

Service	Descriptor	Insurer prior approval required ¹	Item number	Fee – GST not included ²
Treatment Services				
Consultation – Initial for acupuncture	First consultation for acupuncture with worker	No	300004	\$70.00
Consultation - Subsequent for acupuncture	Standard treatment for acupuncture consultation	Any subsequent session/s require insurer prior approval.	300005	\$60.00
Supplementary Services				
Communication	Communication: less than 10 mins	No	300079	\$28.00
	Communication: 11 to 20 mins	No	300100	\$56.00
	<p>Consult list of exclusions before using this item Does not include communication with a worker. Communication with a worker for the purpose of treatment or referred services should be billed under the appropriate treatment or referred service item code. Does not include contact of a general administrative nature such as accepting the referral, or the practitioner requesting further services (eg report) or other calls/faxes/emails of a general administrative nature. Communication does include: Purposeful, direct communication between practitioners and stakeholders (insurer, employer and doctors) to assist faster and more effective rehabilitation and return to work for the worker.</p>			
Case conference	Face-to-face or telephone communication involving the treating practitioner, insurer and one or more of the following: treating medical practitioner; specialist; employer or employee representative; worker; allied health providers or other	Yes	300082	\$168.00 ^ per hour
Report - progress	Brief summary of the worker's progress	Insurer request only	300086	\$56.00
Report - standard	Provides relevant information about the worker's compensable injury	Insurer request only	300088	\$142.00
Report - comprehensive	Only required in a limited number of cases where the case and the treatment are extremely complex; charged at an hourly rate; negotiate the number of hours with the insurer prior to providing the report	Insurer request only	300090	\$168.00 ^ per hour
Patient records	Copies of patient records relating to the workers' compensation claim including file notes; results of relevant tests eg. pathology, diagnostic imaging and reports from specialists	Yes (for more than 50 pages)	300093	\$23.00 plus \$1 per page

Please read the item number descriptions contained in this document for service conditions and exclusions.

¹ Where prior approval is indicated the practitioner must seek approval from the insurer before providing services.

² Rates do not include GST. Check with the Australian Taxation Office if GST should be included. See <https://www.ato.gov.au/Business/Consultation--Business/In-detail/Health/Publications/>

^ Hourly rates are to be charged pro-rata.

Who can provide Chinese medicine services to injured workers?

All acupuncture services performed must be provided by a Chinese Medicine Practitioner who has a current registration in the Division of acupuncture with the Chinese Medicine Board of Australia.

Service conditions

Services provided to injured workers are subject to the following conditions:

- **Referral** – all workers must have a current workers' compensation certificate signed by a medical practitioner or nurse practitioner to cover any acupuncture services provided
- **Treatment sessions** – where the claim has been accepted, the insurer will pay for the initial acupuncture sessions without prior approval. Any subsequent consultation for acupuncture requires insurer approval.
- **Incidentals** – All acupuncture needles are consumables and are not subsidised by the insurer
- **Provider management plan** – this form is available on the Workers' Compensation Regulator's website (www.qcomp.com.au) and is to be completed if treatment is required after any pre-approved sessions or any services where prior approval is required. An insurer may require the *Provider management plan* to be provided either verbally or in written format. (Check with each insurer as to their individual requirements). The insurer will not pay for the preparation or completion of a *Provider management plan*
- **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** – all fees payable are listed in the *Chinese Medicine Practitioner table of costs*. For services not outlined in the table of costs, 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. After this a *Provider management plan* needs to be submitted for further treatment to be provided. (The worker must also obtain another referral)
- **End of treatment** – all payment for treatment ends 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 *Provider management plan* for further treatment outlining the number of sessions the worker has received previously.

Item number descriptions and conditions

Consultations (Item codes 300004, 300005)

For an accepted claim, the insurer will pay the cost of an initial consultation and report when it has been requested by the treating medical practitioner or an accredited workplace/employer. The insurer will not pay for an initial and subsequent consultation on the same day unless in exceptional circumstances, as approved by the insurer.

Consultations may include the following elements:

- **Subjective (history) reporting** – consider 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 (physical) assessment** – assess movement—for example active, passive, resisted, repeated, muscle tone, spasm, weakness, accessory movements, passive intervertebral movements—and pain by carrying out appropriate procedures and tests
- **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 physical 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 (such as ongoing exercise programs) 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 treatment modalities including exercise programs according to the goals of therapy
- **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.

Communication (Item codes 300079, 300100)

Note: most communication would be of short duration and would only exceed ten minutes in exceptional or unusual circumstances.

The communication should be **relevant** to the compensable injury and assist the insurer and other involved parties to resolve barriers and/or agree to strategies or intervention/s proposed.

