

Chiropractic Services Table of Costs

Effective 1 July 2026

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Quick reference table – Common Item Numbers

Item number	Description (High level)	Insurer prior approval required	Fee – GST not included
500021	Initial Consultation	No	\$137
500006	Subsequent Consultation	Yes (see table below)	\$108
500055	Reassessment or Program Review	Yes (see table below)	\$137
500226	Independent Case Review	At the request of the insurer	\$289
558100	X-Ray Cervical Spine	No	\$145
558103	X-Ray Thoracic Spine	No	\$119
558106	X-Ray Lumbosacral Spine	No	\$166
558112	X-Ray- Any Two Regions of the Spine	No	\$209
558115	X-Ray- Any Three Regions of the Spine	No	\$237



You can click on the item numbers in the table to view details.

Item number / service	Description
500021 Initial Consultation Insurer prior approval required No Fee – GST not included ¹ \$137	A one-on-one initial consultation in the treatment of a work-related injury or condition, or the first consultation in a new episode of care for the same work-related injuries or conditions. Services to be conducted in accordance with the Clinical Framework for the Delivery of Health Services². Initial consultation may include: • subjective assessment • objective assessment • treatment/service • tailored goal setting and treatment planning • setting expectations of recovery and return to work • clinical recording • communication with the referrer and insurer about any relevant information for the worker's rehabilitation. Please note: A provider cannot bill for multiple initial consultations or multiple subsequent consultations for the same worker on the same day.

500006 Subsequent Consultation

Insurer prior approval required Yes

Fee – GST not included¹ \$108

A one-on-one subsequent consultation in the treatment of work-related injuries or conditions.

The first **five (5)** consultations (including initial consultation) are pre-approved, provided the injuries or conditions have not previously been treated by an allied health provider.

If additional treatment is required, submit a Provider Management Plan³ (PMP). The PMP should include a comprehensive treatment plan containing:

- expected functional gains
- transition of care to self-management and
- treatment timeframes.

Services to be conducted in accordance with the Clinical Framework for the Delivery of Health Services².

Subsequent consultation may include:

- ongoing assessment (subjective and objective)
- intervention/treatment
- setting expectations of recovery and return to work
- clinical recording
- communication with the referrer and insurer about any relevant information for the worker's rehabilitation.

Please note: A provider cannot bill for multiple initial consultations or multiple subsequent consultations for the same worker on the same day.

[500055](#) Reassessment or Program Review

Insurer prior approval required Yes

Fee – GST not included¹ \$137

Prior approval is required before providing this service.

A one-on-one comprehensive assessment used when:

- the worker has been in active rehabilitation for at least six (6) weeks and further treatment is likely and/or
- there are new clinical findings that might affect ongoing treatment and/or
- there is a rapid change in worker's status and/or
- there is no response to current therapeutic interventions.

It should include:

- all components of initial consultation
- a review of the worker's progress based on established objective measures
- a recommendation for future treatment and management strategies to assist the worker to return to work.

It may include referral recommendations to other providers, a change in therapy or outcome direction requiring a new return to work goal.

Following reassessment submit a Provider Management Plan³ (PMP) which should include an updated comprehensive treatment plan containing:

- expected functional gains
- transition of care to self-management and
- treatment timeframes.

Please note: A provider cannot bill for multiple initial consultations or multiple subsequent consultations for the same worker on the same day.

[500226](#) Independent Case Review

Insurer prior approval required At the request of the insurer

Fee – GST not included¹ \$289 per hour (charged pro-rata as a fraction of an hour)

An independent chiropractic examination and report on a worker and is not carried out by the treating chiropractor.

The review is requested by the insurer where progress of treatment and/or rehabilitation falls outside the plan or expected course of injury management.

The examination and report provide the insurer with an assessment and recommendations for ongoing treatment and prognosis.

[558100](#) X-Ray - Cervical Spine

Insurer prior approval required No

Fee – GST not included¹ \$145

X-Ray - Cervical Spine. Must be clinically justifiable and have a causal link to the work-related injury or condition.

