WorkCover QUEENSLAND

Specialist Supplementary Services Table of Costs

Effective 1 January 2027

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Introduction

The **Specialist Supplementary Services Table of Costs** sets out the maximum amounts payable for supplementary services under the ***Workers' Compensation and Rehabilitation Act 2003*** **(the Act)**.

Under the Act, the insurer may pay for reasonable medical treatment and services provided to a worker for the management of an accepted 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**.

This table should be read in conjunction with the **Medical Items Table of Costs**, which outlines medical services billed using **Medicare Benefits Schedule (MBS)** item numbers. Supplementary services not covered by MBS item numbers are set out in this table.

Specialist supplementary service fees

DESCRIPTION	INSURER APPROVAL REQUIRED	ITEM	TIMEFRAMES	FEE
Communication				
Case conference A face-to-face or telehealth 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	10 minutes or less	$118
		100163	11 – 20 minutes	$236
Medical reports				
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	$245
Completed form (2 – 3 questions) Completion of a brief form by the treating doctor.	No	100808	Received by insurer within 10 working days	$154
		100814	Received by insurer after 10 working days	$77
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	$766
		100151	Received by insurer after 10 working days	$383
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	$461
		100807	Received by insurer after 10 working days	$231
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	$154
		100811	Received by insurer after 10 working days	$77
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 Fee for providing patient records relating to the workers' compensation claim, including file notes and relevant test results.	No	100511		$81 plus
		100514		$0.36 per page

Service requirements

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** – to be billed pro rata in 5-minute increments.
- **Payment** – accounts for services must be sent to the insurer promptly and within two (2) months after the service is completed.

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.**

General report requirements

The full fee is payable where the report or form is received by the insurer within 10 working days. A reduced fee applies after this timeframe.

The 10 working days starts from the later of:

- the date the request is received
- the date of the next consultation.

Reports and forms should be submitted electronically through online services, such as **Provider Connect**, where available.

Case conference

Item 100159

A case conference is a face-to-face or telehealth meeting involving the treating doctor, insurer and one or more of the following:

- the worker or their representative
- a medical or allied health provider
- the employer
- other relevant stakeholders.

The purpose of a case conference is to plan, implement, manage or review treatment and rehabilitation strategies and agree on a coordinated approach to support the worker's recovery and return to work.

Prior approval is required by the insurer. Case conferences are generally approved for a maximum of one hour, excluding travel time.

The insurer will not pay for case conferences involving practitioners who are not part of the treating team (for example, peer review case conferences).

A case conference may be requested by a treating medical or allied health provider, the worker or their representatives, the insurer or the employer.

Communication

Items 100161, 100163

Communication between the treating practitioner and the insurer, employer or rehabilitation provider regarding the worker's treatment, rehabilitation or return to work may be payable where it supports the management of an accepted workers' compensation claim.

Communication must be relevant to the compensable injury and assist the insurer and other involved parties to address barriers, coordinate treatment or rehabilitation, or agree on recovery and return to work strategies.

This item is intended to cover communication that is additional to routine clinical care and is required to support management of the claim. It is not intended to cover communication that forms part of usual treatment, professional practice or administrative processes.

The item cannot be claimed for:

- completing or submitting a work capacity certificate
- communication during a consultation, as this is considered part of the consultation service
- communication between treating medical and allied health practitioners that forms part of usual clinical practice and coordination of care
- conveying non-specific information such as ‘worker progressing well’
- communication regarding referrals, including referral acceptance or acknowledgement
- communication with or from the insurer as part of a quality review process
- general administrative activities, including:
    - communication with the worker
    - transmitting reports or documents by email, fax or online services
    - leaving messages where the recipient is unavailable
    - invoice-related queries.

All invoices must include the names of the parties involved and the reason for contact. Only one communication item is payable where the same communication is sent to multiple recipients.

Suitable duties plans

Item 100161 may be used when the treating medical practitioner reviews a suitable duties plan for the purpose of certifying the worker’s capacity for work. This includes approval, adjustments or recommendations to support return to work planning.

The item is not payable for receipt or acknowledgement of a suitable duties plan without certification of the worker’s capacity for work.

My Recovery Plan (Rehabilitation and Return to Work Plan)

A worker’s **My Recovery Plan** or Rehabilitation and Return to Work (RRTW) plan is developed and updated by the insurer in consultation with the worker, employer and treatment providers. Treatment providers are not required to approve, sign or update the plan.

Communication items may be used when the treating medical practitioner provides new or updated information to the insurer to inform a change to the worker’s plan. This may include feedback or recommendations about the worker’s goals, diagnosis, treatment, capacity for work or return to work planning. Any recommendations must be discussed with the worker first.

A fee is not payable for:

- receiving, reading, reviewing or signing the plan
- discussing the plan with the worker during a consultation.

These activities form part of routine clinical care and are covered by consultation items in the relevant table of costs.

