WorkCover QUEENSLAND

Rehabilitation Counsellor, Social Worker and Vocational Placement Provider Services Table of Costs

Effective 1 July 2021

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ITEM NUMBER / SERVICE	DESCRIPTION
300188 Adjustment Counselling - Initial Consultation **Insurer prior approval required** No **Fee – GST not included**[1] $189 per hour (charged pro-rata as a fraction of an hour)	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 Maximum one (1) hour.

ITEM NUMBER / SERVICE	DESCRIPTION
300285 Adjustment Counselling - Subsequent Consultation **Insurer prior approval required** Yes **Fee – GST not included**[1] $189 per hour (charged pro-rata as a fraction of an hour)	**Prior approval required before providing this service.** 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 provider is expected to submit a Provider Management Plan[3] (PMP) after the Adjustment Counselling - Initial Consultation is completed. 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. Maximum treatment time of one (1) hour per day
300079 Communication - 3 to 10 mins **Insurer prior approval required** No **Fee – GST not included**[1] $32	Direct communication between 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. 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.

ITEM NUMBER / SERVICE		DESCRIPTION
300100 Communication - 11 to 20 mins		Direct communication between 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. 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.
Insurer prior approval required	No	
Fee – GST not included[1]	$63	
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.
Insurer prior approval required	Yes	
Fee – GST not included[1]	$189 per hour (charged pro-rata as a fraction of an hour)	
300086 Progress Report		A written report providing a brief summary of the worker's progress towards recovery and return to work.
Insurer prior approval required	At the request of the insurer	
Fee – GST not included[1]	$63	
300088 Standard Report		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.
Insurer prior approval required	At the request of the insurer	
Fee – GST not included[1]	$160	

ITEM NUMBER / SERVICE		DESCRIPTION
300090 Comprehensive Report		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.
Insurer prior approval required	At the request of the insurer	
Fee – GST not included[1]	$189 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, 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 rehabilitation 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.
Insurer prior approval required	Yes	
Fee – GST not included[1]	$134 per hour (charged pro-rata as a fraction of an hour)	
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 $26 flat fee plus $1 per page.
Insurer prior approval required	No	
Fee – GST not included[1]	$26	

ITEM NUMBER / SERVICE		DESCRIPTION
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.
Insurer prior approval required	At the request of the insurer	
Fee – GST not included[1]	$189 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. The insurer will not pay for the preparation or completion of a PMP.

Who can provide rehabilitation support services to injured workers?

Specific professional groups, referred to as 'registered persons' under s223(a) of the Act, are qualified to deliver return to work and vocational rehabilitation services. Other 'non-registered' professional groups are also able to provide specific rehabilitation services within this table of costs. These 'non-registered approved providers' require insurer approval and are outlined in the service conditions of each item.

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)
- 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)
- A social worker with a tertiary degree in social work.

Please note: Where a psychologist provides adjustment counselling, please refer to the Psychology Services Table of Costs for the correct item number.

Adjustment Counselling (Item numbers 300188 and 300285)

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.

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:

- The provider 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.
- The provider is 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. The insurer will not pay for the preparation or completion of a PMP.
- **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 physiotherapist if the worker has changed providers (not within the same practice). The new physiotherapist will be required to submit a PMP for further treatment outlining the number of consultations the worker has received previously.

Communication (Item numbers 300079, 300100)

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

The communication must be relevant to the work-related injury or condition and assist the insurer and other involved parties to resolve barriers and/or agree to strategies or intervention/s proposed. Communication includes phone calls, emails, and facsimiles.

Each phone call, fax/email preparation must be more than three (3) minutes in duration to be invoiced. Note: most communication would be of short duration and would only exceed ten minutes in exceptional or unusual circumstances.

The insurer will not pay for:

- normal consultation communication that forms part of the usual best practice of ongoing treatment (when not of an administrative nature this must be invoiced under the appropriate item number)
- communication conveying non-specific information such as 'worker progressing well'
- communication made or received from the insurer as part of a quality review process
- General administrative communication, for example:
  - forwarding an attachment via email or fax e.g. forwarding a Suitable Duties Plan or report
  - leaving a message where the party phoned is unavailable
  - queries related to invoices
  - for approval/clarification of a Provider Management Plan or a Suitable Duties Plan by the insurer.

Supporting documentation is required for all invoices that include communication. Invoices must include the reason for contact, names of involved parties and will only be paid once where there are multiple parties involved with the same communication (phone call/email/fax). Line items on an invoice will be declined if the comments on the invoice indicate that the communication was for reasons that are specifically excluded.

If part of the conversation would be excluded, the provider can still invoice the insurer for the communication if the rest of the conversation is valid. The comments on the invoice should reflect the valid communication. Providing comments on an invoice that indicates that the communication was specifically excluded could lead to that line item being declined by the insurer.

Case Conference (Item number 300082)

The objectives of a case conference are to plan, implement, manage, or review treatment options and/or rehabilitation plans and should result in an agreed direction for managing the worker's return to work.

The case conference must be authorised by the insurer prior to being provided and would typically be for a maximum of one hour (this excludes travel to and from the venue).

A case conference may be requested by:

- a treating medical practitioner
- the worker or their representative/s
- the insurer
- an employer
- an allied health provider.

Reports (Item numbers 300086, 300088, 300090)

A report should be provided only following a request from the insurer or where the provider has spoken with the insurer and both parties agree that the worker's status should be documented. Generally, a report will not be required where the information has previously been provided to the insurer.

The provider should ensure:

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

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

All reports include:

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

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

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

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

- **Comprehensive report** – conveys all the information included in a standard report however would only be relevant where the case or treatment are **extremely complex** or the questions raised by the insurer are extensive.

Travel – Treatment (Item number 300092)

Travel 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
- 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 consultation 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 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.

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

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 injured workers claim.

External case management may require the rehabilitation 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.

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. With prior approval from the insurer, a patient can access early psychological support services in relation to a primary and/or secondary work-related psychological injury or condition while the claim is being assessed. Please contact the insurer for further clarification regarding early psychological support services.

All invoices should be sent to the relevant insurer for payment. Check whether the worker is employed by a self-insured employer or an employer insured by WorkCover Queensland.

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

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

Fees listed in the table of costs do not include GST. The provider is responsible for incorporating any applicable GST on taxable services/supplies into the invoice. Refer to a taxation advisor or the Australian Taxation Office for assistance if required.

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

Accounts for treatment must be sent to the insurer promptly, and within two (2) months after the treatment is completed.

To ensure payment, the invoice must contain the following information:

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

Further assistance

Contact the relevant insurer for claim related information such as:

- payment of invoices and account inquiries
- claim numbers/status
- rehabilitation status
- approval of Provider Management Plans.

More information for service providers is available on our website together with the current list of self-insured employers.

If you require further information, call us on 1300 362 128.

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