WorkCover QUEENSLAND

Specialist Supplementary Services

Table of Costs

Effective 1 December 2024

WorkCover QUEENSLAND

Specialist Supplementary Services Table of Costs

DESCRIPTION	INSURER PRIOR APPROVAL REQUIRED	ITEM NO.	TIMEFRAMES	FEE – GST NOT INCLUDED
Communication				
Case conference A face-to-face or telephone meeting involving the treating doctor, insurer and one or more other relevant parties.	Yes	100159		$690 per hour (pro-rata in 5 minute increments)
Communication Telephone, email, online or other communication between the treating doctor and relevant stakeholders regarding rehabilitation or return to work.	No	100161	Less than 10 minutes	$114
		100163	11 – 20 minutes	$228
Medical reports (see pages 8– 10 for report conditions)				
Report review and response A written response to 1 – 3 questions after reviewing a medical report supplied by the insurer from another medical provider, inclusive of reading time.	At the request of the insurer	100790	Received by insurer within 10 working days	$228
Completed form (2 – 3 questions) Completion of a brief form by the treating doctor.	No	100808	Received by insurer within 10 working days	$143
		100814	Received by insurer after 10 working days	$71
Comprehensive report A written response to the insurer's request for detailed information on diagnosis, treatment, return to work, and recovery timeframes.	At the request of the insurer	100150	Received by insurer within 10 working days	$711
		100151	Received by insurer after 10 working days	$356
Progress report A written response to the insurer's request for an update on the worker's treatment, recovery and return to work progress.	At the request of the insurer	100806	Received by insurer within 10 working days	$429
		100807	Received by insurer after 10 working days	$214

DESCRIPTION	INSURER PRIOR APPROVAL REQUIRED	ITEM NO.	TIMEFRAMES	FEE – GST NOT INCLUDED
Short report A written response to 2 or 3 questions seeking specific information about the worker's condition.	At the request of the insurer	100810	Received by insurer within 10 working days	$143
		100811	Received by insurer after 10 working days	$70
Ancillary Services				
Workplace assessment Attendance at the workplace to assess aspects of the injured worker's job or environment.	Yes	100157		$690 per hour (pro-rata in 5 minute increments)
Travel	No	100809	Vehicle cost	$0.78 / km
Travel from normal place of practice to provide services to a worker at their place of residence or workplace.	Yes	100800	Travelling time per hour	$345 per hour (pro-rata in 5 minute increments)
Patient records	No	100511		$78 plus
Application fee for the provision of patient records relating to the workers' compensation claim including file notes, results of relevant tests.	No	100514		$0.35 per page

Independent Medical Examination and Permanent Impairment Services

DESCRIPTION	INSURER PRIOR APPROVAL REQUIRED	ITEM NO.	TIMEFRAMES	FEE – GST NOT INCLUDED
Independent Medical Examination (IME) report Provision of a written report with response to all questions outlined in the IME referral.	At the request of the insurer	100211	Received by insurer within 10 working days	$773
		100212	Received by insurer after 10 working days	$388
Permanent Impairment (PI) report Provision of a written report assessing permanent impairment using the *Guidelines for Evaluation of Permanent Impairment*.	At the request of the insurer	100802	Received by insurer within 10 working days	$927
		100803	Received by insurer after 10 working days	$463
Consultation - Consultant physician Consultations associated with a written report for the purpose of an IME or PI service.	No	100300	Initial consultation	$434
		100301	Subsequent consultation	$200
Consultation - Specialist Consultations associated with a written report for the purpose of an IME or PI service.	No	100279	Initial consultation	$228
		100293	Subsequent consultation	$122
Consultation - Psychiatrist Consultations associated with a written report for the purpose of an IME or PI service.	No	100296	Consultation between 45 -75 minutes	$545
		100302	Consultation more than 75 minutes	$607
Telehealth Consultation – Psychiatrist Telehealth consultations associated with a written report for the purpose of an IME or PI service.	No	100369	Consultation between 45 -75 minutes	$545
		100370	Consultation more than 75 minutes	$607

