WorkCover QUEENSLAND

Private Hospital Services Table of Costs

Effective 1 January 2027

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Introduction

The **Private Hospital Services Table of Costs** sets out the maximum amounts payable for private hospital services provided to workers entitled to treatment under the ***Workers' Compensation and Rehabilitation Act 2003* (the Act)**.

Under the Act, the insurer may pay reasonable costs of medical treatment and hospitalisation provided to a worker for the management of a work-related injury or illness.

For the purposes of this table of costs, **insurer** refers to WorkCover Queensland (WorkCover) or a licensed self-insurer. A list of current self-insurers can be found on the **WorkSafe Queensland website**.

The fees in this table of costs apply from **1 January 2027**.

Eligibility

This table of costs applies to services provided to workers who have an accepted Queensland workers' compensation claim and are treated as a **private patient** in a **private hospital**.

It includes services provided in private hospital:

- emergency departments
- inpatient settings
- outpatient facilities.

This table of costs does not apply to workers who are treated as a **public patient** under the care of a **public hospital doctor**. Fees for public health services can be found on our **website**.

Private hospitalisation

The insurer's liability for private hospitalisation is outlined in sections 216 and 217 of the Act.

For non-elective admissions, prior approval is not required where clinically necessary. However, where the admission is expected to exceed four (4) days, approval must be obtained from the insurer for the continued hospitalisation.

For elective admissions, approval must be obtained from the insurer before admission or treatment occurs.

Approval of private hospitalisation will be considered where:

- a public hospital is not reasonably available, or admission to a public hospital cannot occur within a reasonable timeframe
- private hospitalisation is required to relieve the worker's pain and suffering
- treatment in a private hospital will result in a cost saving.

Work capacity certificates

A **work capacity certificate** must be in place to cover the period of medical treatment and hospitalisation.

If a worker does not present with a valid work capacity certificate upon presentation to a private hospital facility, one may be issued by the private emergency department or treating private hospital during treatment or on discharge.

Under the Act, a work capacity certificate must be issued **free of charge**. No fee is payable for completing or submitting a work capacity certificate.

For more information on completing and submitting a work capacity certificate, please visit our **website**.

Recovery and return to work

Supporting recovery and a safe return to work is a shared responsibility. Workers, providers, employers and insurers each play an important role in supporting a worker's recovery and return to work.

Work as part of recovery

Good work plays an important role in recovery and is beneficial for physical, mental and emotional health and wellbeing.

Research shows that workers who stay connected to work, or return to work when it is safe to do so, generally experience better recovery outcomes than those who remain away from work for longer periods.

Chance of returning to work



Source: The Royal Australasian College of Physicians (RACP)

Focus on capacity

Medical practitioners can support recovery by identifying what the worker can do, rather than what they can't. Returning to work does not need to wait until symptoms have completely resolved.

A return to work may involve:

- reduced hours
- modified duties
- additional supports
- a change in environment
- a gradual increase in work activities as recovery progresses.

Staying connected to the workplace, even when duties or hours are adjusted, can help workers maintain routine, social connection, confidence, independence and a sense of control during their recovery.

How to invoice us

Submitting an invoice

Submission requirements may vary between insurers. Providers should contact the relevant insurer to confirm invoice submission requirements and preferred submission methods.

WorkCover encourages hospital providers to submit invoices electronically through **Provider Connect** or **business-to-business software (B2B) integration**.

Invoice requirements

Invoices must comply with the insurer's invoicing requirements and include all information required for a valid tax invoice.

At a minimum, all invoices must include:

- hospital provider name, ABN, business address and contact details
- invoice number and invoice date
- worker's name and date of birth
- claim number (if known)
- employer name and address (if known)
- treating practitioner name (where applicable)
- table of costs item code and description of service provided
- date of service
- cost of service clearly showing the correct GST component.

