WorkCover QUEENSLAND

Exercise Physiology Services Table of Costs

Effective 1 July 2021

Exercise Physiology Services Table of Costs

ITEM NUMBER / SERVICE	DESCRIPTION
300186 Initial Consultation – Work Specific Functional Exercise Program **Insurer prior approval required** No **Fee – GST not included**[1] $189 per hour (charged pro-rata as a fraction of an hour)	Initial development and instruction of an exercise program focused on improving function of the work-related injury or condition, relevant to their work role. This service may only be charged once for development of an exercise program to meet the worker's work specific functional goals. Refer item number 300228 for Gym and Pool Entry Fees. The exercise physiologist is then expected to submit a Provider Management Plan[3] (PMP) following the initial consultation for approval before any treatment commences. The PMP should include a comprehensive treatment plan containing: • expected functional gains, • transition of care to self-management; and • treatment timeframes. The PMP form is available on the Workers' Compensation Regulatory Services' website (www.worksafe.qld.gov.au). The insurer will not pay for the preparation or completion of a Provider Management Plan. The entire consultation must be 1 on 1 with the worker. Maximum of one (1) hour.

ITEM NUMBER / SERVICE	DESCRIPTION
300187 Subsequent Consultation – Work Specific Functional Exercise Program **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 this service. The insurer may request justification and will consider seeking an independent opinion if more than six (6) consultations are requested per episode of care.** A one-on-one consultation with the worker for ongoing monitoring, review and progression of a work-specific functional exercise program as developed during initial consultation (300186). The focus must be on improving function of the work-related injury or condition relevant to the work role and include education and progression to self-management. Services to be conducted in accordance with the Clinical Framework for the Delivery of Health Services[2]. A Provider Management Plan[3] (PMP) is to be submitted for approval following the initial consultation (300186), before any further treatment commences. The PMP should include a comprehensive treatment plan containing: – expected functional gains, – transition of care to self-management; and – treatment timeframes. Maximum one (1) hour.
300401 Group Exercise Sessions **Insurer prior approval required** Yes **Fee – GST not included**[1] $48 per person	**Prior approval is required before providing this service.** A group session where a common exercise programs is delivered to more than one individual at the same time. The group can consist of a maximum of eight (8) persons. The group session must be attended, conducted, and supervised by an exercise physiologist.
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 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.

ITEM NUMBER / SERVICE		DESCRIPTION
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 list of exclusions before using this item number). Treating provider 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 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, - 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 (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.
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
300094 Incidental Expenses **Insurer prior approval required** **Fee – GST not included**[1]	Yes $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.
300159 Activities of Daily Living Assessment **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 series of standardised tests and measures to assess a worker's activities of daily living and mobility **(including Modified Barthel Index assessments for registered occupational therapy only).** Service includes assessment and report, noting that WorkCover Queensland's template for Modified Barthel Index is to be used (for WorkCover claims).
300228 Gym and Pool Entry Fees **Insurer prior approval required** **Fee – GST not included**[1]	Yes	**Prior approval is required before providing this service. The insurer may request justification and will consider seeking a second opinion if more than three (3) months facility membership is requested per episode of care.** Entry fee for the worker to attend a gym or pool for assessment and treatment (up to a maximum three-month membership). Entry fees will be paid for the worker, only where the facility is not owned or operated by the provider, their employer, or where either party contracts their services to the facility. Entry fees will not be paid for providers. A Provider Management Plan[3] (PMP) is expected to be submitted for approval before any treatment commences. The PMP should include a comprehensive treatment plan containing: – expected functional gains, – transition of care to self-management; and – treatment timeframes.

ITEM NUMBER / SERVICE		DESCRIPTION
300295 External Case Management		This service includes an initial needs assessment and report which must outline a case management plan indicating the goals of the program, services required, timeframes and costs.
Insurer prior approval required	At the request of the insurer	
Fee – GST not included[1]	$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 exercise physiology services to workers?

All exercise physiology services performed must be provided by an Accredited Exercise Physiologist (AEP) with Exercise & Sports Science Australia (ESSA).

Telehealth services

Telehealth services are only related to video consultations. Phone consultations are not covered under the current table of costs.

