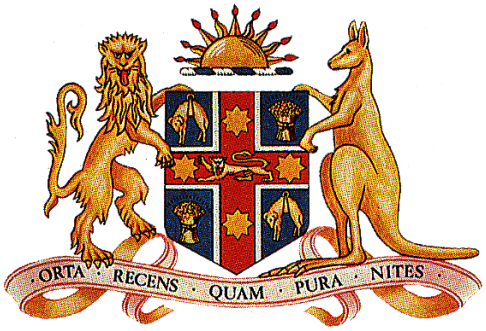

Government Gazette

of the State of

New South Wales

Number 180
Friday, 20 December 2019

The New South Wales Government Gazette is the permanent public record of official NSW Government notices. It also contains local council, private and other notices.

From 1 January 2019, each notice in the Government Gazette has a unique identifier that appears in round brackets at the end of the notice and that can be used as a reference for that notice (for example, (n2019-14)).

The Gazette is compiled by the Parliamentary Counsel's Office and published on the NSW legislation website (www.legislation.nsw.gov.au) under the authority of the NSW Government. The website contains a permanent archive of past Gazettes.

To submit a notice for gazettal – see Gazette Information.

ISSN 2201-7534

By Authority
Government Printer

WORKERS COMPENSATION
(SURGEON FEES) ORDER 2020

under the

Workers Compensation Act 1987

I, Carmel Donnelly, Chief Executive, State Insurance Regulatory Authority, make the following Order pursuant to section 61(2) of the *Workers Compensation Act 1987*.

Dated this 11 day of December 2019

Carmel Donnelly
Chief Executive
State Insurance Regulatory Authority

Explanatory Note

Treatment by a Medical Practitioner who is a Surgeon is medical or related treatment covered under the *Workers Compensation Act 1987*. This Order sets the maximum fees for which an employer is liable under the Act for treatment by a Surgeon provided to a NSW worker. It must not exceed the maximum fee for the treatment or service as specified in this Order. Workers are not liable for the cost of any medical or related treatment covered by this Order. The effect of this Order is to prevent a Surgeon from recovering from the worker or employer any extra charge for treatments covered by this Order.

Under section 60(2A)(a) of the *Workers Compensation Act 1987,* medical or related treatment requires prior insurer approval unless treatment is provided within 48 hours of the injury happening or treatment is exempt from pre-approval under the *Workers Compensation Act 1987* or the State Insurance Regulatory Authority's *Workers Compensation Guidelines* in effect at the time.

Treatment by an Orthopaedic Surgeon is covered by the *Workers Compensation (Orthopaedic Surgeon Fees) Order 2020.* However, maximum fees under this Order may apply to procedures carried out by an Orthopaedic Surgeon which are covered by the *Workers Compensation (Surgeon Fees) Order 2020.*

Surgeons should also refer to the *Workers Compensation (Medical Practitioner Fees) Order 2020.*

This Order adopts the items listed as Surgical Procedures in the *List of Medical Services and Fees* issued by the Australian Medical Association (AMA).

To bill an AMA item number a Surgeon must be confident they have fulfilled the service requirements as specified in the item descriptor.

Where only one service is rendered, only one item should be billed. Where more than one service is rendered on one occasion of service, the appropriate item for each discrete service may be billed, provided that each item fully meets the item descriptor. Where an operation comprises a combination of procedures, which are commonly performed together, and for which there is an

AMA item that specifically describes the combination of procedures, then only that item should be billed. Where a comprehensive item number is used, separate items must not be claimed for any of the individual items included in the comprehensive service. The invoice should cover the total episode of treatment.

The incorrect use of any items referred to in this Order can result in penalties, including the Medical Practitioner being required to repay monies that the Medical Practitioner has incorrectly received.

Workers Compensation (Surgeon Fees) Order 2020

1. Name of Order

This Order is the *Workers Compensation (Surgeon Fees) Order 2020*.

2. Commencement

This Order commences on 1 January 2020.

3. Definitions

In this Order (including Schedules A, B, C and D):

the Act means the *Workers Compensation Act 1987*.

the Authority **means** the State Insurance Regulatory Authority as constituted under section 17 of the *State Insurance and Care Governance Act 2015.*

Aftercare visits are covered by the surgical procedure fee during the first six weeks following the date of surgery or until wound healing has occurred. Unrelated visits or incidental reasons for visits that are not regarded as routine aftercare must be explained with accounts rendered.

Assistance at operation means a Medical Practitioner, but only where an assistant's fee is allowed for in the Commonwealth Medicare Benefits Schedule (MBS). An assistant fee may only be applicable for surgical procedures EA015 to MY330 and MZ731 to MZ871. Assistance at operation is only payable once per item number performed by the principal Surgeon irrespective of the number of medical practitioners providing Assistance at operation.

Note: *Assistance at Operation* fees are not payable to health practitioners who are not a Medical Practitioner eg. perioperative nurses.

In accordance with NSW Health policy directive *Employment Arrangements for Medical Officers in the NSW Public Health Service* (**Doc No:** PD2019_027), assistant fees cannot be charged for workers compensation cases performed in a public hospital when the assistant is a resident medical officer or registrar. If a resident medical officer or registrar is on rotation to an accredited private hospital, the relevant assistant fee may be charged. Payment of these fees are to be directed into a hospital or departmental trust fund account and the invoice should include details of this account. The Authority reserves the right to conduct an audit of assistant fee payments to ensure their proper distribution into the named trust fund.

AMA List means the document entitled List of Medical Services and Fees issued by the Australian Medical Association dated 1 November 2019 and any subsequent amendments to this List published by the AMA in the period 1 November 2019 – 31 October 2020.

Compound (open) wound refers to a situation where a Surgeon is treating a fracture and the injury is associated with a compound (open) wound. In an open fracture wound that requires debridement, a 50% loading for open fracture fixation can be applied. Debridement item EA075/30023 is not to be billed when applying this loading.

Extended initial consultation means a consultation involving significant multiple trauma or complex "red flag" spinal conditions (systemic pathology, carcinoma, infection, fracture or nerve impingement) involving a lengthy consultation and extensive physical examination.

GST means the Goods and Services Tax payable under the GST Law.

GST Law has the same meaning as in the *A New Tax System (Goods and Services Tax) Act 1999* of the Commonwealth.

Initial consultation and report covers the first consultation, the report to the referring Medical Practitioner and the copy of the report to the insurer.

The report will contain:

- the worker's diagnosis and present condition;
- an outline of the mechanism of injury
- the worker's capacity for work
- the need for treatment or additional rehabilitation; and
- medical co-morbidities that are likely to impact on the management of the worker's condition (in accordance with privacy considerations).

The receipt of this report and any certificates of capacity under section 44B of the Act post-treatment will provide sufficient information for insurers, employers and workplace rehabilitation providers to develop management plans.

Instrument fee covers procedures where the Surgeon supplies all the equipment or a substantial number of specialised instruments in exceptional circumstances and must be justified. This fee does not apply for all operations or if only incidental instruments (non-critical) are supplied by the Surgeon. Routine items such as loupes are not included.

Insurer means the employer's workers compensation insurer.

Medical Practitioner means a person registered in the medical profession under the *Health Practitioner Regulation National Law (NSW) No 86a,* or equivalent in their jurisdiction with the Australian Health Practitioner Regulation Agency. In accordance with section 60(2A)(d) of the Act, the employer will not be liable for the treatment provided if the treatment or service is provided by a Medical Practitioner who is suspended or disqualified from practice under any relevant law or the Medical Practitioner's registration is limited or subject to any condition imposed as a result of a disciplinary process.

Multiple operations or injuries refer to situations that require two or more operations or for the treatment of two or more injuries carried out at the same time. It applies to the AMA items EA015 to MY330 and MZ731 to MZ871, with the exception of items specifically listed

as a multiple procedure item in the AMA List, or where Schedules in this Order prevent combining of items. The fee for the main procedure or injury is to be paid in full as per Schedule A (1.5 x of AMA List fee), and for each additional item or injury at 1.125 x AMA List Fee specified in Schedule A.

Opinion on file request includes retrieval of a file from whatever source, reading time, and reporting where a request for such an opinion has been made in writing to the Surgeon and in accordance with privacy principles.

Out-of-hours consultation means a call-out to a public or private hospital or a private home for an urgent case before 8.00am or after 6:00pm Monday to Friday, or anytime on the weekend and public holidays. This fee is not to be utilised where a consultation is conducted for non-urgent cases.

Out-of-hours loading only applies when a Surgeon is called back to perform a procedure(s) in isolation rather than for cases scheduled before 8.00am or after 6.00 pm on a weekday or a routine weekend operating list. Loading is to be calculated at 20% of the total procedure fee. The item must be reflected in the invoice as a separate entry against code WCO008.

Revision surgery refers to a procedure carried out to correct earlier surgery. Only where the revision surgery is performed by a Surgeon other than the original Surgeon, shall it attract a fee of 50% of the amount for the principal procedure in the initial surgery, in addition to the fee payable for the new procedure. Where the new procedure is specified as a revision procedure in the AMA List, the 50% loading does not apply.

Spinal surgical rules and conditions provided in the current Medicare Benefits Schedule apply to spinal surgical items MZ731 (MBS 51011) to MZ871 (MBS 51171) conducted on or after 1 January 2020.

Surgical procedures are those listed in the AMA List but do not include the cost of bandages, dressings, plaster of Paris bandages, splints, metallic fixation agents, and prosthetic implants which may be charged in addition to the fee set out in Schedule A, if purchased by the Surgeon. The fee for surgical procedures includes pre-surgery consultations conducted on the same day of surgery and aftercare visits.

Subsequent consultation and report is each attendance subsequent to the first in a single course of treatment. A subsequent consultation fee is not to be billed if conducted on the same day as surgery or in the normal aftercare that applies following surgery. The cost of these consultations is included in the fee for the surgical procedure.

The subsequent consultation fee includes a subsequent consultation, a report from the subsequent consultation to the referring General Practitioner and copy of the report to the insurer. Providing copies of these reports does not attract a fee.

Surgeon means a Medical Practitioner who is currently a Fellow of the Royal Australasian College of Surgeons or who is recognised by Medicare Australia as a Specialist Surgeon. It includes a Surgeon who is a staff member at a public hospital providing services at that hospital.

4. Application of Order

This Order applies to treatment provided on or after the commencement date of this Order, whether it relates to an injury received before, on, or after that date.

5. Maximum fees for treatment by Surgeon

The maximum fee amount for which an employer is liable under the Act for treatment of a worker by a Surgeon, being treatment of a type specified in Column 1 of Schedule A to this Order, is the corresponding amount specified in Column 3 of that Schedule.

A fee charged by a Surgeon for a patient's treatment (including the management of fractures and other conditions) will be in addition to the fee in Schedule A for the initial consultation and report.

6. Billing items for hand surgery (Schedule B)

Schedule B provides mandatory guidelines for billing items used in hand and wrist surgery only.

Table 1 details items that are not billable for hand surgery procedures.

Table 2 details items with restricted application for hand surgery and where clinical justification is required that they are reasonably necessary given the circumstances of the case.

7. Billing items for shoulder and elbow surgery (Schedule C)

Schedule C provides mandatory guidelines for billing items used in shoulder and elbow surgery only.

Any item number where the term "flag" is used in the "Clinical Indication" column highlights a potential exception that will require further justification. Should a Surgeon seek an exception to the mandatory guidelines the Surgeon must provide a written explanation to support the request.

8. Billing items for general upper limb surgery (Schedule D)

Schedule D provides mandatory guidelines for billing items used in general upper limb surgery.

Any item number where the term "flag" is used in the Clinical Indication column highlights a potential exception that will require further justification. Should a Surgeon seek an exception to the guidelines, the Surgeon must provide a written explanation to support the request.

9. GST

An amount fixed by this Order is exclusive of GST. An amount fixed by this Order may be increased by the amount of any GST payable in respect of the service to which the cost relates, and the cost so increased is taken to be the amount fixed by this Order. This clause does not permit a Surgeon to charge or recover more than the amount of GST payable in respect of the service to which the cost relates.