Invoices for surgical procedures must also include:

- relevant MBS item number(s)
- applicable theatre band
- medical device or human tissue items and description as per the **Prescribed List**.

Goods and Services Tax (GST)

Fees published in this table of costs do not include GST.

For more detailed information on GST, including general requirements and which services GST applies to, please refer to the **ATO website.**

Two-month time frame

Invoices must be submitted within two months after the treatment is completed (date of service).

For more information on invoicing, please visit our **website** or contact the relevant self-insurer.

Patient health records

The insurer may request patient health records relevant to a worker's compensation claim to support claim decisions and ongoing claim management.

Patient health records include all records relevant to the worker's compensation claim, including clinical notes, diagnostic test results and operation records.

ITEM	DESCRIPTION	FEE
400591	Application fee for patient health records	$85
400594	Copying charge – per page	$0.38

Patient health records should be provided electronically where available. Hard copy records will only be accepted where records are not maintained electronically.

Patient health records must be provided within **14 days of the insurer's request**.

Accident and emergency attendance

Attendance at an accident and emergency (A&E) facility for the immediate treatment of a work-related injury may be payable where the treatment relates to an accepted claim.

A&E services must be provided by a private facility operating under the licence of a private hospital.

The A&E attendance item is only payable where the worker is not admitted to hospital and cannot be billed with any accommodation or theatre item.

ITEM	DESCRIPTION	FEE
400599	Accident and emergency attendance where the patient is not admitted. Can also be used for community / outreach services for a non-admitted patient.	$239

Cast technician services

Cast technician service items may be payable where a cast technician provides services as part of an A&E attendance.

Cast technician services provided during an inpatient admission are not separately payable, as these services are included in the applicable accommodation fee.

A cast technician fee and associated incidental charges may only be billed where the treating technician holds either:

- a Certificate IV in Cast Technology (HLT41412 or HLT41407, where issued before 13 June 2017), or
- a Diploma of Orthopaedic Technology (HLT57821).

ITEM	DESCRIPTION	FEE
400505	Cast technician – consultation	$118
400506	Cast technician – incidentals • Short arm • Long arm • Short leg • Long leg	 $54 $108 $63 $186

Additional services

The following services are not included in the A&E attendance fee and may be billed separately by the relevant service provider in accordance with the relevant **tables of costs**:

- specialist consultations
- diagnostic imaging service
- pathology services
- allied health services.

Private hospital accommodation

Private hospital accommodation may be payable where it is required as part of treatment for an accepted work-related injury.

The applicable accommodation item is determined by the classification assigned to the relevant Medicare Benefits Schedule (MBS) item in the **National Procedure Banding List**. Classifications are applied in accordance with the **Private Health Insurance (Benefit Requirements) Rules 2011**.

Same-day accommodation fees

Same-day accommodation fees apply where a worker is admitted to, and discharged from, hospital on the same day.

The National Procedure Banding List classifies same-day procedures as either:

- Type B Band 1
- Type B Non-band specific.

Where a procedure is classified as **Type B Band 1**, the Band 1 accommodation fee applies.

Where a procedure is classified as **Type B Non-specific band**, the applicable accommodation band is determined by the level of anaesthesia or sedation and, where applicable, theatre time. Where no anaesthesia or theatre time is involved, the Band 1 accommodation fee applies.

ITEM	PROCEDURE TYPE	DESCRIPTION	FEE
400501	Band 1	Gastrointestinal endoscopies, certain minor surgical items, and nonsurgical procedures that do not normally require anaesthetic and are not Band 2, 3 or 4 treatments.	$574
400502	Band 2	Procedures (other than Band 1) carried out under local anaesthetic with no sedation.	$644
400503	Band 3	Procedures (other than Band 1) carried out under general or regional anaesthesia or intravenous sedation. Theatre time less than 1 hour.	$694
400504	Band 4	Procedures (other than Band 1) carried out under general or regional anaesthesia or intravenous sedation. Theatre time 1 hour or more.	$773

Certified Type C procedure

Type C procedures do not normally require hospital admission. Same-day accommodation for Type C procedures is payable only where the treating medical practitioner certifies that, due to the worker's medical condition or special circumstances, hospital admission is medically necessary.

