised outcome measurements to assess brain functioning or psychological and mental illness.
- **Assessment results (prognosis formulation)** – provide a provisional prognosis for treatment, limitations to function and progress for return to work.
- **Treatment (intervention)** – give feedback to the worker at a later date when requested by the insurer. This may be in a case conference format and includes the neuropsychologist, worker, insurer and where appropriate, treating psychologist.
- **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.

Independent Case Review (Item number 400226)

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 psychological treatment.
- propose a recommended course of psychological management.
- make recommendations for strategic planning to progress the case. Recommendations should relate to functional goals and steps to achieve these goals, which will assist in a safe and durable return to work.
- provide a professional opinion on the worker's prognosis where this is unclear from the current psychological 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) (**Psychology only** - standard report item code 1000237 and comprehensive report 1000238)

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 worker's compensation claim including file notes, results of relevant tests e.g., pathology, diagnostic imaging, and reports from specialists.

Paid at $29 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.
- 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.

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

General guidance on payment for services

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 2023. 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).

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.

WorkCover
QUEENSLAND

we cover, we care

worksafe.qld.gov.au