10. Requirements for invoices

All invoices should be submitted to the insurer within 30 calendar days of the service provided and must comply with the Authority's itemised invoicing requirements for the

invoice to be processed. Refer to the Doctors in workers compensation webpage on the SIRA website - https://www.sira.nsw.gov.au/for-service-providers/A-Z-of-service-providers/doctors-and-other-medical-professionals#Doctors_in_Workers_Comp

All invoices with surgical items must also be accompanied by the following:

(1) Detailed operation report including a description of the initial injury and an outline of the mechanism of injury, time surgery commenced and finished, intra-operative findings and the procedures performed, including structures that were repaired (stating the anatomic location) and technique of repair.

(2) Usage of any of the restricted item numbers (Schedule B, Table 2, Schedule C and Schedule D) must be accompanied by clinical justification in order to process the claim.

Note: The Medical Practitioner/s providing Assistance at Operation are to invoice for their services separately to the principal Surgeon/Medical Practitioner.

11. Surgery requests

For any proposed surgery – a list of proposed applicable AMA item numbers will need to be provided prior to approval being given.

Where questions arise in individual clinical situations, supply of additional information may be required to assist in determinations.

12. No pre-payment of fees

Pre-payment of fees for reports and services is not permitted.

13. Nil payment for cancellation or non – attendance

No fee is payable for cancellation or non-attendance by a worker for treatment services with a Surgeon.

SCHEDULE A
MAXIMUM FEES FOR SURGEONS

Item	Column 1 Type of service	Column 2 AMA Item(s)	Column 3 Maximum amount
Consultations			
1.	Initial consultation and report.	AC500 (MBS 104) AC600 (MBS 6007)	$340.40
2.	Extended initial consultation and report.	WCO006	$468.90
3.	Subsequent consultation and report.	AC510 (MBS 105) AC610 (MBS 6009)	$234.50

Item	Column 1 Type of service	Column 2 AMA Item(s)	Column 3 Maximum amount
4.	Out of hours consultation.	WCO007	$196.70 in addition to consultation fee
Procedures			
5.	Surgical procedure(s).	EA015 (MBS 30001) to MY330 (MBS 50239) and MZ731 (MBS 51011) to MZ871 (MBS 51171)	1.5 x AMA List Fee for the primary item number. (For any additional item numbers refer to item 8 of this schedule).
6.	Instrument fee.	WCO003	$234.50
7.	Assistance at operation. (*Assistance at Operation* fees are only payable to Medical Practitioners, not other health practitioners eg. perioperative nurses). Note: Assistance at operation is only payable once per item number performed by the principal Surgeon irrespective of the number of medical practitioners providing Assistance at operation.	MZ900	A fee of 20% of the surgeon's fee for surgical procedure/s performed, but only those surgical procedure/s where an assistant is allowed for in the MBS, or $393.20, whichever is the greater.
8.	Multiple operations or injuries.		Primary item number to be paid in full (1.5 x AMA List Fee) and additional AMA item number(s) at 1.125 x AMA List Fee.
9.	Aftercare visits. (As defined in this Order)		As per AMA List.
10.	Compound (open) wound.		In an open fracture wound that requires debridement, a 50% loading for open fracture fixation can be applied. Debridement item EA075/30023 is not to be billed when applying this loading.
11.	Out of hours loading.	WCO008	20% of total procedure fee.
Insurer/lawyer requests			
12.	Opinion on file request.	WCO009	$234.50

Item	Column 1 Type of service	Column 2 AMA Item(s)	Column 3 Maximum amount
13.	Telephone requests including Case conferences (refer to the definition within the *Workers Compensation (Medical Practitioner Fees) Order 2020)* or where there is a request to provide medical records and the medical practitioner needs to review the records prior to provision (to redact non work-related injury information).	WCO002	$45.30 per 5 minutes.
14.	Lost reports and reprints		$158.90 per report
15.	Consulting Surgeon reports. (where additional information that is not related to the routine injury management of the patient is requested by either party to a potential or current dispute). Note: The party requesting a report must agree the category of report with the Medical Practitioner in advance and confirm the request in writing at the time of referral.	Relevant IMS/WIS code	Please refer to the *Workplace Injury Management and Workers Compensation (Medical Examinations and Reports Fees) Order 2020* Schedule 2.
16.	Fees for providing copies of clinical notes and records.	WCO005	Where medical records are maintained electronically by a medical practitioner/practice a flat fee of $60 is payable (for provision of all requested medical records held by the medical practice) inclusive of postage and handling. A medical practitioner/practice should not provide or bill for hard copy medical records if they are maintained electronically. Where medical records are not maintained electronically the maximum fee for providing hard copies of medical records (including Consulting Surgeon's notes and reports) is $38 (for 33 pages or less) and an additional $1.40 per page if more than 33 pages. This fee is inclusive of postage and handling. Where a medical practitioner has been requested to provide medical records and the doctor needs to review the records prior to provision (to redact non work-related injury information), the time taken to review the records is to be billed under **WCO002** at the rate specified

Item	Column 1 Type of service	Column 2 AMA Item(s)	Column 3 Maximum amount
			at item 13, Schedule A. The hourly rate is to be pro-rated into 5 minute blocks to reflect the time taken. This fee can be billed in addition to the fees stated above for provision of medical records by hard copy or electronically.

SCHEDULE B
BILLING ITEMS USED IN HAND SURGERY

Table 1: Item numbers and descriptors not applicable to hand surgery procedures

AMA/MBS item number	Descriptor	Reason for decline
CV233/18266 CV082/Nil	INJECTION OF AN ANAESTHETIC AGENT, ulnar, radial or median nerve of main trunk, one or more of, not being associated with a brachial plexus block. MINOR NERVE BLOCK (specify type) to provide post-operative pain relief (this does not include subcutaneous infiltration).	The MBS does not allow a claim for nerve blocks performed as a method of postoperative analgesia. Infiltration is included in both the anaesthetic schedule AND in the surgical item number fee if performed by the Surgeon. This item can only be billed in circumstances where a formal nerve block is performed by the Surgeon as the only form of anaesthesia and no charge is raised for another anaesthetic service.
MG540/45051	CONTOUR RECONSTRUCTION for open repair of contour defects, due to deformity, requiring insertion of a non-biological implant, if it can be demonstrated that contour reconstructive surgery is indicated because the deformity is secondary to congenital absence of tissue or has arisen from trauma (other than trauma from previous cosmetic surgery), excluding the following: (a) insertion of a non-biological implant that is a component of another service listed in Surgical Operations; (b) injection of liquid or semisolid material; and (c) services to insert mesh.	This relates to the insertion of foreign implant for pathological deformity by an open operation i.e. facial reconstruction and was not intended for usage in hand surgery.
MH480/45445	FREE GRAFTING (split skin) as inlay graft to 1 defect including elective dissection using a mould (including insertion of and removal of mould).	The appropriate item is MH490/45448.
MR170/47954	TENDON, repair of, not being a service to which another item in this Group applies.	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
MR210/47966	TENDON OR LIGAMENT TRANSFER, not being a service to	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.

AMA/MBS item number	Descriptor	Reason for decline
	which another item in this Group applies.	
MR220/47969	TENOSYNOVECTOMY, not being a service to which another item in this Group applies.	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
MR230/47972	TENDON SHEATH, open operation for tenovaginitis, not being a service to which another item in this Group applies	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
MS015/48403	PHALANX OR METATARSAL, osteotomy or osteectomy of, with internal fixation.	This item is from the orthopaedic group of items and relates to foot surgery only. There already exist appropriate items in the hand surgery section.
MY015/50103	JOINT, arthrotomy of, not being a service to which another item in this Group applies.	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
MY025/50104	JOINT, synovectomy of, not being a service to which another item in this Group applies.	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
MY045/50109	JOINT, arthrodesis of, not being a service to which another item in this Group applies.	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
MY105/50127	JOINT OR JOINTS, arthroplasty of, by any technique not being a service to which another item applies.	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
OF820/60506	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting less than 1 hour, not being a service to which another item in this table applies (R).	This item cannot be billed for use of image intensification when operated by the Surgeon in the absence of a radiographer.
OF824/60509	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting 1 hour or more, not being a service associated with a service to which another item in this table applies (R).	This item cannot be billed for use of image intensification when operated by the Surgeon in the absence of a radiographer.

Table 2: Item numbers with restricted application for hand surgery – clinical justification required

AMA/MBS item number	Descriptor	Clinical indication
AC510/30105	Each attendance SUBSEQUENT to the first in a single course of treatment.	Follow up consultations will not be paid within the 6-week period following a procedure as this is included in normal aftercare.

AMA/MBS item number	Descriptor	Clinical indication
EA075/30023	WOUND OF SOFT TISSUE, traumatic, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Assist.).	The repair of wound must be undertaken by suture, tissue adhesive resin (such as methyl methacrylate) or clips. These items are not to be billed for the closure of surgical wound, as such closure is part of a surgical procedure and not additional. Item EA075/30023 covers debridement of traumatic, "deep or extensively contaminated" wound. Benefits are not billable under this item for debridement which would be expected to be encountered as part of an operative approach to the treatment of fractures. Debridements are also not billable when removing percutaneous wire fixation. This item can be billed for deep chronic wounds or in combination with open fractures requiring debridement. This item is not to be billed in combination with EA215/30068. Limit of one debridement per episode of care or per limb. This item cannot be billed when a surgeon applies the 50% loading for open fracture fixation. Flag if this procedure is requested more than once per episode of care or per limb.
EA095/30029	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7CM IN LENGTH), involving deeper tissue, not being a service to which another item in Group 3.4 applies.	This item is for use in wound suture when no other vital tissue is involved. It cannot be billed in conjunction with item EA075/30023 for the same wound/zone of injury, nor when repair of a performed and deeper structure is also claimed for.
EA755/30223	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS OR SIMILAR LESION, requiring admission to hospital or day-hospital facility, INCISION WITH DRAINAGE OF (excluding aftercare).	This item cannot be billed in conjunction with item EA075/30023 for the same wound/zone of injury.
EA825/30238	FASCIA, DEEP, repair of, FOR HERNIATED MUSCLE.	This item is rarely indicated and cannot be billed in conjunction with: items EA075/30023 MR240/47975, MR250/47978, MR260/47981.
ET560/33815 ET570/33818	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by lateral suture. MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by direct anastomosis.	This item is applicable for repair of radial, ulnar or brachial arteries proximal to wrist crease.

AMA/MBS item number	Descriptor	Clinical indication
LN740/39312	NEUROLYSIS, internal (interfascicular) neurolysis of, using microsurgical techniques.	This item is never indicated in acute trauma. It is rarely indicated in elective surgery and is reserved for use in revision nerve decompression surgery. This item is not to be billed in conjunction with item MU400: Wrist carpal tunnel release (division of transverse carpal ligament), by open procedure, unless for a revision procedure.
LN750/39315	NERVE TRUNK, nerve graft to, (cable graft) including harvesting of nerve graft using microsurgical techniques.	This item can only be billed once per named nerve trunk, regardless of the number and distal distribution of individual cables. This item cannot be billed in conjunction with items LN790, LN800 or LN810.
LN760/39318	CUTANEOUS NERVE (including digital nerve), nerve graft to, using microsurgical techniques.	This item cannot be billed in conjunction with items LN790, LN800 or LN810. This item cannot be billed for prosthetic neural tubes or wraps. In this setting, items LN700 or LN710 are applicable.
LN790/39324 LN800/39327	NEURECTOMY, NEUROTOMY or removal of tumour from superficial peripheral nerve, by open operation.	This item cannot be billed in conjunction with item LN810.
LN810/39330	NEUROLYSIS by open operation without transposition, not being a service associated with a service to which item LN740 applies.	This item is not for the identification of nerves during surgical exposure. It is not to be billed in combination with item LN700. This item is not to be billed in conjunction with item MU400: Wrist carpal tunnel release (division of transverse carpal ligament) by open procedure. However, items LN810 and MU400 can be billed together for combined open carpal tunnel release and cubital tunnel release surgery. This item is not to be billed in conjunction with item ML235 Tendon sheath of hand/wrist open operation for stenosing tenovaginitis.
MH115/45203	SINGLE STAGE LOCAL FLAP, where indicated to repair 1 defect, complicated or large, and excluding flap for male pattern baldness and excluding H-flap or double advancement flap, not in association with any of items EN036 to EN084.	This item is rarely indicated in the hand and wrist as a large defect will not be readily amenable to a local flap reconstruction. It is not to be billed for suturing of traumatic skin flaps.
MH125/45206	SINGLE STAGE LOCAL FLAP where indicated to repair 1 defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excluding H-flap or double advancement flap, not in association with any of items EN036 to EN084.	This item can only be billed once for a z-plasty.