Communication time – each call, fax/email preparation must be more than three (3) minutes in duration to be billable. Supporting documentation is required for all invoices that include communication. The communication item is not intended to cover normal consultation communication that forms part of the usual best practice process of ongoing treatment. Normal consultation communication that is not administrative in nature should be billed under the appropriate treatment or referred service item code. Communication made to the worker and employer/host employer for the purpose of monitoring suitable duties should be billed under the appropriate “monitoring of suitable duties” item code.

Invoices – must include the reason for contact, names of involved parties and will only be paid once, regardless of the number of recipients of the 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.

Valid communication (see exclusions) – relates to treatment or rehabilitation of a specific worker involving any of the parties listed:

- the insurer
- the worker’s referring/treating medical practitioner
- the worker’s rehabilitation provider
- the worker’s other allied health provider
- the worker’s employer (where the practitioner is a treating practitioner).

Exclusions

The insurer will not pay for the following calls/emails/faxes:

- where the party phoned is unavailable
- to and from the worker (if it is not administrative in nature, this can be billed under the appropriate treatment or referred service item code)
- from employer representatives for guidance on case management (they should be referred to the insurer)
- about the referral eg. acceptance and basic acknowledgement of accepting referrals
- of a general administrative nature
- made during the duration of a billable service—these are considered part of the consultation
- for approval/clarification of a *Provider management plan* or a *Suitable duties plan* by the insurer
- conveying non-specific information such as ‘worker progressing well’
- made or received from the insurer as part of a quality review process
- calls about job seeking, job placement and job preparation
- forwarding email/fax information as an attachment e.g. Suitable duties program, report or *Provider management plan*.

If part of the conversation would be excluded, the practitioner 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 Code 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 travelling to venue and return).

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 - Clinical and return to work (Item codes 300086, 300088, 300090)

A report should be provided only following a request from the insurer or where the practitioner has spoken with the insurer and both parties agree that the worker's status should be documented.

The practitioner 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 compensable injury
- the report communicates the worker's progress or otherwise
- all reports are received by the insurer within ten (10) working days from when the practitioner received request.

In general, reports delayed longer than six (6) weeks are of little use to the insurer and will not be paid for without prior approval from the insurer.

Report essentials

All reports should contain the following information:

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

Different types of report

Progress – A progress report provides an update on the worker's functional/psychosocial progress towards recovery and/or return to work (RTW). It is appropriate to use this report where the worker is progressing toward treatment/RTW goals or where minor changes to their program are required.

Standard – A standard report may be appropriate where the goals of a worker's program has altered or changed substantially, such that the original goal or treatment approach is no longer appropriate. A report is deemed to be standard when re-examination of the worker is not a pre-requisite for the preparation of the report and the report is based on a transcription of existing clinical records, relates to the status of the claim and comprises a clinical/professional opinion, statement or response to specific questions.

Comprehensive – A comprehensive report contains all the elements of a standard report but with more detailed information of the assessment and interventions performed. This type of report would only be required in a limited number of cases where the case and the treatment are extremely complex.

Generally, a practitioner may be requested to provide either a clinical report or a return to work report.

Clinical reports

A clinical report will include some or all of the following elements:

- interventions to date—type of treatment provided
- functional status—statement of the individual's current status as compared to evaluation baseline data and any prior reports, including objective measures of the individual's function relating to the treatment goals
- progress with plan of care
- completion of goals to date
- future recommendations/durations if appropriate.

Insurers may request either a progress clinical report, a standard clinical report or a comprehensive clinical report. Each report should include the basic report elements and further information as outlined:

- Progress report – a prognosis update
- Standard report – any changes in prognosis, plan of care and goals along with the reasons for those changes
- Comprehensive report – an examination or re-examination of the worker is a pre-requisite for the preparation of the report e.g. neuropsychological report, multi-trauma patient.

Return to work reports

A return to work (RTW) report will include some or all of the following elements:

- return to work status—statement of the individual's current status as compared to evaluation baseline data and any prior reports, including objective measures of the individual's function relating to RTW goals
- progress with RTW plan
- completion of RTW goals to date
- future recommendations/durations if appropriate.

Insurers may request either a progress RTW report, a standard RTW report or a comprehensive RTW report. Each report should include the basic elements and further information as outlined:

- Progress report – a prognosis update
- Standard report – barriers to RTW, any changes in RTW plan of care and goals along with the reasons for those changes
- Comprehensive report – issues and barriers to RTW are complex and detailed documentation of the requisites for RTW are critical for a successful outcome e.g. where extensive workplace modifications are required, or there are complex psychosocial issues to be addressed as part of the RTW process includes future recommendations/durations if appropriate.

Patient records (Item codes 300093)

The fee is payable upon request from the insurer for copies of patient records relating to the workers compensation claim. If the copies of records are to exceed 50 pages the practitioner is required to seek approval from the insurer before finalising the request.

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*.

For a current list of insurers, visit www.gcomp.com.au. For more information on the Table of Costs, visit www.workcoverqld.com.au or call 1300 362 128.