Allied Health Services Table of Costs General Information

Who can provide allied health services to injured workers?

Each table of costs outlines the professional requirements that a workers' compensation insurer will recognise. Providers should be registered with the appropriate board or the appropriate professional association if not covered under the Australian Health Practitioners Regulation Agency (AHPRA). Please check that you have the appropriate qualifications and registration prior to providing a service as an insurer may decline to pay for your services if you are not appropriately qualified and registered.

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.

Service conditions

Services provided to workers are subject to the following conditions:

- **Treatment consultations** – each table of costs will outline the requirements of each item number and whether it needs to be referred by an insurer or approved by an insurer.

- **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. For services not outlined in the table of costs above, prior approval from the insurer is required.
- **Treatment period** – treatment will be deemed to have ended if there is no treatment for a period of two (2) calendar months. If further treatment is then required, the worker must obtain another referral from their treating medical provider and a PMP will need to be submitted prior to any services being delivered.
- **End of treatment** – all payments for treatment end where there is either no further medical certification, the presenting condition has been resolved, the insurer finalises/ceases the claim, the worker is not complying with treatment or the worker has achieved maximum function.
- **Change of provider** – the insurer will pay for another initial consultation by a new provider if the worker has changed providers (not within the same practice). The new provider will be required to submit a PMP for further treatment outlining the number of consultations the worker has received previously.

Treatment standards and expectations

When treating a worker with a work-related injury or condition, the provider should, where appropriate:

- Deliver outcome-focused and goal-orientated services, which are focused on achieving maximum function and safely returning the worker to work.
- Consider biopsychosocial factors that may influence the injured worker's return to work.
- Advise and liaise with the relevant treating practitioners and insurer.
- Keep detailed, appropriate, up-to-date treatment records and any relevant information obtained in the service delivery.
- Ensure that the worker has given their written authority prior to the exchange of information with third parties other than the referrer.
- Be accountable for the services provided, ensuring those services incurred for the work-related injury or condition are reasonable.
- Maintain practice competencies relevant to the provider's profession and the delivery of services within the Queensland workers' compensation environment.

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

General guidance on payment for services

The insurer's objective under section 5 of the *Workers' Compensation and Rehabilitation Act 2003* (the Act) is to ensure that workers receive timely treatment and rehabilitation to assist with their return to work. This table of costs sets out the maximum fees payable by the insurer for the applicable services. This table of costs applies to all work-related injury or condition claims whether insured through WorkCover Queensland or a self-insured employer. The maximum fees in this schedule apply to services provided on or after 1 July 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). For primary and/or secondary work-related psychological injuries or conditions, a patient can access early psychological support services while the claim is being assessed. Prior approval from the insurer is needed for early access.

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.