AMA/MBS item number	Descriptor	Clinical indication
MJ025/45500	MICROVASCULAR REPAIR using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit.	This item relates to microvascular repair of an artery or vein. This item cannot be billed for repair of dorsal veins with volar skin intact, branches of digital arteries, branches of radial/ulnar vessels and venae comitantes of major arteries. Microvascular repairs distal to the metacarpophalangeal joint will also require clinical documentation of appropriate surgical technique utilising an operating microscope.
MJ030/45501 MJ035/45502	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for re-implantation of limb or digit/ MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for re-implantation of limb or digit.	These items specifically relate to replantation of limb and digit. i.e. the amputated portion must be completely detached.
MJ045/45503	MICRO-ARTERIAL or MICRO-VENOUS graft using microsurgical techniques.	This item includes the remuneration for harvesting the graft and performing any microvascular anastomoses to the graft.
MJ075/45515	SCAR, other than on face or neck, NOT MORE THAN 7 CMS IN LENGTH, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital or approved day hospital facility, or where performed by a Specialist in the practice of his or her specialty.	This item cannot be billed in conjunction with other items e.g. nerve repair, tendon repair, flap repair (i.e. intended to be an independent procedure).
MJ245/45563	NEUROVASCULAR ISLAND FLAP, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness	This item is for a true island flap, elevated on a neurovascular pedicle for an existing traumatic defect. This item is not to be billed for VY advancement flaps where item MH125/45206 is applicable.
ML105/46325	CARPAL BONE replacement or resection arthroplasty using adjacent tendon or other soft tissue including associated tendon transfer or realignment when performed.	This item is primarily intended for use in reconstruction for basal thumb arthritis. It is not approved for excision of the pisiform.
ML115/46327	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrotomy of.	This item is not to be billed in addition to item EA075/30023 when arthrotomy is performed to facilitate joint lavage within an open wound.
ML125/46330	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous or capsular repair with or without arthrotomy.	This item is only billable for repair of named ligaments where preoperative or intraoperative findings document significant joint instability.

AMA/MBS item number	Descriptor	Clinical indication
ML135/46333	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous repair of using free tissue graft or implant.	This item is only billable for repair of named ligaments using free grafts or alloplast where preoperative or intraoperative findings document significant joint instability. This item cannot be billed for reattachment of ligament using a bone anchor. Item ML125/46330 is the approved number.
ML145/46336	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, synovectomy, capsulectomy or debridement of, not being a service associated with any other procedure related to that joint.	This item cannot be billed in conjunction with any other item or procedure related to the joint. This item cannot be billed in conjunction with item EA075/30023.
ML155/46339	EXTENSOR tendons or FLEXOR tendons of hand or wrist synovectomy of	Rare in a workers' compensation setting. Not for use for De Quervain's (refer to ML235/46363). Note: If performing a complete flexor tenosynovectomy, a release of the Carpal Tunnel is part of the operation and therefore MU400 or MU410 should not be billed. If this item is requested in conjunction with MU400 or MU410 (Wrist carpal tunnel release) or ML235/46363 (De Quervain's), clinical documentation of gross synovitis is required, preferably with histological confirmation. Flag if this procedure is requested two or more times.
ML185/46348 – ML225/46360	Digit, synovectomy of flexor tendon or tendons.	ML185/46348 – 1 digit ML195/46351 – 2 digits ML205/46354 – 3 digits ML215/46357 – 4 digits ML225/46360 – 5 digits Not in combination with ML155/46339.
ML235/46363	Tendon sheath of hand or wrist, open operation on, for stenosing tenovaginitis.	This item is not to be billed in combination with LN810/39330. Item used for De Quervain's Release or Trigger Finger Release. De Quervain's tenosynovitis - can only be billed once per side (ie. includes both APL and EPB tendons).
ML245 – ML335 / 46366 – 46393	Dupuytren's contracture, fasciotomy.	Flag if this procedure is requested for an acute injury or trauma.
ML345/46396	PHALANX or METACARPAL of the hand, osteotomy or osteectomy of.	This item is applicable for removing excess bone formation in an *intact* bone. This is no longer to be applied to removal of loose pieces of bone in trauma or bone shortening for terminalisation or replantation. This is part of the debridement and is included in item EA075/30023 if applicable. This item is not to be billed in combination with MR130/47933 or MR140/47936. Flag if this procedure is requested for an acute injury or trauma.

AMA/MBS item number	Descriptor	Clinical indication
ML405/46414	ARTIFICIAL TENDON PROSTHESIS, INSERTION OF in preparation for tendon grafting.	Tenolysis (items ML545/46453, ML535/ 46450) or tenotomy (item MR200/47963) of the tendon to be grafted cannot be billed with this item.
ML425/46420	Extensor tendon of hand or wrist, primary repair, each tendon.	For an acutely injured tendon as a primary procedure. This item should not be billed for repair of extensor tendon split as part of an access to phalangeal fractures/osteotomies.
ML445/46426	Flexor tendon of hand or wrist, primary repair of, proximal to A1 pulley, each tendon.	Not to be billed more than once to repair FDS tendon in a digit. This item can only be billed a maximum of twice per digit.
ML465/46432	Flexor tendon of hand, primary repair of, distal to A1 pulley, each tendon.	This item is only to be billed for acute injuries. This item can only be billed a maximum of twice per digit.
ML475/46435	Flexor tendon of hand, secondary repair of, distal to A1 pulley, each tendon.	This item is not to be billed in acute injuries. This item can only be billed a maximum of twice per digit.
ML535/46450 ML545/46453	EXTENSOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft. FLEXOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft.	These items are applicable for freeing tendons from scar following previous surgery or trauma. They are not indicated in an acute hand injury. Items ML545 and ML535 cannot be billed in conjunction with release of trigger finger or for release of DeQuervians' (see ML235/46363).
ML695/46494	Ganglion of Hand, excision of.	Not being a service associated with a service to which another item in this Group applies.
ML705/46495	Ganglion or mucous cyst of distal digit, excision of.	Not being a service associated with a service to which item EA355/30107 applies.
ML715/46498	Ganglion of flexor tendon sheath, excision of.	Not being a service associated with a service to which item EA355/30107 applies.
ML725/46500	Ganglion of dorsal wrist joint (excision).	This item is not to be billed in combination with EA355/30107.
ML735/46501	Ganglion of volar wrist joint (excision).	This item is not to be billed in combination with EA355/30107.
ML745/46502	Recurrent ganglion of dorsal wrist joint (excision).	This item is not to be billed in combination with EA355/30107.
ML755/46503	Recurrent ganglion of volar wrist joint (excision).	This item is not to be billed in combination with EA355/30107.
ML765/46504	NEUROVASCULAR ISLAND FLAP, for pulp innervation.	These items are only to be billed for a heterodigital neurovascular island flap used to resurface pulp loss (e.g. Littler flap, first dorsal metacarpal artery or Kite flap). There is a limit of one flap per digit. Flag if this procedure is requested two or more times.

AMA/MBS item number	Descriptor	Clinical indication
ML795/46513	Digital nail of finger or thumb, removal of.	This item should not be billed in association with nailbed repair (items ML665/46486 or ML675/46489). This item is not to be billed in combination with ML805/46516.
ML805/46516	DIGITAL NAIL OF FINGER OR THUMB, removal of, in the operating theatre of a hospital or approved day hospital facility.	This item is not to be billed in association with primary or secondary nail bed repair (items ML665/46486, ML675/46489). This item is not to be billed in combination with ML795/46513.
ML825/46522	FLEXOR TENDON SHEATH OF FINGER OR THUMB - open operation and drainage for infection.	This item is applicable only for drainage of suppurative flexor tenosynovitis. It does not apply to washout of flexor sheath in acute injury.
ML835/46525	Pulp space infection, paronychia of hand, incision for, when performed in an operating theatre of a hospital.	Not being a service to which another item in this Group applies (excluding after-care).
MR088/47920	BONE GROWTH STIMULATOR, insertion of.	This is only billable where a mechanical bone growth stimulator has been inserted. It is not for the insertion of OP1 or other bone morphogenic proteins in the setting of hand surgery.
MR090/47921	ORTHOPAEDIC PIN OR WIRE, insertion of, as an independent procedure.	This item cannot be billed when the k-wire has been used as part of fracture fixation. Can be billed for the insertion of a temporary pin in association with a ligament/tendon repair.
MR110/47927	BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of, in the operating theatre of a hospital or approved day hospital facility - per bone.	This item applies for removal of *buried* k-wire. Where a k-wire or wires cross more than 2 bones, only 1 item number is billable.
MR630/48239 MR640/47306	BONE GRAFT (with or without internal fixation), not being a service to which another item in this Group applies.	These items cannot be billed in conjunction with fracture fixation numbers or the following items: ML005/46300, ML015/46303, ML355/46399, ML365/46402, ML375/46405, MR560/48218-MR620/48236.
MS005/48400	PHALANX, METATARSAL, ACCESSORY BONE OR SESAMOID BONE, osteotomy or osteectomy of.	Excluding services to which items MX660 or MX670 applies. This item is only applicable to sesamoidectomy.
MS015/48403	Phalanx or metatarsal, osteotomy or osteectomy of, with internal fixation.	Excluding services to which items MR130/47933 or MR140/47936 apply.
MS025/48406	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of.	This item <u>is</u> the appropriate number for excision of the pisiform. This item is <u>not</u> appropriate for simple removal of bone prominence, osteophytes or small quantities of excess bone.

AMA/MBS item number	Descriptor	Clinical indication
MU400 and MU410	Carpal tunnel release (division of transverse carpal ligament), by open (MU400) or endoscopic (MU410) approach.	These are the appropriate item numbers for a primary carpal tunnel release. Ultrasound costs are not billable in conjunction with this surgery procedure. Nerve Conduction Studies (NCS) preferable prior to surgical consideration, other than in acute cases. This item is rarely indicated in combination with ML155/46339: Extensor tendons or flexor tendons of hand or wrist (synovectomy of). MU400 and MU410 cannot be billed with ML155/46339 – Billing is only approved for one OR the other of these codes. Flag if this code combination is billed.
MU460/49209	Wrist, total replacement arthroplasty of.	Flag if this procedure is requested.
MU462/49210	Wrist, total replacement arthroplasty of, revision procedure, including removal of prosthesis.	Flag if this procedure is requested.
MU464/49211	Wrist, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis.	Flag if this procedure is requested.
MU470/49212	WRIST, arthrotomy of.	This item is not to be billed in conjunction with excision of primary or recurrent wrist ganglia (items ML725/46500; ML735/46501; ML475/46502; ML755/46503).
MU480/49215	Wrist, reconstruction of, including repair of single or multiple ligaments or capsules, including associated arthrotomy.	Including repair of single or multiple ligaments or capsules, including associated arthrotomy. Can be used in combination with MR210/47966 for chronic scapholunate repair where the original ligament is not repairable or ML415/46417.
MU490/49218	Wrist, diagnostic arthroscopy of, including radiocarpal or midcarpal joints, or both (including biopsy).	Not being a service associated with any other arthroscopic procedure of the wrist joint.
MU500/49221	Wrist, Arthroscopic surgery of wrist.	Involving any 1 or more of: drilling of defect; removal of loose body; release of adhesions; local synovectomy; or debridement of one area. Not being a service associated with any other arthroscopic procedure of the wrist joint.
MU510/49224	Wrist, arthroscopic debridement of 2 or more distinct areas; or osteoplasty including excision of the distal ulna; or total synovectomy.	Not being a service associated with any other arthroscopic procedure of the wrist.
MU520/49227	Wrist, arthroscopic pinning of osteochondral fragment or stabilisation procedure for ligamentous disruption.	Not being a service associated with any other arthroscopic procedure of the wrist joint.

AMA/MBS item number	Descriptor	Clinical indication
MY035/50106	JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this group applies.	This item is applicable for stabilization of CMC joints only.

SCHEDULE C

BILLING ITEMS USED IN SHOULDER AND ELBOW SURGERY

This Order adopts the *WorkCover Queensland Upper limb Surgery Guidelines (November 2017)* with minor modifications. Relevant items from the *WorkCover Queensland Upper Limb Surgery* Guidelines are provided within Schedule C and their use is mandatory when billing for shoulder and elbow surgery.