ITEM	PROCEDURE TYPE	DESCRIPTION	FEE
400500	Certified Type C procedure	A Type C procedure certified by the treating medical practitioner as requiring same-day hospital admission due to the worker's medical condition or special circumstances.	$521

Overnight accommodation fees

Overnight accommodation fees apply where a worker is admitted to hospital and remains an inpatient overnight for one or more days.

The National Procedure Banding List assigns one of the following patient categories to each MBS item:

- Advanced surgical
- Surgical
- Medical
- Obstetric (not applicable).

The applicable overnight accommodation fee is determined by the patient category assigned to the MBS item and the length of stay.

ITEM	PATIENT CATEGORY	LENGTH OF STAY	FEE
400510	Advanced surgical	1 – 14 days	$1374
400511		Over 14 days	$1060
400512	Surgical	1 – 14 days	$1230
400513		Over 14 days	$951
400514	Medical	1 – 14 days	$1190
400515		Over 14 days	$920

Intensive care services

Intensive care services are payable only where the level of care provided aligns with Levels 4, 5 or 6 of the **Clinical Standard Capability Framework (CSCF) Intensive Care Services** published by Queensland Health.

The insurer may ask for written evidence of the level of care required.

ITEM	DESCRIPTION	LEVEL OF CARE	FEE
400586	Intensive care services	Level A (Level 6)	$4739
400587		Level B (Level 5)	$3597
400588		Level C (Level 4)	$2409

Coronary care services

Services provided in a dedicated coronary care unit are payable under the applicable coronary care unit item.

ITEM	DESCRIPTION	UNIT	FEE
400598	Coronary care unit	Per day rate	$2914

Request for private or single rooms

Private or single rooms are allocated based on clinical need. Detailed clinical justification must be provided to the insurer for prior approval.

Where a worker requests a private or single room, and there is no clinical requirement, the insurer is not responsible for any additional fees, surcharges or gap payments.

ITEM	DESCRIPTION	UNIT	FEE
400520	Clinically required private or single room	Per day rate	$80

Additional services

The following services are not included in accommodation fees and may be billed separately by the relevant service provider in accordance with the relevant **tables of costs**:

- specialist consultations
- diagnostic services
- pathology services
- allied health services.

Theatre services

Theatre services may be payable where a procedure is performed in an operating theatre as part of treatment for an accepted work-related injury.

The applicable theatre item is determined by the theatre band assigned to the relevant MBS item in the National Procedure Banding List.

Where no theatre band is assigned to an MBS item in the National Procedure Banding List, the hospital provider must obtain prior approval from the insurer before billing theatre services.

Theatre fees

ITEM	THEATRE BAND	FEE
400550	Band 1A	$481
400551	Band 1	$711
400552	Band 2	$1043
400553	Band 3	$1380
400554	Band 4	$1742
400555	Band 5	$2182
400556	Band 6	$2679
400557	Band 7	$3887
400558	Band 8	$4960
400559	Band 9A	$5266
400560	Band 9	$6671
400561	Band 10	$7941
400562	Band 11	$9378
400563	Band 12	$11,208
400564	Band 13	$13,778

Multiple Operation Rule (MOR)

When two or more procedures are performed on the same occasion, WorkCover's Multiple Operation Rule (MOR) applies and is used to calculate the total theatre fee.

The procedure with the highest theatre fee is paid in full, with reduced fees payable for additional procedures as follows:

- 100% of the procedure with the highest theatre charge plus
- 50% of the procedure with the next highest theatre charge plus
- 25% of each of the other procedures provided.