The following should be considered prior to delivering the service:

- Providers must consider the appropriateness of this mode of service delivery for each worker on a case-by-case basis i.e. the principles and considerations of good clinical care continue to be essential in telehealth services.
- Providers are responsible for delivering telehealth services in accordance with the principles of professional conduct and the relevant professional and practice guidelines to ensure that all care is taken to ensure the privacy, confidentiality, safety, appropriateness, and effectiveness of the service.
- As with any consultation, it is important to provide sufficient information to enable workers to make informed decisions regarding their care.
- All telehealth services require prior approval from the insurer and must be consented to by all parties – the worker, provider, and insurer.

For invoicing purposes telehealth services do not have specific item numbers and should be invoiced in line with the current item numbers and descriptors in each table of costs.

The word 'Telehealth' must be noted in the comments section on any invoice submitted to the insurer when this service has been utilised.

Service conditions

Services provided to workers are subject to the following conditions:

- **Assessment** – after the initial consultation (under 300186) a Provider Management Plan (PMP) must be provided to the insurer to advise of assessment outcome and before any further treatment commences. More information is available on the Workers' Compensation Regulatory Services' website including a PMP form and approval process.
- **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.
- **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 exercise physiologist if the worker has changed providers (not within the same practice). The new exercise physiologist will be required to submit a PMP for further treatment outlining the number of consultations the worker has received previously.

Work Specific Functional Exercise Program (Item numbers 300186, 300187)

The insurer will not pay for an initial and subsequent consultation on the same day unless in exceptional circumstances, as approved by the insurer.

The objective of these services is to develop a work specific functional exercise program focused on improving function of the work-related injury or condition, relevant to their work role.

Work specific functional exercise programs developed by exercise physiologists must:

- be aimed at increasing the worker's capacity and orientated towards a return to suitable and sustainable employment. Insurers do not pay for gym/pool exercise programs that are only focused on improving a worker's general level of health and fitness

- be outcome-focused such that the exercise physiologist must be able to demonstrate that the worker has achieved an increase in work capacity and a decrease in requirement for ongoing clinical treatment
- be aimed at maximising function
- provide education and direction towards progression to self-management of the exercise program.

The exercise physiologist is then expected to submit Provider Management Plan for approval before any treatment commences.

These consultations must be individual one-on-one consultations between the exercise physiologist and the worker, and the exercise physiologist must be in the gym/pool with the worker for the duration of the consultation.

The insurer may request justification for use of this item number from the requesting exercise physiologist and will consider seeking an independent opinion if more than 6 consultations are requested per episode of care.

Group Exercise Sessions (Item numbers 300401, 300402)

The insurer will only pay for the attendance of workers' compensation claimants in a group exercise session.

Group exercise programs, maximum eight (8) persons per group. Where a common program is delivered to more than one individual at the same time.

The group must be attended, conducted, and supervised by an exercise physiologist.

The objective of any exercise rehabilitation or education program is to ensure that injured workers achieve the best practicable levels of physical recovery along with assisting the worker to understand their injury and the process of rehabilitation.

Exercise programs developed by exercise physiologist:

- be aimed at increasing the worker's capacity and orientated towards a return to suitable and sustainable employment. Insurers do not pay for gym/pool exercise programs that are only focused on improving a worker's general level of health and fitness
- be outcome-focused such that the exercise physiologist must be able to demonstrate that the worker has achieved an increase in work capacity and a decrease in requirement for ongoing clinical treatment
- be aimed at maximising function
- provide education and direction towards progression to self-management of the exercise program.

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 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 closes 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.

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.

Activities of Daily Living Assessment Services (Item number 300159)

Activities of Daily Living (ADLs) is a series of standardised tests used to measure a worker's activities of daily living and mobility, **excluding Modified Barthel Index assessments.**

Fee is charged at an hourly rate with the number of hours negotiated with the insurer prior to providing the service. This service includes the assessment and mandatory report. Generally, an assessment (including report) will take one (1) to two (2) hours. The practitioner must obtain prior approval from the insurer for assessments greater than two (2) hours.

Gym and Pool Entry Fees (Item number 300228)

Insurer approval must be obtained prior to undertaking the service.

The insurer will pay for reasonable costs of gym and/or pool facility memberships when required for a work specific functional exercise program in relation to a work-related injury or condition.

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

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

The providers expected to submit a Provider Management Plan (PMP) for approval before treatment commences. The PMP should include a comprehensive treatment plan containing:

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

The PMP form is available on the Workers' Compensation Regulatory Services' website.

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

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

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.

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.

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