AMA/MBS item number	Descriptor	Clinical indication
	BONE GRAFTS	
MR550/48215	Humerus, bone graft to, with internal fixation.	
MR640/48242	Bone graft, with internal fixation.	Not being a service to which another item in this group applies.
MS005/48400	Phalanx, metatarsal, accessory bone or sesamoid bone, osteotomy or osteectomy of.	Excluding services to which item MX660/49848 or MX670/49851 applies, any of items MX660/49848, MX670/49851, MR130/47933 or MR140 apply.
MS025/48406	Fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, osteotomy or osteectomy of.	Excluding services to which items MR130/47933 or MR140/47936 apply. Not to be billed in combination with item MT770/48951. May be billed with MY035/50106 if excision of the distal clavicle is done in conjunction with the stabilisation – eg: Weaver Dunn Procedure. **Flag if this item is used in combination with any other shoulder items (MT600/48900 to MT800/48960).**
MS035/48409	Fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, osteotomy or osteectomy of, with internal fixation.	Excluding services to which items MR130/47933 or MR140/47936 apply. May be billed with MY035/50106 if the coracoclavicular ligaments are reconstructed in the same procedure. Not to be billed in combination with item MT770/48951. **Flag if this item is billed in combination with any other shoulder items (MT600/48900 to MT800/48960).**

AMA/MBS item number	Descriptor	Clinical indication
MS045/48412	HUMERUS, osteotomy or osteectomy of,	Excluding services to which items MR130/47933 or MR140/47936 apply. Can be billed with item MR020/47903 (tennis elbow release) if a lateral or medial epicondylectomy is performed. Can be billed with LN810/39330 if ulna nerve neuritis or compression has been diagnosed requiring formal surgical decompression.
SHOULDERS		
MT600/48900	Excision or coraco-acromial ligament or removal of calcium deposit from cuff or both.	Open operation not arthroscopic. Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed twice or more.**
MT610/48903	Decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any other combination.	Open operation, also known as open acromioplasty or subacromial decompression (SAD).
MT620/48906	Repair of rotator cuff, including excision of coraco-acromial ligament or removal of calcium deposit from cuff or both.	Known as open cuff repair without acromioplasty. Not to be billed in combination with item MT600/48900. If MS025 is performed it cannot be billed with item MT770. Can be billed in combination with arthroscopic code MT770/48951 (and MR210/47966 if a bicep tenodesis is performed). Note: If MT620/48906 is performed arthroscopically it cannot be billed with item MT770/48951.
MT630/48909	Repair of rotator cuff, including decompression of subacromial space by acromioplasty, excision of coroco-acromial ligament and distal clavicle, or any combination.	Known as open rotator cuff repair with acromioplasty with excision of AC joint. Not being a service to which item MT610/48903 applies. **Flag if this item is billed with item MX670/49851.** Not to be billed with MT770/48951 or in combination with MT610/48903. This item is not to be billed with services associated with any other **arthroscopic** procedure of the shoulder region.
MT640/48912	Shoulder arthrotomy.	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed in combination with any other item code for shoulder surgery.**

AMA/MBS item number	Descriptor	Clinical indication
MT650/48915	Hemi-arthroplasty.	Use of this item rarely seen in State Insurance Regulatory Authority claims. Maybe appropriate for shoulder trauma/fractures only.
MT660/48918	Total replacement arthroplasty including rotator cuff repair.	Use of this item rarely seen in State Insurance Regulatory Authority claims.
MT670/48921	Revision of total replacement arthroplasty.	Use of this item rarely seen in State Insurance Regulatory Authority claims.
MT680/48924	Revision of total replacement arthroplasty with bone graft to scapula or humerus.	Use of this item rarely seen in State Insurance Regulatory Authority claims.
MT690/48927	Removal of shoulder prosthesis.	Use of this item rarely seen in State Insurance Regulatory Authority claims.
MT700/48930	Stabilisation for recurrent anterior/posterior dislocation.	Known as open shoulder stabilisation (including repair of labrum). If recurrent, treatment option: highly recommend looking into claimant's history to determine if surgery is to treat the aggravation or pre-existing condition.
MT710/48933	Stabilisation for multidirectional instability.	Mostly used for open procedures.
MT720/48936	Synovectomy as an independent procedure.	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed in combination with any other item code.**
MT730/48939	Arthrodesis with synovectomy	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed once or more.**
MT740/48942	Arthrodesis with synovectomy, removal of prosthesis and bone grafting.	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed once or more.**
MT750/48945	Diagnostic arthroscopy.	Not to be billed with any **arthroscopic** procedure of the shoulder region. May be billed with open surgery i.e. items MT630/48909, MT620/48906, MT710/48933.
MT760/48948	Arthroscopic surgery, with one or more: removal loose bodies, decompression of calcium deposits, debridement labrum/synovium/rotator cuff, chondroplasty.	Not to be billed with any other **arthroscopic** procedure of the shoulder region. Preparatory for an open procedure. Appropriate with items MT620/48906 and MT630/48909. May be billed with items MT700/48930 and MT710/48933.

AMA/MBS item number	Descriptor	Clinical indication
MT770/48951	Arthroscopic division of the coraco-acromial ligament including acromioplasty.	Not to be billed with any other **arthroscopic** procedure of the shoulder region. Not to be billed in combination with items EA365/30111 or MT780/48954. Can be billed in combination with MT620/48906 when performing an open rotator cuff repair (and MR210/47966 if a biceps tenodesis is performed).
MT780/48954	Arthroscopic total synovectomy including release of contracture (shoulder).	Known as frozen shoulder release; stand-alone item code. Not to be billed with any other **arthroscopic** procedure of the shoulder region. Not to be billed in combination with item MT770/48951. **Flag if this item is billed with any other item for shoulder surgery.**
MT790/48957	Arthroscopic stabilisation for recurrent instability including labral tear or reattachment.	Not to be billed with any other **arthroscopic** procedure of the shoulder region. If recurrent treatment option, highly recommend looking into claimant's history to determine if surgery is to treat the aggravation or pre-existing condition. **Flag if this item billed with any other item for shoulder surgery.**
MT800/48960	Reconstruction or repair of, including rotator cuff by arthroscopic, arthroscopic assisted or mini open means; arthroscopic acromioplasty; or resection of acromioclavicular joint by separate approach.	Not to be billed with any other procedure of the shoulder region. May be billed with item CV218/18256. Not to be billed with item **EA365/30111, MT770/48951 OR MT790/48957.** May be billed in combination with MR210/47966 or MR200/47963. **Flag if practitioner requesting a Superior Capsular Reconstruction (SCR) procedure.**
ELBOW		
LN770/39321	Transposition of Nerve.	Not appropriate for use in epicondylitis surgery – refer to item LN810/39330 (this item applies to transposition of ulna nerve anterior to medial epicondyle to submuscular or subcutaneous site). Not to be combined with MS045/48412 or LN810/39330.
MU035/49100	Arthrotomy of, involving one or more of lavage, removal of loose body or division of contracture.	Not to be billed for tennis elbow surgery.

AMA/MBS item number	Descriptor	Clinical indication
MU045/49103	Ligamentous stabilisation.	Not to be billed in conjunction with item LN810/39330 unless the ulnar nerve requires mobilisation or decompression at the time of stabilisation (operation notes should reflect this). Transposition item LN770/39321 is commonly used. Ulnar nerve transposition can occur frequently in large elbow operations. It may be necessary to perform neurolysis of more than one nerve such as radial and ulnar, if there was significant previous injury or previous surgery.
MU055/49106	Arthrodesis with synovectomy.	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed.**
MU065/49109	Total synovectomy.	Known as **common contracture release**. Use of this item rarely seen in State Insurance Regulatory Authority claims. May be appropriate with osteotomy i.e. items MS045/48412 or MS025/48406. **Flag if billed.**
MU075/49112	Silastic replacement of radial head.	Seen with fractures, dislocations and acute trauma. May be associated with other items i.e. MU045/49103 or MU075/49121. Not to be billed in combination with item MU065/49109. **Flag if billed.**
MU085/49115	Total joint replacement.	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if billed.**
MU086/49116	Total replacement arthroplasty, revision procedure, including removal of prosthesis.	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if billed.**
MU087/49117	Total replacement arthroplasty, revision procedure with bone grafting or removal or prosthesis.	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if billed.**
MU095/49118	Diagnostic arthroscopy.	Not to be billed with any other **arthroscopic** procedure of the elbow region. Appropriate for use with open elbow surgery.
MU105/49121	Arthroscopic surgery of elbow involving any 1 or more of: drilling of defect, removal of loose body; release of contracture or adhesions; chondroplasty; or osteoplasty.	Not to be billed with any other **arthroscopic** procedure of the elbow.
OTHER		
EA365/30111	Bursa (large) including olecranon, calcaneum or patella, excision of.	May be billed in combination with olecranon bursa. **Flag if used in combination with any shoulder surgery.** Not to be billed in combination with item MT800/48960.

AMA/MBS item number	Descriptor	Clinical indication
LN810/39330	Neurolysis by open operation without transposition.	Not being a service associated with a service to which item LN740/39312 applies. Can be billed in combination with elbow surgery (eg: MS045/48412 if performing an ulna nerve release with medial epicondylectomy or MR020/47903 lateral or medial epicondylitis debridement). Not to be billed in combination with item MT760/48948. **Flag if billed in combination with any item codes for shoulder surgery or in acute trauma.**
LIMB LENGTHENING AND DEFORMITY CORRECTION		
MZ330/50405	Elbow, flexorplasty, or tendon transfer to restore elbow function.	MR170/47954 is the appropriate code for repair of a distal bicep tendon rupture. Use of this item rarely seen in State Insurance Regulatory Authority claims – set of item numbers address congenital conditions. **Flag if billed.**
OTHER JOINTS		
MY035/50106	Joint, stabilisation of, involving one or more of: repair of capsule, repair of ligament or internal fixation.	Not being a service to which another item in this group applies – stand-alone item. May be billed with MS025/48406 if excision of the distal clavicle is used in conjunction with the stabilisation – e.g. Weaver Dunn procedure. Flag if requested in combination with MR210/47966, MS025/48406 or MS035/48409.
MY055/50112	Cicatricial flexion or extension contraction of joint, correction of, involving tissues deeper than skin and subcutaneous tissue.	Not being a service to which another item in this group applies. Not to be billed with any other **arthroscopic** procedure of the shoulder region. Not to be billed in combination with item MT780/48954. **Flag if billed in combination with any item code for elbow and shoulder surgery.** Implies a release for stiffness after injury or surgery. May occur with other numbers in relation to a large release of a stiff elbow. Three to five item numbers should be in association with an operation that took two to three hours and is usually a revision situation or after serious trauma. The complexity should be reflected in the history of injury, number of prior operations, duration of surgery, complexity of the operation.

AMA/MBS item number	Descriptor	Clinical indication
MY065/50115	Joint or joints, manipulation of, performed in the operating theatre of a hospital.	Code used for adhesive capsulitis (frozen shoulder) manipulation under anaesthetic (MAU). Not to be billed for an 'examination' of a joint under general anaesthetic prior to an operation, where the general anaesthetic is for the operation itself. Not being a service associated with a service to which another item in this group applies. **Flag if this item is used two or more times.**
MY105/50127	Joint or joints, arthroplasty of, by any technique.	Not being a service to which another item applies Not to be billed in combination with any item for shoulder, elbow or sternoclavicular surgery.
	GENERAL	
MP455/47429	Humerus, proximal, treatment of fracture of, by open reduction.	
MP465/47432	Humerus, proximal, treatment of intra-articular fracture of, by open reduction.	
MP485/47438	Humerus, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction.	
MP495/47441	Humerus, proximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by open reduction.	
MR020/47903	Epicondylitis, open operation for.	This is the only item number appropriate for Tennis or Golfers Elbow Debridement (Lateral or Medial Epicondylitis). Can be combined with MS045/48412 where a formal excision of the epicondyle is justified, not just for debridement of epicondyle. Can also be combined with LN810/39330 if ulna nerve neuritis or compression has been diagnosed which requires formal surgical decompression. **Flag if billed in combination with any other item numbers.**
MR100/47924	Buried wire, pin or screw (1 or more inserted for internal fixation purposes), removal of requiring incision and suture – per bone.	Not being a service to which item MR410/47927 or MR120/47930 applies.
MR110/47927	Buried wire, pin or screw, one or more of, which were inserted for internal fixation purposes, removal of, in the operating theatre of a hospital.	This item applies for removal of one or more buried k-wire per bone. Where fixation crosses two or more bones, only one item number is claimable.
MR120/47930	Plate, rod or nail and associated wires, pins or screws, one or more of, all of which were inserted for internal fixation purposes, removal of.	Not being a service associated with a service to which items MR100/47924 or MR110/47927 apply - per bone. Where fixation crosses two or more bones, only one item number is billable.

