WorkCover QUEENSLAND

Support Services Table of Costs

Effective 1 July 2021

Support Services Table of Costs

ITEM NUMBER / SERVICE	DESCRIPTION
300309 Ambulance Transport - Non QAS - Initial Transportation **Insurer prior approval required** No **Fee – GST not included**[1] $	Transport provided immediately after the work-related injury or condition is sustained.
300310 Ambulance Transport - Non QAS - Subsequent Transportation **Insurer prior approval required** No **Fee – GST not included**[1] $	Subsequent transport must be certified in writing by a doctor as necessary because of the worker's physical condition resulting from a work-related injury or condition.
300190 Dietary Assessment **Insurer prior approval required** Yes **Fee – GST not included**[1] $115 per session	Consultation to evaluate dietary issues and objective tests to formulate an intervention plan focused on a return to work goal. Prior approval required before providing service. **Services must be provided by a person with a tertiary degree in dietetics.**
300198 Personal Care Assistance **Insurer prior approval required** Yes **Fee – GST not included**[1] $51 per hour (charged pro-rata as a fraction of an hour)	**Prior approval is required before providing this service** Provided through an agency - includes services for injury/wound care, personal hygiene and grooming etc. where the worker is living at home and has been assessed as incapable (for physical, cognitive or emotional reasons) of undertaking these tasks and has no family or other social support network. Day rate: $51 per hour. Weekend rate: $72 per hour.

ITEM NUMBER / SERVICE		DESCRIPTION
300200 Diversional Therapy Program		**Prior approval is required before providing this service** Services to be provided by a diversional therapist at a nursing home including therapeutic activities. Services must be provided by a person with a minimum of an Associate Diploma in Diversional Therapy. The service should only be used under the supervision of an occupational therapist, who has recommended therapeutic activities as part of the overall treatment program.
Insurer prior approval required	Yes	
Fee – GST not included[1]	$45 per hour per hour (charged pro-rata as a fraction of an hour)	
300201 Domestic Assistance		**Prior approval is required before providing this service** Provided through an agency - includes cleaning, shopping and washing etc. where the worker is living at home and has been assessed by an occupational therapist as incapable of undertaking these tasks (for physical, cognitive or emotional reasons) of undertaking these tasks, and has no family or other social support network. **Note:** weekend and public holiday rates may be negotiated with the insurer.
Insurer prior approval required	Yes	
Fee – GST not included[1]	$42 per hour (charged pro-rata as a fraction of an hour)	
300202 Literacy Skills		**Prior approval is required before providing this service** Private tutoring by a qualified tutor to improve literacy skills for job placement prospects. Program should be limited to achieving a base level of competency – up to four (4) to six (6) weeks. Typically, literacy services are provided through the local TAFE or appropriately qualified private literacy services.
Insurer prior approval required	Yes	
Fee – GST not included[1]	$	
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.
Insurer prior approval required	No	
Fee – GST not included[1]	$32	

ITEM NUMBER / SERVICE	DESCRIPTION
300100 Communication - 11 to 20 mins **Insurer prior approval required** No **Fee – GST not included**[1] $63	Direct communication between treating provider and insurer, employer, insurer referred allied health provider and doctors to assist with faster and more effective rehabilitation and return to work for a worker. Excludes communication with a worker, and of a general administrative nature or conveying non-specific information. Must be more than ten (10) minutes. Refer to details below the tables for a list of exclusions before using this item number. Treating providers are expected to keep a written record of the details of communication, including date, time, and duration. The insurer may request evidence of communication at any time.
300086 Progress Report **Insurer prior approval required** At the request of the insurer **Fee – GST not included**[1] $63	A written report providing a brief summary of the worker's progress towards recovery and return to work.

1. Rates do not include GST. Check with the Australian Taxation Office or your tax advisor if GST is applicable.

Telehealth services

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

The following should be considered prior to delivering telehealth services:

- 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 the above 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 injured 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** – 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 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.

Ambulance Transport (non-QAS) (Item numbers 300309, 300310)

Definition – under s219 of the *Workers' Compensation and Rehabilitation Act 2003*, ambulance transportation is defined as:

- transportation, irrespective of distance, first provided immediately after the injury is sustained. Transportation must be from the place where the injury is sustained to a place where appropriate medical treatment is available to seek the treatment.
- transportation, irrespective of distance, subsequently provided. There must be certification in writing by a doctor stating such transportation is necessary because of the workers' physical condition resulting from the injury.

All insurers must pay the cost of transportation provided by services other than the Queensland Ambulance Service e.g. the Royal Flying Doctor Service.

Note: insurers are not required to pay for Queensland Ambulance Services (QAS) transportation—payment is covered under a workers' compensation grant.

Dietary Consultation (Item number 300190)

Services must be provided by a person with a tertiary degree in dietetics.

A consultation may include all or some of the following elements:

- **Subjective (history) assessment** – consider major symptoms and lifestyle dysfunction; current and past history and treatment; aggravating and relieving factors; general health, medication, and risk factors.
- **Objective assessment** – where appropriate, use standardised outcome measurements to provide a baseline prior to commencing treatment.
- **Assessment results (prognosis formulation)** – provide provisional prognosis for treatment, limitations to function and progress for return to work
- **Treatment (intervention)** – formulate and discuss the treatment goals and expected outcomes with the worker; goal setting; strategies to improve return to work with the worker. Advise the worker on self-management strategies.
- **Reassessment (subjective and objective)** – evaluate the progress of the worker using outcome measures that are relevant, reliable, and sensitive assessment. Compare against the baseline measures. Identify factors compromising outcomes and treatment goals. Identify factors compromising treatment outcomes and implement strategies to improve the workers' ability to return to work and normal functional activities. Actively promote self-management (such as ongoing exercise programs) and empower the worker to play an active role in their rehabilitation.
- **Clinical recordings** – record information in the workers' 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 the insurer. Acknowledge referral and liaise with the treating medical practitioner about treatment.

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.

Reports (Item number 300086)

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 brief summary (progress report) on a worker's progress including return to work status, completion of goals, future recommendations, and timeframes.

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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