DESCRIPTION	INSURER PRIOR APPROVAL REQUIRED	ITEM NO.	TIMEFRAMES	FEE – GST NOT INCLUDED
Complex case review Provision of a written report providing claim guidance for complex or unusual medical conditions through a review of the available medical information.	At the request of the insurer	100815	Received by insurer within 10 working days	$572 per hour (pro-rata)
ILO report Chest x-ray review and report conducted according to *ILO Classification Guidelines* to assess occupational lung diseases.	At the request of the insurer	100818	Received by insurer within 10 working days	$150
		100819	Received by insurer after 10 working days	$73
Supplementary report – Short A written response to 1 – 3 questions from the insurer seeking further information following an IME or PI report.	At the request of the insurer	400603	Received by insurer within 10 working days	$259
Supplementary report – Long A written response to 4 - 6 questions from the insurer seeking further information following an IME or PI report.	At the request of the insurer	400602	Received by insurer within 10 working days	$429
Interpreter Additional loading fee for IME and PI services conducted with the assistance of an interpreter.	No	100816		$188
Pre-reading time Additional reading and pre-consultation time required for IME and PI services above the included 30 minutes.	Yes	100805		$536 per hour (pro-rata in 5 minute increments)
Non-attendance or cancellation fee – Consultant Cancellation or non-attendance of an IME or PI service with less than 3 working days' notice.	No	100303		$391
Non-attendance or cancellation fee – Specialist Cancellation or non-attendance of an IME or PI service with less than 3 working days' notice.	No	100304		$205

DESCRIPTION	INSURER PRIOR APPROVAL REQUIRED	ITEM NO.	TIMEFRAMES	FEE – GST NOT INCLUDED
Non-attendance or cancellation fee – Psychiatrist Cancellation or non-attendance of an IME or PI service with less than 3 working days' notice.	No	100305		$491

Specialist MRI Services

SERVICE	DESCRIPTION	INSURER PRIOR APPROVAL REQUIRED	ITEM NO.	FEE – GST NOT INCLUDED
Specialist MRI	**MBS item codes 63491, 63494**	No	100501	$90
Specialist MRI	**MBS item codes 63010, 63040, 63334, 63548**	No	100502	$672
Specialist MRI	**MBS item codes 63043, 63151, 63154, 63167, 63170, 63179 - 63185, 63461**	No	100503	$717
Specialist MRI	**MBS item codes 63301, 63304, 63307**	No	100504	$762
Specialist MRI	**MBS item codes 63001 - 63007, 63046 - 63073, 63322, 63340, 63401, 63404**	No	100505	$806
Specialist MRI	**MBS item codes 63201, 63204, 63219 - 63243, 63385, 63388**	No	100506	$869
Specialist MRI	**MBS item codes 63101, 63111, 63114, 63125, 63128, 63131, 63271 - 63280**	No	100507	$986
Specialist MRI	**MBS item codes 63173, 63176, 63325, 63328, 63331, 63337**	No	100508	$717
Specialist MRI	**MBS item codes 63464, 63467, 63487, 63547**	No	100509	$1,380
Specialist MRI	**MBS item code 63473**	No	100510	$1,254

Specialist MRI services must meet the following service level standards:

1. The patient must be referred by a specialist.
2. Services must be provided in DIAS-accredited diagnostic imaging practices.
3. Appointments are to be scheduled within three working days of receiving a valid request for a workers' compensation patient with an open and accepted claim, unless clinically inappropriate or additional preparation is needed.
4. Reports must comprehensively address all information requested by the referrer and required for interpreting results, per **RANZCR Standards of Practice for Clinical Radiology, V11, 5.5.1 Interpretation and Reporting the Result**.
5. Reports are to be provided within 24 hours of the service, except when additional radiology or further clinical information is required.
6. If further scans are clinically indicated, the provider will seek prior approval from the insurer.
7. If referral clarification is needed, the radiologist will contact the referring practitioner.
8. An electronic version of the report will be available upon the referring practitioner's request.
9. Radiologists should submit invoices and reports electronically when possible.