AMA/MBS item number	Descriptor	Clinical indication
MR170/47954	Tendon, repair of, as an independent procedure.	Can be billed in treating biceps tenodesis. Can be billed in treating distal biceps tendon rupture (Refer to item MR210/47966 for proximal biceps tenodesis). **Flag if billed with any other item code.**
MR190/47960	Tenotomy, subcutaneous.	Not being a service to which another item in this group applies.
MR200/47963	Tenotomy, open, with or without tenoplasty.	Not being a service to which another item in this group applies. Not to be billed for epicondylitis/tennis elbow release. Could be billed in combination with items MT770/48951 or MT800/48960.
MR210/47966	Tendon or ligament, transfer.	As an independent procedure. Could be billed in combination with items MT770/48951 or MT800/48960.
MR220/47969	Tenosynovectomy.	Not being a service to which another item in this group applies. Should not be billed for tennis elbow or shoulder surgery. **Flag if billed for shoulder or elbow procedures.**

SCHEDULE D

ADDITIONAL ITEMS USED IN UPPER LIMB SURGERY

This Order adopts the *WorkCover Queensland Upper Limb Surgery Guidelines (November 2017) with minor modifications*. The relevant items from the *WorkCover Queensland Upper Limb Surgery Guidelines* are provided in Schedule D and their use is mandatory when billing for upper limb surgery.

AMA/MBS item number	Descriptor	Clinical indication
EA080 – EA155 / 30024 - 30049	Repair of Wounds.	The repair of wound referred to in these items must be undertaken by suture, tissue adhesive resin (such as methyl methacrylate) or clips. These items are not to be billed for the closure of surgical wound, as such closure is part of a surgical procedure and not additional. The term 'superficial' means affecting skin and subcutaneous tissue including fat and the term 'deeper tissue' means all tissues deep to but not including subcutaneous tissue such as fascia and muscle.
EA355/30107	Ganglion or small bursa, excision of.	Not being a service associated with a service to which another item in this Group applies.
MN020 – MN160/ 47003 - 47045	Treatment of upper limb dislocations.	Check AMA Fees List for item descriptions and exclusions of item combinations.
MS055/48415	Humerus, osteotomy or osteectomy, with internal fixation.	Excluding services to which items MR130/47933 or MR140/47936 apply.

AMA/MBS item number	Descriptor	Clinical indication
		Not to be billed with item LN810/47903 (tennis elbow release) unless a lateral epicondylectomy is performed. Flag if this item is requested, particularly if requested for tennis elbow surgery.
MY005/50100	Joint, diagnostic arthroscopy of (including biopsy).	Not being a service to which another item in this Group applies and not being a service associated with any other arthroscopic procedure.
MY010/50102	Joint, arthroscopic surgery of.	Not being a service to which another item in this Group applies.

WORKERS COMPENSATION
(ORTHOPAEDIC SURGEON FEES) ORDER 2020

under the

Workers Compensation Act 1987

I, Carmel Donnelly, Chief Executive, State Insurance Regulatory Authority, make the following Order pursuant to section 61(2) of the *Workers Compensation Act 1987*.

Dated this 11 day December 2019

Carmel Donnelly
Chief Executive
State Insurance Regulatory Authority

Explanatory Note

Treatment by a Medical Practitioner who is an Orthopaedic Surgeon is medical or related treatment covered under the *Workers Compensation Act 1987*. This Order sets the maximum fees for which an employer is liable under the Act for treatment by an Orthopaedic Surgeon provided to a NSW worker. It must not exceed the maximum fee for the treatment or service as specified in this Order. Workers are not liable for the cost of any medical or related treatment covered by this Order. The effect of this Order is to prevent an Orthopaedic Surgeon from recovering from the worker or employer any extra charge for treatments covered by this Order.

Under section 60(2A)(a) of the *Workers Compensation Act 1987,* medical or related treatment requires prior insurer approval unless treatment is provided within 48 hours of the injury happening or treatment is exempt from pre-approval under the *Workers Compensation Act 1987* or the State Insurance Regulatory Authority's *Workers Compensation Guidelines* in effect at the time.

Treatment by a Surgeon other than an Orthopaedic Surgeon is covered by the *Workers Compensation (Surgeon Fees) Order 2020.* However, maximum fees under this Order may apply to procedures carried out by a Surgeon which are covered by the *Workers Compensation (Surgeon Fees) Order 2020.*

Orthopaedic Surgeons should also refer to the *Workers Compensation (Medical Practitioner Fees) Order 2020.*

This Order adopts the items listed as Orthopaedic Procedures in the *List of Medical Services and Fees* issued by the Australian Medical Association (AMA).

To bill an AMA item number an Orthopaedic Surgeon must be confident they have fulfilled the service requirements as specified in the item descriptor.

Where only one service is rendered, only one item should be billed. Where more than one service is rendered on one occasion of service, the appropriate item for each discrete service may be billed, provided that each item fully meets the item descriptor. Where an operation comprises a

combination of procedures which are commonly performed together, and for which there is an AMA item that specifically describes the combination of procedures, then only that item should be billed. Where a comprehensive item number is used, separate items must not be claimed for any of the individual items included in the comprehensive service. The invoice should cover the total episode of treatment.

The incorrect use of any items referred to in this Order can result in penalties, including the Medical Practitioner being required to repay monies that the Medical Practitioner has incorrectly received.

Workers Compensation (Orthopaedic Surgeon Fees) Order 2020

1. Name of Order

This Order is the *Workers Compensation (Orthopaedic Surgeon Fees) Order 2020.*

2. Commencement

This Order commences on 1 January 2020.

3. Definitions

In this Order (including Schedules A, B, C and D):

the Act means the *Workers Compensation Act 1987.*

the Authority means the State Insurance Regulatory Authority as constituted under section 17 of the *State Insurance and Care Governance Act 2015.*

Aftercare visits are covered by the surgical procedure fee during the first six weeks following the date of surgery or until wound healing has occurred. Unrelated visits or incidental reasons for visits that are not regarded as routine aftercare must be explained with accounts rendered.

Assistance at operation means a Medical Practitioner, but only where an assistant's fee is allowed for in the Commonwealth Medicare Benefits Schedule (MBS). An assistant fee may only be applicable for surgical procedures EA015 to MY330 and MZ731 to MZ871. Assistance at operation is only payable once per eligible item number performed by the principal Orthopaedic Surgeon irrespective of the number of Medical Practitioners providing Assistance at operation.

Note: *Assistance at Operation* fees are not payable to health practitioners who are not a Medical Practitioner eg. perioperative nurses.

In accordance with NSW Health policy directive *Employment Arrangements for Medical Officers in the NSW Public Health Service* (**Doc No:** PD2019_027), assistant fees cannot be charged for workers compensation cases performed in a public hospital when the assistant is a resident medical officer or registrar. If a resident medical officer or registrar is on rotation to an accredited private hospital, the relevant assistant fee may be charged. Payment of these fees are to be directed into a hospital or departmental trust fund account and the invoice should include details of this account. The Authority reserves the right to conduct an audit of assistant fee payments to ensure their proper distribution into the named trust fund.

AMA List means the document entitled List of Medical Services and Fees issued by the Australian Medical Association and dated 1 November 2019 and any subsequent amendments to this List published by the AMA in the period 1 November 2019 – 31 October 2020.

Compound (open) wound refers to a situation where an Orthopaedic Surgeon is treating a fracture and the injury is associated with a compound (open) wound. In an open fracture wound that requires debridement, a 50% loading for open fracture fixation can be applied. Debridement item EA075/30023 is not to be billed when applying this loading.

Extended initial consultation means a consultation involving significant multiple trauma or complex "red flag" spinal conditions (systemic pathology, carcinoma, infection, fracture or nerve impingement) involving a lengthy consultation and extensive physical examination.

GST means the Goods and Services Tax payable under the GST Law.

GST Law has the same meaning as in the *A New Tax System (Goods and Services Tax) Act 1999* of the Commonwealth.

Initial consultation and report covers the first consultation, the report to the referring Medical Practitioner and the copy of the report to the insurer.

The report will contain:

- the worker's diagnosis and present condition;
- an outline of the mechanism of injury;
- the worker's capacity for work;
- the need for treatment or additional rehabilitation; and
- medical co-morbidities that are likely to impact on the management of the worker's condition (in accordance with privacy considerations).

The receipt of this report and any certificates of capacity under section 44B of the Act post-treatment will provide sufficient information for insurers, employers and workplace rehabilitation providers to develop management plans.

Insurer means the employer's workers compensation insurer.

Instrument fee covers procedures where the Orthopaedic Surgeon supplies all the equipment or a substantial number of specialised instruments in exceptional circumstances and must be justified. This fee does not apply for all operations or if only incidental instruments (non-critical) are supplied by the Orthopaedic Surgeon. Routine items such as loupes are not included.

Medical Practitioner means a person registered in the medical profession under the *Health Practitioner Regulation National Law (NSW) No 86a,* or equivalent in their jurisdiction with the Australian Health Practitioner Regulation Agency. In accordance with section 60(2A)(d) of the Act, the employer will not be liable for the treatment provided if the treatment or service is provided by a medical practitioner who is suspended or disqualified from practice under any relevant law or the medical practitioner's registration is limited or subject to any condition imposed as a result of a disciplinary process.

Multiple operations or injuries refer to situations that require two or more operations or for the treatment of two or more injuries carried out at the same time. It applies to the AMA

items EA015 to MY330 and MZ731 to MZ871, with the exception of items specifically listed as a multiple procedure item in the AMA List, or where Schedules in this Order prevent combining of items. The fee for the main procedure or injury is to be paid in full as per Schedule A (1.5 x AMA List fee), and for each additional item or injury at 1.125 x AMA List Fee specified in Schedule A.

Opinion on file request includes retrieval of a file from whatever source, reading time, and reporting where a request for such an opinion has been made in writing to the Orthopaedic Surgeon and in accordance with privacy principles.

Orthopaedic procedures are those listed in the AMA List but do not include the cost of bandages, dressings, plaster of Paris bandages, splints, metallic fixation agents, and prosthetic implants which may be charged in addition to the fee set out in Schedules in this Order, if purchased by the Orthopaedic Surgeon. The fee for orthopaedic procedures includes pre-surgery consultations conducted on the same day of surgery and aftercare visits.

Orthopaedic Surgeon means a Medical Practitioner who is recognised by the Medical Board of Australia or by Medicare Australia as a Specialist in orthopaedic surgery and who is registered with the Australian Health Practitioner Regulation Agency as a Specialist in surgery, in the field of orthopaedic surgery. It includes an Orthopaedic Surgeon who is a staff member at a public hospital providing services at the hospital.

Out-of-hours consultation means a call-out to a public or private hospital or a private home for an urgent case before 8.00am or after 6:00pm Monday to Friday, or anytime on the weekend and public holidays. This fee is not to be utilised where a consultation is conducted for non-urgent cases.

Out-of-hours loading only applies when an Orthopaedic Surgeon is called back to perform a procedure(s) in isolation, rather than for cases scheduled before 8.00am or after 6.00pm on a weekday or a routine weekend operating list. Loading to be calculated at 20% of the total procedure fee. Item must be reflected in the invoice as a separate entry against code WCO008.

Revision surgery refers to a procedure carried out to correct earlier surgery. Only where the revision surgery is performed by an Orthopaedic Surgeon other than the original Orthopaedic Surgeon, shall it attract a fee of 50% of the amount for the principal procedure in the initial surgery, in addition to the fee payable for the new procedure. Where the new procedure is specified as a revision procedure in the AMA List, the 50% loading does not apply.

Spinal surgical rules and conditions provided in the current Medicare Benefits Schedule apply to spinal surgical items MZ731 (MBS 51011) to MZ871 (MBS 51171) conducted on or after 1 January 2020.

Subsequent consultation and report is each attendance subsequent to the first in a single course of treatment. A subsequent consultation fee is not to be billed if conducted on the same day as surgery or in the normal aftercare that applies following surgery. The cost of these consultations is included in the fee for the orthopaedic procedure.

