WorkCover
QUEENSLAND

General Practitioner Supplementary Services **Table of Costs**

Effective 1 December 2024

General Practitioner 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	100158		$494 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	100160	Less than 10 minutes	$84
		100162	11 – 20 minutes	$168
Medical reports (see pages 5 – 7 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	100780	Received by insurer within 10 working days	$168
Completed form (2 – 3 questions) Completion of a brief form by the treating doctor.	No	100140	Received by insurer within 10 working days	$86
		100139	Received by insurer after 10 working days	$42
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	100144	Received by insurer within 10 working days	$426
		100145	Received by insurer after 10 working days	$213
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	100141	Received by insurer within 10 working days	$172
		100142	Received by insurer after 10 working days	$86

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	100297	Received by insurer within 10 working days	$85
		100298	Received by insurer after 10 working days	$42
Ancillary Services				
Workplace assessment Attendance at the workplace to assess aspects of the injured worker's job or environment.	Yes	100156		$494 per hour (pro-rata in 5 minute increments)
Travel Travel from normal place of practice to provide services to a worker at their place of residence or workplace.	Yes	100237	Vehicle cost	$0.78 / km
		100155	Travelling time per hour	$247 per hour (pro-rata in 5 minute increments)
Facility fee	No	100164		$109
Patient records Application fee for the provision of patient records relating to the workers' compensation claim including file notes, results of relevant tests.	No	100512		$78
		100513		$0.35 per page

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.
- **Hourly rates** are to be billed pro-rata in 5 minute increments.
- **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 100158)

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 100160, 100162)

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 the names of the parties involved 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 100208, 100140, 100139, 100144, 100145, 100141, 100142, 100297, 100298)

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. A full fee is payable if the form or report is received by the insurer within 10 working days.

Report review and response (Item 100780)

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.

Completed form (Items 100140, 100139)

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

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 100144, 100145)

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

Comprehensive reports 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).

The treating doctor's opinion should be given outlining the nature of the injury, capacity for work and advice on further management of the case.

Progress report (Items 100141, 100142)

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 100297, 100298)

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 100156)

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 100237, 100155)

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.

Facility fee (Item 100164)

For the use of a specially set up, dedicated treatment room for emergency procedures.

The fee is payable once only on the initial visit.

The use of this item number is not associated with registered private health facilities[1] who offer private emergency departments and occupational medical clinics. Please refer to the Private Hospital Services Table of Cost for further information on appropriate billing.

The fee is payable **only** on the initial visit and includes all drugs, plasters, suture materials and dressings used in the procedure. The fee does not cover repeat dressings, removal of sutures or normal aftercare.

Procedures could include:

- sutures
- removal of a foreign body requiring local anaesthetic
- surgical excision and closure

[1] https://www.health.qld.gov.au/__data/assets/pdf_file/0033/443994/private-facilities-addresses.pdf

- removal of a foreign body from the eye using local anaesthetic
- initial burns dressings
- fractures requiring plaster cast
- ECG and monitoring of an injured worker while waiting for arrival of an ambulance.

Patient records (Items 100512, 100513)

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.

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.

WorkCover

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