Imaging examinations will be conducted by radiologists registered as specialists in Diagnostic Radiology with AHPRA. 'Specialist MRI' services will be provided by MRI Radiologists registered with RANZCR and participating in the MRI Quality and Accreditation Program, including MRI-specific CPD per **RANZCR Standards of Practice for Clinical Radiology, V11, 13.2.4 CPD - MRI Radiologist**.

Service conditions

Services provided to workers are subject to the following conditions:

- **Prior approval** – approval must be obtained for any service requiring prior approval from the insurer.
- **Approval for other services** – for services not outlined in the table of costs, prior approval from the insurer is required.
- **Payment** – accounts for treatment must be sent to the insurer promptly, and within two (2) months after the treatment is completed.

Fees listed in the Specialists Supplementary Services Table of Costs do not include GST. Refer to the Australian Taxation Office or your tax advisor if GST is applicable.

Case conference (Item 100159)

Face-to-face or telephone communication involving the treating doctor, insurer and one or more of the following: worker or worker's representative, GP, specialist, employer, allied health provider or other.

Prior approval is required by the insurer.

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 pre-approved 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).

The insurer **will not pay** for case conferences with practitioners who are not part of the treating medical team, (e.g., peer review case conferences).

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.

Communication (Items 100161, 100163)

Communication between doctors and stakeholders (insurer, employer, and rehabilitation providers) relating to rehabilitation, treatment or return to work options for the worker.

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.

This item may be used for the **approval of documents** provided by other health professionals or the insurer, such as approved suitable duties program sent via facsimile or online services. It may also be used for contributions to or updates of a **Rehabilitation and Return to Work (RRTW) plan**. However, this excludes the completion of a Work Capacity Medical Certificate as outlined in section 213(4) of the *Workers' Compensation and Rehabilitation Act 2003*.

All invoices must include names of involved parties and reasons for contact. Item will only be paid once regardless of multiple recipients to email / fax.

The communication item is not intended to cover normal consultation communication that forms part of the usual best practice process of ongoing treatment.

The insurer **will not pay** for communication:

- made during the duration of a consultation as these are considered part of the billable service
- conveying non-specific information such as 'worker progressing well'
- between treating medical and allied health providers that form part of usual best practice
- about the referral (e.g., acceptance and basic acknowledgement of accepting referrals)
- made or received from the insurer as part of a quality review process
- general administrative communication, for example:
    - to and from the worker
    - provision of reports or documents via email, fax or online services
    - leaving a message where the party phoned is unavailable
    - queries related to invoices.

Medical reports (Items 100801, 100808, 100814, 100150, 100151, 100806, 100807, 100810, 100811, 100818, 100819)

Two (2) fee levels apply to written communication:

- A full fee is payable if the form or report is received by the insurer within 10 working days.
- A reduced fee applies if the form or report is received after 10 working days or if prepayment is requested.

Reports / forms must be submitted to the insurer through online services (i.e., Provider Connect), where possible.

The specified timeframe begins from the date the insurer's request is received or from the initial consultation, whichever is later.

All reports should include:

- Worker's full name
- Date of birth
- Date of injury
- Claim number
- Work-related diagnosis
- Date first seen
- Time period covered by the report
- Contact details, signature, and title of the reporting practitioner.

Report review and response (Item 100790)

Written response to 1 – 3 questions from the insurer for the purpose of seeking commentary from the treating doctor on a medical report written by another medical provider.

This includes reviewing a medical report provided by the insurer, such as independent medical reports, and providing a response to questions addressing specific information for the management of the claim.

The service includes reading time, completion of the report, and submission through online services (i.e., Provider Connect), where possible.