The subsequent Orthopaedic Surgeon consultation fee includes a subsequent consultation, a report from the subsequent consultation to the referring General

Practitioner and copy of the report to the insurer. Providing copies of these reports does not attract a fee.

4. Application of Order

This Order applies to treatment provided on or after the commencement date of this Order, whether it relates to an injury received before, on, or after that date.

5. Maximum fees for treatment by Orthopaedic Surgeon

The maximum fee amount for which an employer is liable under the Act for treatment of a worker by an Orthopaedic Surgeon, being treatment of a type specified in Column 1 of Schedule A to this Order, is the corresponding amount specified in Column 3 of that Schedule.

A fee charged by an Orthopaedic Surgeon for a patient's treatment (including the management of fractures and other conditions) will be in addition to the fee in Schedule A for the initial consultation and report.

6. Billing items for hand surgery (Schedule B)

Schedule B provides mandatory guidelines for billing items used in hand and wrist surgery only.

Table 1 details items that are not billable for hand surgery procedures.

Table 2 details items with restricted application for hand surgery and where clinical justification is required that they are reasonably necessary given the circumstances of the case.

7. Billing items for shoulder and elbow surgery (Schedule C)

Schedule C provides mandatory guidelines for billing items used in shoulder and elbow surgery only.

Any item number where the term "flag" is used in the Clinical Indication column highlights a potential exception that will require further justification. Should an Orthopaedic Surgeon seek an exception to the guidelines, the Orthopaedic Surgeon must provide a written explanation to support the request.

8. Billing items for general upper limb surgery (Schedule D)

Schedule D provides mandatory guidelines for billing items used in general upper limb surgery.

Any item number where the term "flag" is used in the Clinical Indication column highlights a potential exception that will require further justification. Should an Orthopaedic Surgeon seek an exception to the guidelines, the Orthopaedic Surgeon must provide a written explanation to support the request.

9. GST

An amount fixed by this Order is exclusive of GST. An amount fixed by this Order may be increased by the amount of any GST payable in respect of the service to which the cost relates, and the cost so increased is taken to be the amount fixed by this Order. This clause does not permit a Medical Practitioner or an Orthopaedic Surgeon to charge or recover more than the amount of GST payable in respect of the service to which the cost relates.

10. Requirements for invoices

All invoices should be submitted to the insurer within 30 calendar days of the service provided and must comply with the Authority's itemised invoicing requirements for the invoice to be processed. Refer to the Doctors in workers compensation webpage on the SIRA website - https://www.sira.nsw.gov.au/for-service-providers/A-Z-of-service-providers/doctors-and-other-medical-professionals#Doctors_in_Workers_Comp

All invoices with surgical items must also be accompanied by the following:

(1) Detailed operation report including a description of the initial injury and an outline of the mechanism of injury, time surgery commenced and finished, intra-operative findings and the procedures performed, including structures that were repaired (stating the anatomic location) and technique of repair.

(2) Usage of any of the restricted item numbers (Schedule B, Table 2, Schedule C and Schedule D) must be accompanied by clinical justification in order to process the claim.

Note: The Medical Practitioner/s providing Assistance at Operation are to invoice for their services separately to the principal Orthopaedic Surgeon/Medical Practitioner.

11. Surgery requests

For any proposed surgery – a list of proposed applicable AMA item numbers will need to be provided prior to approval being given.

Where questions arise in individual clinical situations, supply of additional information may be required to assist in determinations.

12. No pre-payment of fees

Pre-payment of fees for reports and services is not permitted.

13. Nil payment for cancellation or non-attendance

No fee is payable for cancellation or non-attendance by a worker for treatment services with an Orthopaedic Surgeon.

SCHEDULE A
MAXIMUM FEES FOR ORTHOPAEDIC SURGEONS

Item	Column 1 Type of service	Column 2 AMA Item(s)	Column 3 Maximum amount
Consultations			
1.	Initial consultation and report	AC500 (MBS 104)	$340.40
2.	Extended initial consultation and report	WCO006	$468.90
3.	Subsequent consultation and report	AC510 (MBS 105)	$234.50
4.	Out-of-hours consultation	WCO007	$196.70 in addition to consultation fee
Procedures			
5.	Orthopaedic procedure(s)	ML005 (MBS 46300) to MY330 (MBS 50239) and MZ731 (MBS 50950) to MZ871 (MBS 51171)	1.5 x AMA List Fee for the primary item number. (for any additional item numbers refer to item 8 of this schedule).
6.	Instrument fee	WCO003	$234.50
7.	Assistance at operation (*Assistance at Operation* fees are only payable to Medical Practitioners, not other health practitioners eg. perioperative nurses). Note: Assistance at operation is only payable once per eligible item number performed by the principal Orthopaedic Surgeon irrespective of the number of medical practitioners providing Assistance at operation.	MZ900	A fee of 20% of the surgeon's fee for surgical procedure/s performed, but only those surgical procedure/s where an assistant is allowed for in the MBS, or $393.20, whichever is the greater.
8.	Multiple operations or injuries		Primary item number to be paid in full (1.5 x AMA List Fee) and

Item	Column 1 Type of service	Column 2 AMA Item(s)	Column 3 Maximum amount
			additional AMA item number(s) at 1.125 x AMA List Fee.
9.	Aftercare visits (As defined in this Order)		As per AMA List
10.	Compound (open) wound		In an open fracture wound that requires debridement, a 50% loading for open fracture fixation can be applied. Debridement item EA075/30023 is not to be billed when applying this loading.
11.	Out of hours loading	WCO008	20% of total procedure fee
Insurer/lawyer requests			
12.	Opinion on file request	WCO009	$234.50
13.	Telephone requests including Case conferences (refer to the definition within the *Workers Compensation (Medical Practitioner Fees) Order 2020)* or where there is a request to provide medical records and the medical practitioner needs to review the records prior to provision (to redact non work-related injury information)	WCO002	$45.30 per 5 minutes
14.	Lost reports and reprints		$158.90 per report
15.	Consulting Orthopaedic Surgeon reports (where additional information that is not related to the routine injury management of the patient is requested by either party to a potential or current dispute) Note: The party requesting a report must agree on the category of report with the Medical Practitioner in	Relevant IMS/WIS code	Please refer to the *Workplace Injury Management and Workers Compensation (Medical Examinations and Reports Fees) Order 2020* Schedule 2

Item	Column 1 Type of service	Column 2 AMA Item(s)	Column 3 Maximum amount
	advance and confirm the request in writing at the time of referral.		
16.	Fees for providing copies of clinical notes and records	WCO005	Where medical records are maintained electronically by a medical practitioner/practice a flat fee of $60 is payable (for provision of all requested medical records held by the medical practice) inclusive of postage and handling. A medical practitioner/practice should not provide or bill for hard copy medical records if they are maintained electronically. Where medical records are not maintained electronically the maximum fee for providing hard copies of medical records (including Consulting Orthopaedic Surgeon's notes and reports) is $38 (for 33 pages or less) and an additional $1.40 per page if more than 33 pages. This fee is inclusive of postage and handling. Where a medical practitioner has been requested to provide medical records and the doctor needs to review the records prior to provision (to redact non work-related injury information), the time taken to review the records is to be billed under **WCO002** at the rate specified at item 13, Schedule A. The hourly rate is to be pro-rated into 5 minute blocks to reflect the time taken. This fee can be billed in addition to the fees stated above for provision of medical records by hard copy or electronically.

SCHEDULE B

BILLING ITEMS USED IN HAND SURGERY

Table 1: Items numbers and descriptors not applicable to hand surgery procedures

AMA/MBS item number	Descriptor	Reason for decline
CV233/18266 CV082/Nil	INJECTION OF AN ANAESTHETIC AGENT, ulnar, radial or median nerve of main trunk, one or more of, not being associated with a brachial plexus block. MINOR NERVE BLOCK (specify type) to provide post-operative pain relief (this does not include subcutaneous infiltration).	The MBS does not allow a claim for nerve blocks performed as a method of postoperative analgesia. Infiltration is included in both the anaesthetic schedule AND in the surgical item number fee if performed by the Orthopaedic Surgeon. This item can only be billed in circumstances where a formal nerve block is performed by the Orthopaedic Surgeon as the only form of anaesthesia and no charge is raised for another anaesthetic service.
MG540/45051	CONTOUR RECONSTRUCTION for open repair of contour defects, due to deformity, requiring insertion of a non-biological implant, if it can be demonstrated that contour reconstructive surgery is indicated because the deformity is secondary to congenital absence of tissue or has arisen from trauma (other than trauma from previous cosmetic surgery), excluding the following: (a) insertion of a non-biological implant that is a component of another service listed in Surgical Operations; (b) injection of liquid or semisolid material; and (c) services to insert mesh.	This relates to the insertion of foreign implant for pathological deformity by an open operation i.e. facial reconstruction and was not intended for usage in hand surgery.
MH480/45445	FREE GRAFTING (split skin) as inlay graft to 1 defect including elective dissection using a mould (including insertion of and removal of mould)	The appropriate item is MH490/45448.
MR170/47954	TENDON, repair of, not being a service to which another item in this Group applies.	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
MR210/47966	TENDON OR LIGAMENT TRANSFER, not being a service to which another item in this Group applies.	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
MR220/47969	TENOSYNOVECTOMY, not being a service to which another item in this Group applies.	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
MR230/47972	TENDON SHEATH, open operation for tenovaginitis, not being a service to which another item in this Group applies.	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
MS015/48403	PHALANX OR METATARSAL, osteotomy or osteectomy of, with internal fixation.	This item is from the orthopaedic group of items and relates to foot surgery only. There already

AMA/MBS item number	Descriptor	Reason for decline
		exist appropriate items in the hand surgery section.
MY015/50103	JOINT, arthrotomy of, not being a service to which another item in this Group applies.	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
MY025/50104	JOINT, synovectomy of, not being a service to which another item in this Group applies.	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
MY045/50109	JOINT, arthrodesis of, not being a service to which another item in this Group applies.	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
MY105/50127	JOINT OR JOINTS, arthroplasty of, by any technique not being a service to which another item applies.	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
OF820/60506	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting less than 1 hour, not being a service to which another item in this table applies (R).	This item cannot be billed for use of image intensification when operated by the Orthopaedic Surgeon in the absence of a radiographer.
OF824/60509	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting 1 hour or more, not being a service associated with a service to which another item in this table applies (R).	This item cannot be billed for use of image intensification when operated by the Orthopaedic Surgeon in the absence of a radiographer.

Table 2: Item numbers with restricted application for hand surgery – clinical justification required

AMA/MBS item number	Descriptor	Clinical indication
AC510/30105	Each attendance SUBSEQUENT to the first in a single course of treatment.	Follow up consultations will not be paid within the 6-week period following a procedure as this is included in normal aftercare.

AMA/MBS item number	Descriptor	Clinical indication
EA075/30023	WOUND OF SOFT TISSUE, traumatic, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Assist.).	The repair of wound must be undertaken by suture, tissue adhesive resin (such as methyl methacrylate) or clips. These items are not to be billed for the closure of surgical wound, as such closure is part of a surgical procedure and not additional. Item EA075/30023 covers debridement of traumatic, "deep or extensively contaminated" wound. Benefits are not billable under this item for debridement which would be expected to be encountered as part of an operative approach to the treatment of fractures. Debridements are also not billable when removing percutaneous wire fixation. This item can be billed for deep chronic wounds or in combination with open fractures requiring debridement. This item is not to be billed in combination with EA215/30068. Limit of one debridement per episode of care or per limb. This item cannot be billed when a surgeon applies the 50% loading for open fracture fixation. Flag if this procedure is requested more than once per episode of care or per limb.
EA095/30029	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7CM IN LENGTH), involving deeper tissue, not being a service to which another item in Group 3.4 applies.	This item is for use in wound suture when no other vital tissue is involved. It cannot be billed in conjunction with item EA075/30023 for the same wound/zone of injury, nor when repair of a performed and deeper structure is also claimed for.
EA755/30223	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS OR SIMILAR LESION, requiring admission to hospital or day-hospital facility, INCISION WITH DRAINAGE OF (excluding aftercare).	This item cannot be billed in conjunction with item EA075/30023 for the same wound/zone of injury.
EA825/30238	FASCIA, DEEP, repair of, FOR HERNIATED MUSCLE.	This item is rarely indicated and cannot be billed in conjunction with: items EA075/30023 MR240/47975, MR250/47978, MR260/47981.
ET560/33815 ET570/33818	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by lateral suture. MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by direct anastomosis.	This item is applicable for repair of radial, ulnar or brachial arteries proximal to wrist crease.