558103 X-Ray - Thoracic Spine Insurer prior approval required No Fee – GST not included¹ \$119	X-Ray - Thoracic Spine. Must be clinically justifiable and have a causal link to the work-related injury or condition.
558106 X-Ray - Lumbosacral Spine Insurer prior approval required No Fee – GST not included¹ \$166	X-Ray - Lumbosacral Spine. Must be clinically justifiable and have a causal link to the work-related injury or condition.
558112 X-Ray – Any Two Regions of the Spine Insurer prior approval required No Fee – GST not included¹ \$209	X-Ray - Any two regions of the spine. Must be clinically justifiable and have a causal link to the work-related injury or condition.
558115 X-Ray – Any Three Regions of the Spine Insurer prior approval required No Fee – GST not included¹ \$237	X-Ray - Any three regions of the spine. Must be clinically justifiable, and have a causal link to the work-related injury or condition.

1. Rates do not include GST. Check with the [Australian Taxation Office](#) or your tax advisor if GST is applicable.
2. WorkCover Queensland encourages the adoption of the nationally recognised [Clinical Framework for the Delivery of Health Services](#) when treating a worker with a work-related injury or condition.
3. The [Provider Management Plan](#) (PMP) template is available on the WorkCover Queensland website.

Who can provide chiropractic services to workers?

All chiropractic services performed must be provided by a chiropractor who has a current registration in the [Australian Health Practitioner Regulation Agency \(AHPRA\)](#).

Consultations (Item number 500006, 500021)

For an accepted claim, the insurer will pay the cost of an initial consultation, however not for an initial and subsequent consultation on the same day unless in exceptional circumstances, as approved by the insurer.

A provider cannot bill for multiple initial consultations or multiple subsequent consultations for the same worker on the same day.

Consultations may include the following elements:

- **Subjective (history) assessment** – consider major symptoms and lifestyle dysfunction, current/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. Assess overall work function level and any physical impairments preventing the worker's pain from resolving.
- **Assessment results (prognosis formulation)** – provide a provisional prognosis for treatment, limitations to function and return to work progress.
- **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 according to the goals of therapy.
- **Clinical recording** – record information in the worker's clinical records, including the purpose and results of procedures and tests
- **Communication with the referrer and insurer** – communicate any relevant information for the worker's rehabilitation to the insurer. Acknowledge referral and liaise with the treating medical practitioner about treatment.

When transitioning between pre-approved and prior approved services, it is recommended that you contact the insurer for clarification on what (if any) restrictions may apply.

The insurer will not pay a fee for the completion of a Provider Management Plan (PMP).

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Reassessment/Program Review (Item number 500055)

This reassessment or program review is indicated when:

- the worker has been in active rehabilitation for at least six weeks; and further treatment is likely and/or
- there are new clinical findings that might affect ongoing treatment and/or
- there is a rapid change in the worker's status and/or
- there is no response to current therapeutic interventions.

A reassessment/program review is a comprehensive assessment including:

- all components of the initial consultation
- a review of the worker's progress based on established objective measures
- a recommendation for future treatment and management strategies to assist the worker to return to work.

A reassessment/program review may include referral recommendations to other practitioners, a change in therapy direction or a change in outcome direction requiring a new return to work goal.

The insurer's prior approval is required before a reassessment/program review is undertaken. The chiropractor is expected to submit a PMP following the reassessment. Check with each insurer as to their individual requirements in relation to the PMP.

A reassessment/program review is not required:

- during routine reassessments as part of each treatment consultation
- where the worker is already on a clear management plan and is progressing as expected
- following postoperative protocols
- where a rehabilitation program extends beyond the reassessment period
- where the treating medical practitioner assesses the worker and recommends continued or more specific treatment.

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Independent Case Review (Item number 500226)

An independent case review is only requested by the insurer. The payment for this service includes assessment and report.

The purpose of an independent clinical assessment is to:

- assess and make recommendations about the appropriateness and necessity of current or proposed chiropractic treatment
- propose a recommended course of chiropractic management
- make recommendations for strategic planning to progress the case. Recommendations must relate to treatment goals and steps to achieve those goals, which will assist in a safe and durable return to work
- provide a professional opinion on the worker's prognosis where this is unclear from the current chiropractic program
- provide an opinion and/or recommendation on the other criteria as determined by the insurer.

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X-Rays (Item numbers 558100, 558103, 558106, 558112, 558115)

All x-rays performed on injured workers must be clinically justifiable and have a causal link to the work-related injury or condition. Indications for x-ray must be clear, and the results of such imaging will assist in the prognosis and management of the patient.

Please note: Radiology fees for chiropractic assessment are aligned with the current [Medical Items Table of Costs](#).

Routine x-ray screening of patients other than for exceptional circumstance is inappropriate. This includes serial or follow-up x-rays when the patient is making adequate clinical recovery. Exceptions include progressive pathology and fracture repair.

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