The insurer will not pay for this service when:

- The report is sent to the treating provider for record purposes only and a response is not requested
- The report was not provided by the insurer to the treating provider
- There is a more appropriate service item available.

At the request of the insurer.

Completed form (Items 100808, 100814)

Completion of a brief form (2 or 3 questions) by the treating doctor to provide specific information for the management of a claim.

This includes completing additional questions on the Request for surgery approval form.

Forms must be submitted to the insurer via online services, where possible, and within the specified timeframe.

This item excludes the completion of work capacity medical certificates under as per section 213(4) of the *Workers' Compensation and Rehabilitation Act 2003*.

Comprehensive report (Items 100150, 100151)

Written response to insurer's request for detailed information on diagnosis, investigations, prognosis, clarification of treatment and return to work goals

Comprehensive reports may be requested following an initial consultation and/or investigations are undertaken, post-surgical intervention or prior to a Medical Assessment Tribunal (MAT) referral.

May include clinical findings, summation and medical opinion helpful to the insurer management of the workers' compensation claim

Insurer questions may pertain phases of the claim (e.g., establishment, ongoing management and return to work).

Treating specialist opinion should be given outlining nature of the injury, capacity for work and advice on further management of case.

Progress report (Items 100806, 100807)

Written response to insurer's request for specific information at a specific stage of the claim (e.g., information about a specific line of treatment or progress for return to work only information subsequent to previous reports should be provided).

A progress report provides information 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.

A progress report may also be appropriate where the goals of a worker's program have altered or changed substantially, such that the original goal or treatment approach is no longer appropriate. This report would be used 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.

Short report (Items 100810, 100811)

Written responses to insurer's very limited number of questions (2 or 3) seeking further information about the worker's condition at a specific stage of the claim.

A short report provides relevant information about the worker's compensable injury and may be used for conveying brief information that relates to simple injuries.

Workplace assessment (Item 100157)

Workplace assessment involves attending the workplace to assess aspects of the injured worker's job or environment. Item can be used in connection with the planning and/or implementation of a rehabilitation plan.

Travel (Items 100809, 100800)

Travel time will only be paid when the medical practitioner is required to leave their normal place of practice to provide services to a worker at their place of residence or workplace.

Approval is required for travel exceeding a one (1) hour round trip. Prior approval is not necessary if the total travel time for multiple workers on the same trip averages one (1) hour or less per worker.

The insurer **will not pay** travel:

- When traveling between multiple practice sites owned by the practitioner’s business.
- For regular sessional visits to hospitals, specialist rooms, or other facilities.
- When visiting multiple workers at the same location - travel costs should be divided evenly among workers.
- When visiting multiple worksites in the same journey - travel costs should be divided among the workers involved and itemised separately.

Patient records (Items 100511, 100512)

Application fee for the provision of patient records relating to the workers compensation claim including file notes; result of relevant tests (e.g., Pathology, diagnostic imaging and reports).

The fee is payable upon request from the insurer for copies of patient records relating to the workers' compensation claim.

Independent Medical Examination (IME) report (Items 100211, 100212)

An Independent Medical Examination (IME) report is a report completed by an appropriately qualified medical specialist for the purpose of providing an independent opinion on specific medical aspects of a worker's injury.

When completing an IME, doctors can charge the following:

- a consultation fee
- the IME report fee
- a fee for pre-reading and/or consultation time required over the 30 mins included in the IME report fee (with prior approval).

Where an IME referral includes a request for a permanent impairment (PI) assessment contingent on the injury/ies being deemed stable and stationary, the doctor is to charge the applicable PI report fee if they complete the PI assessment. The insurer will only pay for one report fee per referral.

If the injury/ies are not stable and stationary and no PI assessment is completed, the IME report fee will apply. The insurer will not pay both an IME report fee and a PI report fee for the same referral.

The report must provide a response to all report template questions in plain language that is easy to read, understand, and use. If the report does not comply, the insurer may request clarification and further details before payment for the report is processed.