AMA/MBS item number	Descriptor	Clinical indication
LN740/39312	NEUROLYSIS, internal (interfascicular) neurolysis of, using microsurgical techniques.	This item is never indicated in acute trauma. It is rarely indicated in elective surgery and is reserved for use in revision nerve decompression surgery. This item is not to be billed in conjunction with item MU400: Wrist carpal tunnel release (division of transverse carpal ligament), by open procedure, unless for a revision procedure.
LN750/39315	NERVE TRUNK, nerve graft to, (cable graft) including harvesting of nerve graft using microsurgical techniques.	This item can only be billed once per named nerve trunk, regardless of the number and distal distribution of individual cables. This item cannot be billed in conjunction with items LN790, LN800 or LN810.
LN760/39318	CUTANEOUS NERVE (including digital nerve), nerve graft to, using microsurgical techniques.	This item cannot be billed in conjunction with items LN790, LN800 or LN810. This item cannot be billed for prosthetic neural tubes or wraps. In this setting, items LN700 or LN710 are applicable.
LN790/39324 LN800/39327	NEURECTOMY, NEUROTOMY or removal of tumour from superficial peripheral nerve, by open operation.	This item cannot be billed in conjunction with item LN810.
LN810/39330	NEUROLYSIS by open operation without transposition, not being a service associated with a service to which item LN740 applies.	This item is not for the identification of nerves during surgical exposure. It is not to be billed in combination with item LN700. This item is not to be billed in conjunction with item MU400: Wrist carpal tunnel release (division of transverse carpal ligament) by open procedure. However, items LN810 and MU400 can be billed together for combined open carpal tunnel release and cubital tunnel release surgery. This item is not to be billed in conjunction with item ML235 Tendon sheath of hand/wrist open operation for stenosing tenovaginitis.
MH115/45203	SINGLE STAGE LOCAL FLAP, where indicated to repair 1 defect, complicated or large, and excluding flap for male pattern baldness and excluding H-flap or double advancement flap, not in association with any of items EN036 to EN084.	This item is rarely indicated in the hand and wrist as a large defect will not be readily amenable to a local flap reconstruction. It is not to be billed for suturing of traumatic skin flaps.
MH125/45206	SINGLE STAGE LOCAL FLAP where indicated to repair 1 defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excluding H-flap or double advancement flap, not in association with any of items EN036 to EN084.	This item can only be billed once for a z-plasty.

AMA/MBS item number	Descriptor	Clinical indication
MJ025/45500	MICROVASCULAR REPAIR using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit.	This item relates to microvascular repair of an artery or vein. This item cannot be billed for repair of dorsal veins with volar skin intact, branches of digital arteries, branches of radial/ulnar vessels and venae comitantes of major arteries. Microvascular repairs distal to the metacarpophalangeal joint will also require clinical documentation of appropriate surgical technique utilising an operating microscope.
MJ030/45501 MJ035/45502	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for re-implantation of limb or digit/ MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for re-implantation of limb or digit.	These items specifically relate to replantation of limb and digit. i.e. the amputated portion must be completely detached.
MJ045/45503	MICRO-ARTERIAL or MICRO-VENOUS graft using microsurgical techniques.	This item includes the remuneration for harvesting the graft and performing any microvascular anastomoses to the graft.
MJ075/45515	SCAR, other than on face or neck, NOT MORE THAN 7 CMS IN LENGTH, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital or approved day hospital facility, or where performed by a Specialist in the practice of his or her specialty.	This item cannot be billed in conjunction with other items e.g. nerve repair, tendon repair, flap repair (i.e. intended to be an independent procedure).
MJ245/45563	NEUROVASCULAR ISLAND FLAP, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness.	This item is for a true island flap, elevated on a neurovascular pedicle for an existing traumatic defect. This item is not to be billed for VY advancement flaps where item MH125/45206 is applicable.
ML105/46325	CARPAL BONE replacement or resection arthroplasty using adjacent tendon or other soft tissue including associated tendon transfer or realignment when performed.	This item is primarily intended for use in reconstruction for basal thumb arthritis. It is not approved for excision of the pisiform.
ML115/46327	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrotomy of.	This item is not to be billed in addition to item EA075/30023 when arthrotomy is performed to facilitate joint lavage within an open wound.
ML125/46330	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous or capsular repair with or without arthrotomy.	This item is only billable for repair of named ligaments where preoperative or intraoperative findings document significant joint instability.

AMA/MBS item number	Descriptor	Clinical indication
ML135/46333	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous repair of using free tissue graft or implant.	This item is only billable for repair of named ligaments using free grafts or alloplast where preoperative or intraoperative findings document significant joint instability. This item cannot be billed for reattachment of ligament using a bone anchor. Item ML125/46330 is the approved number.
ML145/46336	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, synovectomy, capsulectomy or debridement of, not being a service associated with any other procedure related to that joint.	This item cannot be billed in conjunction with any other item or procedure related to the joint. This item cannot be billed in conjunction with item EA075/30023.
ML155/46339	EXTENSOR tendons or FLEXOR tendons of hand or wrist synovectomy of.	Rare in a workers' compensation setting. Not for use for De Quervain's (refer to ML235/46363). Note: If performing a complete flexor tenosynovectomy, a release of the Carpal Tunnel is part of the operation and therefore MU400 or MU410 should not be billed. If this item is requested in conjunction with MU400 or MU410 (Wrist carpal tunnel release) or ML235/46363 (De Quervain's), clinical documentation of gross synovitis is required, preferably with histological confirmation. Flag if this procedure is requested two or more times.
ML185/46348 – ML225/46360	Digit, synovectomy of flexor tendon or tendons.	ML185/46348 – 1 digit ML195/46351 – 2 digits ML205/46354 – 3 digits ML215/46357 – 4 digits ML225/46360 – 5 digits Not in combination with ML155/46339.
ML235/46363	Tendon sheath of hand or wrist, open operation on, for stenosing tenovaginitis.	This item is not to be billed in combination with LN810/39330. Item used for De Quervain's Release or Trigger Finger Release. De Quervain's tenosynovitis - can only be billed once per side (ie: includes both APL and EPB tendons).
ML245 – ML335 / 46366 – 46393	Dupuytren's contracture, fasciotomy.	Flag if this procedure is requested for an acute injury or trauma.
ML345/46396	PHALANX or METACARPAL of the hand, osteotomy or osteectomy of.	This item is applicable for removing excess bone formation in an *intact* bone. This is no longer to be applied to removal of loose pieces of bone in trauma or bone shortening for terminalisation or replantation. This is part of the debridement and is included in item EA075/30023 if applicable. This item is not to be billed in combination with MR130/47933 or MR140/47936. Flag if this procedure is requested for an acute injury or trauma.

AMA/MBS item number	Descriptor	Clinical indication
ML405/46414	ARTIFICIAL TENDON PROSTHESIS, INSERTION OF in preparation for tendon grafting.	Tenolysis (items ML545/46453, ML535/ 46450) or tenotomy (item MR200/47963) of the tendon to be grafted cannot be billed with this item.
ML425/46420	Extensor tendon of hand or wrist, primary repair, each tendon.	For an acutely injured tendon as a primary procedure. This item should not be billed for repair of extensor tendon split as part of an access to phalangeal fractures/osteotomies.
ML445/46426	Flexor tendon of hand or wrist, primary repair of, proximal to A1 pulley, each tendon.	Not to be billed more than once to repair FDS tendon in a digit. This item can only be billed a maximum of twice per digit.
ML465/46432	Flexor tendon of hand, primary repair of, distal to A1 pulley, each tendon.	This item is only to be billed for acute injuries. This item can only be billed a maximum of twice per digit.
ML475/46435	Flexor tendon of hand, secondary repair of, distal to A1 pulley, each tendon.	This item is not to be billed in acute injuries. This item can only be billed a maximum of twice per digit.
ML535/46450 ML545/46453	EXTENSOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft. FLEXOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft.	These items are applicable for freeing tendons from scar following previous surgery or trauma. They are not indicated in an acute hand injury. Items ML545 and ML535 cannot be billed in conjunction with release of trigger finger or for release of DeQuervians' (see ML235/46363).
ML695/46494	Ganglion of Hand, excision of.	Not being a service associated with a service to which another item in this Group applies.
ML705/46495	Ganglion or mucous cyst of distal digit, excision of.	Not being a service associated with a service to which item EA355/30107 applies.
ML715/46498	Ganglion of flexor tendon sheath, excision of.	Not being a service associated with a service to which item EA355/30107 applies.
ML725/46500	Ganglion of dorsal wrist joint (excision).	This item is not to be billed in combination with EA355/30107.
ML735/46501	Ganglion of volar wrist joint (excision).	This item is not to be billed in combination with EA355/30107.
ML745/46502	Recurrent ganglion of dorsal wrist joint (excision).	This item is not to be billed in combination with EA355/30107.
ML755/46503	Recurrent ganglion of volar wrist joint (excision).	This item is not to be billed in combination with EA355/30107.
ML765/46504	NEUROVASCULAR ISLAND FLAP, for pulp innervation.	These items are only to be billed for a heterodigital neurovascular island flap used to resurface pulp loss (e.g. Littler flap, first dorsal metacarpal artery or Kite flap). There is a limit of one flap per digit.

AMA/MBS item number	Descriptor	Clinical indication
		Flag if this procedure is requested two or more times.
ML795/46513	Digital nail of finger or thumb, removal of	This item should not be billed in association with nailbed repair (items ML665/46486 or ML675/46489). This item is not to be billed in combination with ML805/46516.
ML805/46516	DIGITAL NAIL OF FINGER OR THUMB, removal of, in the operating theatre of a hospital or approved day hospital facility.	This item is not to be billed in association with primary or secondary nail bed repair (items ML665/46486, ML675/46489). This item is not to be billed in combination with ML795/46513.
ML825/46522	FLEXOR TENDON SHEATH OF FINGER OR THUMB - open operation and drainage for infection.	This item is applicable only for drainage of suppurative flexor tenosynovitis. It does not apply to washout of flexor sheath in acute injury.
ML835/46525	Pulp space infection, paronychia of hand, incision for, when performed in an operating theatre of a hospital.	Not being a service to which another item in this Group applies (excluding after-care).
MR088/47920	BONE GROWTH STIMULATOR, insertion of.	This is only billable where a mechanical bone growth stimulator has been inserted. It is not for the insertion of OP1 or other bone morphogenic proteins in the setting of hand surgery.
MR090/47921	ORTHOPAEDIC PIN OR WIRE, insertion of, as an independent procedure.	This item cannot be billed when the k-wire has been used as part of fracture fixation. Can be billed for the insertion of a temporary pin in association with a ligament/tendon repair.
MR110/47927	BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of, in the operating theatre of a hospital or approved day hospital facility - per bone.	This item applies for removal of *buried* k-wire. Where a k-wire or wires cross more than 2 bones, only 1 item number is billable.
MR630/48239 MR640/47306	BONE GRAFT (with or without internal fixation), not being a service to which another item in this Group applies.	These items cannot be billed in conjunction with fracture fixation numbers or the following items: ML005/46300, ML015/46303, ML355/46399, ML365/46402, ML375/46405, MR560/48218 - MR620/48236.
MS005/48400	PHALANX, METATARSAL, ACCESSORY BONE OR SESAMOID BONE, osteotomy or osteectomy of.	Excluding services to which items MX660 or MX670 applies. This item is only applicable to sesamoidectomy.
MS015/48403	Phalanx or metatarsal, osteotomy or osteectomy of, with internal fixation.	Excluding services to which items MR130/47933 or MR140/47936 apply.
MS025/48406	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of.	This item <u>is</u> the appropriate number for excision of the pisiform. This item is <u>not</u> appropriate for simple removal of bone prominence, osteophytes or small quantities of excess bone.