Example

ITEM	THEATRE BAND	PAYABLE FEE
Item A	Band 5	100%
Item B	Band 3	50%
Item C	Band 1	25%
Item D	Band 1	25%

Consumables and disposable items

Theatre fees include the costs of surgical consumables and disposable items used during the procedure, excluding items listed on the **Prescribed List of Medical Devices and Human Tissue Products**.

In exceptional circumstances, high-cost surgical consumables and disposable items may be necessary for the management and treatment of the worker's accepted injury. Prior approval from the insurer is required and requests must be supported by appropriate clinical justification.

Where exigent clinical circumstances exist and high-cost surgical consumables or disposable items are required immediately to provide life-saving treatment, prior approval is not required. The insurer may request clinical evidence to support the use of the item.

Robotic devices

Theatre fees include the costs associated with the use of robotic devices and associated equipment.

Separate payment for special access robotic devices will only be considered in exceptional circumstances where the hospital can demonstrate that the device is reasonably necessary for the management of the worker's compensable injury and the costs are not otherwise captured within the applicable theatre fee.

Requests for additional funding must be supported by detailed clinical justification and a breakdown of the applicable costs and must be approved in writing by the insurer prior to treatment. Where prior approval has been granted, item **400507** is to be used for invoicing approved special access robotic device costs.

Medical devices and human tissue products

Medical devices and human tissue products listed on the **Department of Health Prescribed List of Medical Devices and Human Tissue Products** (formerly known as the Prostheses List) may be payable where required for the treatment of an accepted work-related injury.

All invoices for medical devices and human tissue products must include the relevant Prescribed List billing code.

For medical devices or human tissue products removed from the Prescribed List as part of the Australian Government's staged Prostheses List reforms, reimbursement is subject to prior approval from the insurer. Requests must be supported by appropriate clinical justification and a supplier quotation or invoice.

ITEM	DESCRIPTION	FEE
400521	Medical device or human tissue product	Applicable fee as per the **Prescribed List**
400522	Handling fee	5% of device or product fee capped at $221

Medical devices or human tissue products that are opened during a procedure but not implanted are not payable, unless clinical circumstances prevented successful implantation. Claims for these devices or products must be supported by the operation record and/or relevant device or product details recorded in the intraoperative report, count record or implant record, or by written clinical justification from the treating specialist.

The insurer may request a copy of the intraoperative report, count record or implant record to support reimbursement of medical devices and human tissue products.

Pharmacy

Pharmaceuticals may be payable when supplied on discharge from an inpatient admission and relate to the treatment of an accepted injury.

Pharmaceuticals provided during an inpatient admission are not separately payable, as these are included in the applicable accommodation fee.

In exceptional circumstances, additional reimbursement may be payable for high-cost pharmaceuticals that are reasonably necessary for the management and treatment of the worker's accepted injury. Prior approval from the insurer is required and requests must be supported by appropriate clinical justification.

For the purposes of this table of costs, high-cost pharmaceuticals are those that are not:

- listed on the Pharmaceutical Benefits Scheme (PBS)
- funded through the Section 100 (s100) Program under the National Health Act 1953
- funded through the Life Saving Drugs Program (LSDP).

ITEM	DESCRIPTION	FEE
400596	Pharmaceuticals supplied: • on discharge following an inpatient admission • as part of life-saving treatment (prior approval not required) • with prior approval for high-cost pharmaceuticals.	As per reasonable fee for relevant pharmaceuticals

Exigent circumstances

Where exigent clinical circumstances exist, and a high-cost drug is required immediately to provide life-saving treatment, prior approval from the insurer is not required. The insurer may request clinical evidence to support the use of the drug.

Rehabilitation and treatment program

Rehabilitation and treatment programs may be payable where required as part of treatment for an accepted work-related injury.

Approval for rehabilitation and treatment programs must be obtained prior to commencement of treatment using the **Request for Specialised Program (FM303)** form.