Assessment of Permanent Impairment (Items 100802, 100803)

A permanent impairment (PI) report is a written response to the insurer's request for examination and report assessing permanent impairment (PI) using:

For injuries on or after 15 October 2013:

- Guidelines for Evaluation of Permanent Impairment (GEPI), 2nd Edition:
- American Medical Association Guides 5th Edition (AMA5); and
- in the approved template available at www.worksafe.qld.gov.au/service-providers/medical-providers/permanent-impairment.

For injuries before 15 October 2013:

- American Medical Association Guides 4th Edition
- the Table of injuries schedule 2 (Regulation 2003 s92)
- using the endorsed template for reporting Pl template available at www.worksafe.qld.gov.au/service-providers/medical-providers/permanent-impairment).

When completing a PI assessment, doctors can charge the following:

- a consultation fee
- the PI report fee
- a fee for pre-reading and/or consultation time required over the 30 mins included in the IME report fee (with prior approval).

A PI report should include the following information:

- Past medical history and relevant pre-existing conditions

- Date and description of the work-related injury/ies, including treatment, progress and return-to-work status
- Investigations undertaken for the work-related injury/ies
- Clinical examination and consistency of findings
- Diagnosis of the work-related injury/ies being assessed
- Stabilisation of injuries, including any injuries that are not stable or stationary
- Impairment assessment performed according to the methodology outlined in the relevant chapter of GEPI, including justification, calculations and any graphs, tables or diagrams used.
- List and apportionment of pre-existing impairments or injuries relevant to the injury/ies being assessed
- Percentage of Whole Person Impairment (WPI) attributed to each injury and the combined total Degree of Permanent Impairment (DPI) using the Combined Values Chart.

The report must provide a response to all report template questions in plain language that is easy to read, understand, and use. If the report does not comply, the insurer may request clarification and further details before payment for the report is processed.

Consultations associated with a report (Items 10030, 100301, 100279,100293,100296, 100302, 10369,100370)

Specialists completing an IME must not have previously reviewed a worker in a treating capacity and should not provide any opinion or advice to workers, unless advice is required in accordance with the Medical Board of Australia Code of Conduct.

Specialists must declare any potential conflicts of interest before accepting a referral or immediately once identified.

A **subsequent IME consultation** only applies where a worker is examined by the same specialist within 12 months of a previous examination for the same claim and injury.

To be eligible for recognition as a **specialist**, you should:

- be registered with the AHPRA to practice as a specialist in the relevant specialty or hold Fellowship and status as a Fellow of the relevant Australasian Specialist Medical College in the specialty. Recognition can only be granted for those medical specialties listed in Schedule 4 of the Health Insurance Regulations.

To be eligible for recognition as a consultant physician, you should:

- be registered with the AHPRA to practice as a specialist in a sub-specialty of general medicine, psychiatry, or rehabilitation medicine. Recognised sub-specialties general medicine are listed in Schedule 4 of the Health Insurance Regulations, or
- hold Fellowship of the Royal Australasian College of Physicians or Fellowship of the Royal Australian and New Zealand College of Psychiatrists and have status as a Fellow of the relevant College in relation to the specialty.

Telehealth consultation with a Psychiatrist is one that complies with the same MBS rules outlined in item codes 306 and 308 (see para A48 of explanatory notes in this category). The conditions of service are detailed in para A48 of explanatory notes in the telepsychiatry category.

Providers are to comply with the International Telecommunications Union Standards which cover all types of videoconferencing.

Complex case review (Item 100815)

A thorough written response to provide advice and guidance about a worker's claim for complex or unusual medical conditions through a review of the available medical information.

The complex case review includes:

- review of supplied or approved medical information
- report writing.

ILO report (Item 100818, 100819)

Chest x-ray review and associate ILO report conducted according to ILO Classification Guidelines.

Review and report must be performed by a single qualified, NIOSH accredited B-reader.