Report review and response

Item 100790

Written response to 1 - 3 questions from the insurer seeking commentary on a medical report prepared by another medical provider.

This item includes review of a medical report provided by the insurer, such as an independent medical report, and preparation of a written response relevant to the management of a claim.

The response must address specific questions from the insurer or provide clinically relevant information intended to inform, clarify or support claim decisions.

The item includes report review, preparation of the response and submission to the insurer.

This item is not payable where:

- the report was not provided by the insurer
- a more appropriate service item applies.

Completed form

Items 100808, 100814

Completion of a brief form containing 2 or 3 questions requested by the insurer to obtain specific information for management of a claim.

This includes completion of the additional questions on a **Request for Surgery Approval** form when answered in full.

This item cannot be claimed for completing or submitting a work capacity certificate, which must be issued free of charge under the Act.

Comprehensive report

Items 100150, 100151

Written response to an insurer's request for detailed information regarding diagnosis, investigations, prognosis, treatment and return to work goals.

A comprehensive report may be requested following consultation, investigation, surgical intervention or prior to referral to a Medical Assessment Tribunal (MAT).

The report may include clinical findings, medical opinion, treatment recommendations and advice regarding capacity for work and future management of the compensable injury.

Progress report

Items 100806, 100807

Written response to an insurer's request for information about the worker's progress at a specific stage of a claim. A progress report provides information regarding recovery, functional capacity and progress towards treatment and return to work goals. It may also be used where goals, treatment approaches or rehabilitation strategies have changed significantly since a previous report.

Short report

Items 100810, 100811

Written response to a limited number of insurer questions (typically two or three) seeking specific information regarding the worker's condition at a specific stage of a claim.

A short report conveys brief information relevant to management of the worker's compensable injury.

Workplace assessment

Item 100157

Attendance at a workplace to assess aspects of a worker's job, duties or work environment.

A workplace assessment may be used to support the development or implementation of a worker's rehabilitation or return to work plan.

Travel

Items 100800, 100809

Travel time may be payable where a medical practitioner is required to leave their normal place of practice to provide services at a worker's residence or workplace.

Prior approval is required by the insurer.

Travel is not payable:

- between practice locations owned or operated by the medical practitioner's business
- for regular sessional visits to hospitals, specialist consulting rooms or other facilities.

Where multiple workers are seen during the same journey or at the same location, travel time must be apportioned between the workers and invoiced separately.

Patient records

Items 100511, 100514

Provision of patient records relevant to a workers' compensation claim at the request of the insurer.

Patient records may include:

- clinical file notes
- pathology, diagnostic imaging and other investigation results
- reports and other clinical information relevant to the claim.

The fee includes the time required to review records and remove information unrelated to the workers' compensation claim.

This item is payable only where records are requested by the insurer.

Specialist MRI service fees

ITEM	DESCRIPTION	INSURER APPROVAL REQUIRED	FEE
100501	Specialist MRI MBS item codes 63491, 63494, 63498	No	$90
100502	MBS item codes 63010, 63040, 63334	No	$672
100503	MBS item codes 63043, 63151, 63154, 63161, 63167, 63170, 63173, 63176, 63179, 63182, 63185, 63461	No	$717
100504	MBS item codes 63301, 63304, 63307	No	$762
100505	MBS item codes 63001, 63004, 63007, 63046, 63049, 63055, 63058, 63061, 63064, 63067, 63070, 63073, 63322, 63340, 63391, 63401, 63404, 63482	No	$806
100506	MBS item codes 63201, 63204, 63219, 63222, 63225, 63228, 63231, 63234, 63237, 63240, 63243, 63337, 63388	No	$869
100507	MBS item codes 63101, 63111, 63114, 63125, 63128, 63131, 63271, 63274, 63277, 63280	No	$986
100508	MBS item codes 63325, 63328, 63331	No	$717

Specialist MRI service level standards

1. Patients must be referred by a specialist.
2. Imaging examinations must be performed by a radiologist registered as a specialist in Diagnostic Radiology with AHPRA.
3. Services must be provided in a DIAS-accredited diagnostic imaging practice.
4. Appointments should be scheduled within three working days of receiving a valid referral for a worker with an accepted workers' compensation claim, unless clinically inappropriate or additional preparation is required.
5. Interventional procedures requiring specialised expertise or access to operating facilities should be prioritised, with appointments provided within seven days where clinically appropriate.
6. Reports must address all information requested by the referrer and information necessary to interpret the examination, consistent with the **RANZCR Standards of Practice for Clinical Radiology**.
7. Reports and images should be provided within 48 hours of the examination unless additional imaging, comparison studies or clinical information are required.
8. If referral clarification is required, the radiologist must contact the referring practitioner.
9. If additional imaging is clinically indicated, prior approval must be obtained from the insurer.
10. Reports must be submitted to the insurer before payment of an invoice can be made. Reports and invoices should be submitted electronically to the insurer wherever possible.

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**