WorkCover QUEENSLAND

Specialist Supplementary Services

Table of Costs

Effective 1 December 2025

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		$715 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	$118
		100163	11 – 20 minutes	$236
Medical reports (see pages 6- 8 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	$236
Completed form (2 – 3 questions) Completion of a brief form by the treating doctor.	No	100808	Received by insurer within 10 working days	$148
		100814	Received by insurer after 10 working days	$74
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	$737
		100151	Received by insurer after 10 working days	$369
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	$444
		100807	Received by insurer after 10 working days	$222

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	$148
		100811	Received by insurer after 10 working days	$74
Ancillary Services				
Workplace assessment Attendance at the workplace to assess aspects of the injured worker's job or environment.	Yes	100157		$715 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.	No	100809	Vehicle cost	$0.82 / km
	Yes	100800	Travelling time per hour	$357 per hour (pro-rata in 5-minute increments)
Patient records Application fee for the provision of patient records relating to the workers' compensation claim including file notes, results of relevant tests.	No	100511		$81 plus
		100514		$0.36 per page

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.

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. It may also be claimed when a provider actively reviews and confirms agreement with, or contributes updates and recommendations to, a **Rehabilitation and Return to Work (RRTW) plan**.

This item cannot be claimed for simply receiving, filing or signing documents without review and consideration by the provider.

This item 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 100150, 100151, 100806, 100807, 100808, 100810, 100811, 100814)

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.

*If the treating provider submits a written response or report addressing the content of a medical report, regardless of whether the report was originally sent for information purposes only, the treating provider may claim item 100780. This billing allowance only applies when the response is clinically relevant and intended to inform, clarify or provide additional information to support claim decisions.

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

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 100800, 100809)

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 preparation and provision of patient records relating to a workers’ compensation claim. It includes:

- File notes
- Results of relevant investigations and tests (e.g., pathology, diagnostic imaging and reports)

- Any other relevant clinical information relevant to the claim

The fee also accounts for the time required to review records and remove information not related to the worker's claim.

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

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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