Supplementary reports (Items 400602, 400603)

Supplementary reports are requested when additional information is needed following an IME or PI consultation and report.

A supplementary report is at the request of the insurer only.

Short supplementary report

Written responses to insurer's limited number of questions (1 -3) seeking further information following an independent medical examination or permanent impairment report. They may:

- be requested for additional opinion on new medical information or treatment recommendations
- exclude requests for additional clarification where report questions have not been answered in the initial report
- exclude requests for clarification of assessment results or subsequent amendments to these results.

Long supplementary report

Should be requested in limited instances.

Written responses to insurer's limited (4-6) seeking further information following an independent medical examination or permanent impairment report. They may:

- be requested for additional opinion on new medical information or treatment recommendations
- exclude requests for additional clarification where report questions have not been answered in the initial report
- exclude requests for clarification of assessment results or subsequent amendments to these results.

Interpreter (Item 100816)

An interpreter fee is payable in addition to IME or PI consultation and report fees when additional time is

required to conduct the examination and report due to the additional assistance of an interpreter.

Pre-reading time (Item 100805)

Additional reading time is for any pre-reading and pre consultation time required for IME and PI services above the included 30 minutes.

Pre-reading and pre-consultation time covers reading of material provided or approved by the insurer in preparation for a consultation for an Independent Medical Examination (IME) or a Permanent Impairment (PI) assessment.

Administrative tasks such as printing of claim documentation are excluded.

Hourly rates for reading time are to be charged pro-rata per 5 mins. All invoices must include the time taken for the service as well as the fee.

Non-attendance / cancellation fee (Items 100303, 100305)

Fee payable only:

- when insurer-arranged appointment for Independent Medical Examination (IME) or Permanent Impairment (PI) assessment is cancelled or not kept
- when insurer or injured worker does not provide notice of cancellation or fails to attend a prescheduled appointment inside the 3 working day timeframe above (excluding weekends and public holidays).

Specialist MRI services (Items 100501, 100502, 100503, 100504, 100505, 100506, 100507, 100508, 100509, 100510)

Radiologists must meet the service level standards outlined on page six (6), in addition to the following service conditions:

Appointments

- Appointments should be scheduled within three working days upon receiving a valid, pre-approved request for a workers' compensation patient with an accepted and open claim, unless clinically inappropriate or additional services are required.
- Priority scheduling will be provided for interventional procedures requiring specialised expertise and access to operating suites, with a maximum wait time of seven days.
- Appointments may be delayed if deemed clinically appropriate.

Comprehensive reporting

- Reports must comprehensively address the mechanism of injury (if provided), any pre-existing conditions, and all information requested by the referrer, required for the procedure, and essential for interpreting the results, as outlined in RANZCR Standards of Practice for Clinical Radiology, V11, 5.5.1 Interpretation and Reporting the Result.

Additional imaging

- If further scans are deemed necessary by the provider’s clinical judgement, prior approval must be sought from the insurer.

Referral clarification

- The radiologist will contact the referring practitioner if referral clarification is required.

Report and image delivery

- Reports and images will be available electronically to referring practitioners, with formats including CD-ROM, web delivery (JPEG or DICOM), film, and paper, as per referrer or treating specialist preference.
- For digital formats, reports and images are to be delivered within two working days of the examination unless further review (e.g., consultation with another radiologist or comparison with prior images) is necessary. For urgent or same-day requests, arrangements should be pre-arranged.
- Hard copies will be provided as requested, with delivery times dependent on the means of delivery.
- Imaging provider will maintain a record of each referring practitioner's preferred report and image delivery format to ensure consistent service.

Billing and submission

- Invoices and a copy of the report are to be submitted electronically to the insurer where possible, and the payee must be a provider of radiological services.

Further assistance

Contact the relevant insurer for claim related information such as:

- payment of invoices and account inquiries
- claim numbers / status
- rehabilitation status.

More information for service providers is available on our website. If you require further information, call us on 1300 362 128.

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