Mental health programs

Mental health programs may be delivered as an inpatient admission or a day patient program, depending on the worker's clinical needs.

Inpatient programs must be provided within a designated psychiatric hospital, or psychiatric unit or ward within a general hospital, and delivered by a multidisciplinary team under the oversight of a consultant psychiatrist.

Day patient programs may be provided following discharge from an inpatient program or where an inpatient admission is not clinically appropriate or available.

Programs must have clearly defined treatment goals and outcome measures and may include psychology, occupational therapy, physiotherapy, group education, graded exercise, relaxation therapy, case conferencing and discharge planning. Day patient programs should include a gradual return to work focus.

These services are included in the program fee and are not separately payable where delivered as part of the approved program.

ITEM	DESCRIPTION	UNIT	FEE
400565	Inpatient admission – mental health program	Per day rate	$1112
400567	Day patient – mental health program	Full day patient – per day rate (at least 4.5 hours duration)	$784
400509		Half day patient – per day rate (at least 2.5 hours duration)	$448

Adjunct mental health treatments

Adjunct mental health treatments, such as electroconvulsive therapy (ECT), repetitive transcranial magnetic stimulation (rTMS) and ketamine treatment are not included within mental health programs.

Approval must be obtained from the insurer prior to commencement of treatment.

Medical practitioners should bill the appropriate consultation and treatment items in accordance with the **Medical Services Table of Costs**.

Private hospitals may bill for the applicable same-day accommodation fee based on the level of sedation, or overnight accommodation where overnight admission is required and is separate from an approved inpatient mental health program.

Rehabilitation programs

Rehabilitation programs may be delivered as an inpatient admission or a day patient program, depending on the worker's clinical needs.

Programs must be assessed and overseen by a rehabilitation physician and delivered by a multidisciplinary team. Programs must have clearly defined treatment and return-to-work goals and outcome measures.

Programs may include physiotherapy, graded exercise, aquatic therapy, occupational therapy, psychology, speech therapy, case conferencing, discharge planning and return to work activities.

These services are included in the program fee and are not separately payable where delivered as part of the approved program.

ITEM	DESCRIPTION	UNIT	FEE
400569	Inpatient admission – rehabilitation program	Per day rate	$1112
400571	Day patient – rehabilitation program	Full day patient – per day rate (at least 3 hours duration)	$784
400516		Half day patient – per day rate (at least 1.5 hours duration)	$448

Pain management programs

Pain management programs may be delivered as an inpatient admission or a day patient program, depending on the worker's clinical needs.

Programs must be assessed and overseen by a pain physician and delivered by a multidisciplinary team. Programs must have clearly defined treatment and return-to-work goals and outcome measures.

Programs may include physiotherapy, graded exercise, aquatic therapy, occupational therapy, clinical psychology, group education, relaxation therapy, case conferencing, discharge planning and return to work activities.

These services are included in the program fee and are not separately payable where delivered as part of the approved program.

ITEM	DESCRIPTION	UNIT	FEE
400573	Inpatient admission – pain management program	Per day rate	$1112
400575	Day patient – pain management program	Full day patient – per day rate (at least 3 hours duration)	$784
400517		Half day patient – per day rate (at least 1.5 hours duration)	$448

Alcohol and other drugs (AOD) programs

Alcohol and other drug programs may be delivered as an inpatient admission or a day patient program, depending on the worker's clinical needs.

Programs must be overseen by a consultant psychiatrist or addiction medicine specialist and delivered by a multidisciplinary team. Where clinically required, programs may include the medically supervised withdrawal of drugs or alcohol.

Programs must have clearly defined treatment goals and outcome measures. Day patient programs should include a gradual return to work focus.

Programs may include psychology, relaxation therapy, coping skills training, medication management, case conferencing and discharge planning.

These services are included in the program fee and are not separately payable where delivered as part of the program.

ITEM	DESCRIPTION	UNIT	FEE
400581	Inpatient admission – AOD program	Per day rate	$1112
400583	Day patient – AOD program	Full day patient – per day rate (at least 3 hours duration)	$784
400518		Half day patient – per day rate (at least 1.5 hours duration)	$448

Additional service costs

The following services are not included in rehabilitation and treatment program fees and may be billed separately by the relevant service provider in accordance with the relevant **tables of costs**:

- specialist consultations
- diagnostic services
- pathology services.

Patient outcome data

The insurer may request patient outcome data relating to admissions under these programs to assess patient outcomes, support the delivery of high-value care, and inform future service and fee models.

Haematology and oncology

Hospital admission for haematology and oncology services may be payable where required as part of treatment for an accepted work-related injury.

Prior approval must be obtained from the insurer for all elective haematology and oncology admissions.

Accommodation

Accommodation for haematology and oncology services is payable as follows:

- **Same-day accommodation** is payable at the Band 2 fee (item 400502).
- **Overnight accommodation** is payable at the applicable overnight accommodation fee based on the worker's clinical care requirements.

Treatment services

Treatment services for haematology and oncology services are payable as follows:

ITEM	DESCRIPTION	FEE
Applicable MBS item	Parenteral chemotherapy	Relevant Medical Items Table of Costs fee
400595	PBS-listed haematology and oncology pharmaceuticals	Relevant PBS fee
400597	Infusion pump where required to administer agent or drug	$89 per treatment episode
400600	Other treatment-related hospital services not otherwise provided for, including scalp cooling, oncology maintenance services, patient education and stem cell storage.	As per reasonable service fee
400601	Outpatient services provided to immunocompromised patients only, including Evusheld and subcutaneous non-chemotherapy treatments (e.g. bisphosphonates).	As per reasonable service fee

For billing purposes, haematology and oncology drugs include, but are not limited to, alkylating agents, nitrosoureas, antimetabolites, plant alkaloids, antitumour antibiotics, hormonal agents and biological response modifiers.

Prior approval must be obtained from the insurer for high-cost non-PBS drugs. A pharmacy quotation must be provided to the insurer with the approval request.

Additional service costs

The following services are not included in rehabilitation and treatment program fees and may be billed separately by the relevant service provider in accordance with the relevant **tables of costs**:

- specialist consultations
- diagnostic services
- pathology services.

Other services

Hospital in the Home (HITH)

Hospital in the Home (HITH) services are to be billed as per the relevant medical and allied health **tables of costs**.

Rehabilitation in the Home (RITH)

Rehabilitation in the Home (RITH) services are to be billed as per the relevant medical and allied health **tables of costs.**

Temporary assistive devices

Temporary assistive devices, also referred to as temporary mobility aids or independent living aids, may be payable where they are required for the management of an accepted work-related injury.

The insurer will only fund temporary assistive devices that are reasonably necessary and relate to the hospital admission and treatment of the accepted injury.

Examples of temporary assistive devices include, but are not limited to, the hire of crutches, braces, wheelchairs and toilet seats.

Temporary assistive devices provided at discharge may be billed separately and must be invoiced using item **400508**.

All invoices for the hire or supply of temporary assistive devices must include details of the item supplied and, where applicable, the hire period.

ITEM	DESCRIPTION	FEE
400508	Temporary assistive devices	Reasonable relevant hire charge

Contact us

General enquiries

Phone: 1300 927 928

Hours: Monday to Friday, 8:00 am to 5:30 pm AEST

If you need to contact a self-insured employer, you can find their contact details on the **WorkSafe Queensland website**.

Questions about a claim

For information about a claim, please contact the claim advisor directly.

If you're unsure who the claim advisor is, call 1300 927 928.

Provider questions and support

If you have questions about this table of costs or other provider-related enquiries, please contact our Provider Partnerships Team:

Email: **ProviderEngagement@workcoverqld.com.au**