AMA/MBS item number	Descriptor	Clinical indication
MU400 and MU410	Carpal tunnel release (division of transverse carpal ligament), by open (MU400) or endoscopic (MU410) approach.	These are the appropriate item numbers for a primary carpal tunnel release. Ultrasound costs are not billable in conjunction with this surgery procedure. Nerve Conduction Studies (NCS) preferable prior to surgical consideration, other than in acute cases. This item is rarely indicated in combination with ML155/46339: Extensor tendons or flexor tendons of hand or wrist (synovectomy of). MU400 and MU410 cannot be billed with ML155/46339 – Billing is only approved for one OR the other of these codes. Flag if this code combination is billed.
MU460/49209	Wrist, total replacement arthroplasty of.	Flag if this procedure is requested.
MU462/49210	Wrist, total replacement arthroplasty of, revision procedure, including removal of prosthesis.	Flag if this procedure is requested.
MU464/49211	Wrist, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis.	Flag if this procedure is requested.
MU470/49212	WRIST, arthrotomy of.	This item is not to be billed in conjunction with excision of primary or recurrent wrist ganglia (items ML725/46500; ML735/46501; ML475/46502; ML755/46503)
MU480/49215	Wrist, reconstruction of, including repair of single or multiple ligaments or capsules, including associated arthrotomy.	Including repair of single or multiple ligaments or capsules, including associated arthrotomy. Can be used in combination with MR210/47966 for chronic scapholunate repair where the original ligament is not repairable or ML415/46417.
MU490/49218	Wrist, diagnostic arthroscopy of, including radiocarpal or midcarpal joints, or both (including biopsy).	Not being a service associated with any other arthroscopic procedure of the wrist joint.
MU500/49221	Wrist, Arthroscopic surgery of wrist.	Involving any 1 or more of: drilling of defect; removal of loose body; release of adhesions; local synovectomy; or debridement of one area. Not being a service associated with any other arthroscopic procedure of the wrist joint.
MU510/49224	Wrist, arthroscopic debridement of 2 or more distinct areas; or osteoplasty including excision of the distal ulna; or total synovectomy.	Not being a service associated with any other arthroscopic procedure of the wrist.
MU520/49227	Wrist, arthroscopic pinning of osteochondral fragment or stabilisation procedure for ligamentous disruption.	Not being a service associated with any other arthroscopic procedure of the wrist joint.

AMA/MBS item number	Descriptor	Clinical indication
MY035/50106	JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this group applies.	This item is applicable for stabilization of CMC joints only.

SCHEDULE C

BILLING ITEMS USED IN SHOULDER AND ELBOW SURGERY

This Order adopts the *WorkCover Queensland Upper Limb Surgery Guidelines (November 2017)* with minor modifications. Relevant items from the *WorkCover Queensland Upper Limb Surgery* Guidelines are provided within Schedule C and their use is mandatory when billing for shoulder and elbow surgery.

AMA/MBS item number	Descriptor	Clinical indication
	BONE GRAFTS	
MR550/48215	Humerus, bone graft to, with internal fixation.	
MR640/48242	Bone graft, with internal fixation.	Not being a service to which another item in this group applies.
MS005/48400	Phalanx, metatarsal, accessory bone or sesamoid bone, osteotomy or osteectomy of.	Excluding services to which item MX660/49848 or MX670/49851 applies, any of items MX660/49848, MX670/49851, MR130/47933 or MR140 apply.
MS025/48406	Fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, osteotomy or osteectomy of.	Excluding services to which items MR130/47933 or MR140/47936 apply. Not to be billed in combination with item MT770/48951. May be billed with MY035/50106 if excision of the distal clavicle is done in conjunction with the stabilisation – eg: Weaver Dunn Procedure. **Flag if this item is used in combination with any other shoulder items (MT600/48900 to MT800/48960).**
MS035/48409	Fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, osteotomy or osteectomy of, with internal fixation.	Excluding services to which items MR130/47933 or MR140/47936 apply. May be billed with MY035/50106 if the coracoclavicular ligaments are reconstructed in the same procedure. Not to be billed in combination with item MT770/48951. **Flag if this item is used in combination with any other shoulder items (MT600/48900 to MT800/48960).**

AMA/MBS item number	Descriptor	Clinical indication
MS045/48412	HUMERUS, osteotomy or osteectomy of.	Excluding services to which items MR130/47933 or MR140/47936 apply. Can be billed with item MR020/47903 (tennis elbow release) if a lateral or medial epicondylectomy is performed. Can be billed with LN810/39330 if ulna nerve neuritis or compression has been diagnosed requiring formal surgical decompression.
SHOULDERS		
MT600/48900	Excision or coraco-acromial ligament or removal of calcium deposit from cuff or both.	Open operation not arthroscopic. Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is used twice or more.**
MT610/48903	Decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any other combination.	Open operation, also known as open acromioplasty or subacromial decompression (SAD).
MT620/48906	Repair of rotator cuff, including excision of coraco-acromial ligament or removal of calcium deposit from cuff or both.	Known as open cuff repair without acromioplasty. Not to be billed in combination with item MT600/48900. If MS025 is performed it cannot be billed with item MT770. Can be billed in combination with arthroscopic code MT770/48951 (and MR210/47966 if a bicep tenodesis is performed). Note: If MT620/48906 is performed arthroscopically it cannot be billed with item MT770/48951.
MT630/48909	Repair of rotator cuff, including decompression of subacromial space by acromioplasty, excision of coroco-acromial ligament and distal clavicle, or any combination.	Known as open rotator cuff repair with acromioplasty with excision of AC joint. Not being a service to which item MT610/48903 applies. **Flag if this item is billed with item MX670/49851.** Not to be billed with MT770/48951 or in combination with MT610/48903. This item is not to be billed with services associated with any other **arthroscopic** procedure of the shoulder region.
MT640/48912	Shoulder arthrotomy	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed in combination with any other item code for shoulder surgery.**
MT650/48915	Hemi-arthroplasty	Use of this item rarely seen in State Insurance Regulatory Authority claims. Maybe appropriate for shoulder trauma/fractures only.

AMA/MBS item number	Descriptor	Clinical indication
MT660/48918	Total replacement arthroplasty including rotator cuff repair.	Use of this item rarely seen in State Insurance Regulatory Authority claims.
MT670/48921	Revision of total replacement arthroplasty.	Use of this item rarely seen in State Insurance Regulatory Authority claims.
MT680/48924	Revision of total replacement arthroplasty with bone graft to scapula or humerus.	Use of this item rarely seen in State Insurance Regulatory Authority claims.
MT690/48927	Removal of shoulder prosthesis.	Use of this item rarely seen in State Insurance Regulatory Authority claims.
MT700/48930	Stabilisation for recurrent anterior/posterior dislocation.	Known as open shoulder stabilisation (including repair of labrum). If recurrent, treatment option: highly recommend looking into claimant's history to determine if surgery is to treat the aggravation or pre-existing condition.
MT710/48933	Stabilisation for multidirectional instability.	Mostly used for open procedures.
MT720/48936	Synovectomy as an independent procedure.	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed in combination with any other item code.**
MT730/48939	Arthrodesis with synovectomy.	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed once or more.**
MT740/48942	Arthrodesis with synovectomy, removal of prosthesis and bone grafting.	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed once or more.**
MT750/48945	Diagnostic arthroscopy.	Not to be billed with any **arthroscopic** procedure of the shoulder region. May be billed with open surgery i.e. items MT630/48909, MT620/48906, MT710/48933.
MT760/48948	Arthroscopic surgery, with one or more: removal loose bodies, decompression of calcium deposits, debridement labrum/synovium/rotator cuff, chondroplasty.	Not to be billed with any other **arthroscopic** procedure of the shoulder region. Preparatory for an open procedure. Appropriate with items MT620/48906 and MT630/48909. May be billed with items MT700/48930 and MT710/48933.
MT770/48951	Arthroscopic division of the coraco-acromial ligament including acromioplasty.	Not to be billed with any other **arthroscopic** procedure of the shoulder region. Not to be billed in combination with items EA365/30111 or MT780/48954. Can be billed in combination with MT620/48906 when performing an open rotator cuff repair (and MR210/47966 if a biceps tenodesis is performed).

AMA/MBS item number	Descriptor	Clinical indication
MT780/48954	Arthroscopic total synovectomy including release of contracture (shoulder).	Known as frozen shoulder release; stand-alone item code. Not to be billed with any other **arthroscopic** procedure of the shoulder region. Not to be billed in combination with item MT770/48951. **Flag if this item is used with any other item for shoulder surgery.**
MT790/48957	Arthroscopic stabilisation for recurrent instability including labral tear or reattachment.	Not to be billed with any other **arthroscopic** procedure of the shoulder region. If recurrent treatment option, highly recommend looking into claimant's history to determine if surgery is to treat the aggravation or pre-existing condition. **Flag if this item billed with any other item for shoulder surgery.**
MT800/48960	Reconstruction or repair of, including rotator cuff by arthroscopic, arthroscopic assisted or mini open means; arthroscopic acromioplasty; or resection of acromioclavicular joint by separate approach.	Not to be billed with any other procedure of the shoulder region. May be billed with item CV218/18256. Not to be billed with item **EA365/30111, MT770/48951 OR MT790/48957.** May be billed in combination with MR210/47966 or MR200/47963. **Flag if practitioner requesting a Superior Capsular Reconstruction (SCR) procedure.**
ELBOW		
LN770/39321	Transposition of Nerve.	Not appropriate for use in epicondylitis surgery – refer to item LN810/39330 (this item applies to transposition of ulna nerve anterior to medial epicondyle to submuscular or subcutaneous site). Not to be combined with MS045/48412 or LN810/39330.
MU035/49100	Arthrotomy of, involving one or more of lavage, removal of loose body or division of contracture.	Not to be billed for tennis elbow surgery.
MU045/49103	Ligamentous stabilisation.	Not to be billed in conjunction with item LN810/39330 unless the ulnar nerve requires mobilisation or decompression at the time of stabilisation (operation notes should reflect this). Transposition item LN770/39321 is commonly used. Ulnar nerve transposition can occur frequently in large elbow operations. It may be necessary to perform neurolysis of more than one nerve such as radial and ulnar, if there was significant previous injury or previous surgery.
MU055/49106	Arthrodesis with synovectomy.	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed.**

AMA/MBS item number	Descriptor	Clinical indication
MU065/49109	Total synovectomy.	Known as **common contracture release.** Use of this item rarely seen in State Insurance Regulatory Authority claims. May be appropriate with osteotomy i.e. items MS045/48412 or MS025/48406. **Flag if billed.**
MU075/49112	Silastic replacement of radial head.	Seen with fractures, dislocations and acute trauma. May be associated with other items i.e. MU045/49103 or MU075/49121. Not to be billed in combination with item MU065/49109. **Flag if billed.**
MU085/49115	Total joint replacement.	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if billed.**
MU086/49116	Total replacement arthroplasty, revision procedure, including removal of prosthesis.	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if billed.**
MU087/49117	Total replacement arthroplasty, revision procedure with bone grafting or removal or prosthesis.	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if billed.**
MU095/49118	Diagnostic arthroscopy	Not to be billed with any other **arthroscopic** procedure of the elbow region. Appropriate for use with open elbow surgery.
MU105/49121	Arthroscopic surgery of elbow involving any 1 or more of: drilling of defect, removal of loose body; release of contracture or adhesions; chondroplasty; or osteoplasty.	Not to be billed with any other **arthroscopic** procedure of the elbow.
OTHER		
EA365/30111	Bursa (large) including olecranon, calcaneum or patella, excision of.	May be billed in combination with olecranon bursa. **Flag if billed in combination with any shoulder surgery.** Not to be billed in combination with item MT800/48960.
LN810/39330	Neurolysis by open operation without transposition.	Not being a service associated with a service to which item LN740/39312 applies. Can be billed in combination with elbow surgery (eg: MS045/48412 if performing an ulna nerve release with medial epicondylectomy or MR020/47903 lateral or medial epicondylitis debridement). Not to be billed in combination with item MT760/48948. **Flag if billed in combination with any item codes for shoulder surgery or in acute trauma.**

AMA/MBS item number	Descriptor	Clinical indication
	LIMB LENGTHENING AND DEFORMITY CORRECTION	
MZ330/50405	Elbow, flexorplasty, or tendon transfer to restore elbow function.	MR170/47954 is the appropriate code for repair of a distal bicep tendon rupture. Use of this item rarely seen in State Insurance Regulatory Authority claims – set of item numbers address congenital conditions. **Flag if billed.**
	OTHER JOINTS	
MY035/50106	Joint, stabilisation of, involving one or more of: repair of capsule, repair of ligament or internal fixation.	Not being a service to which another item in this group applies – stand-alone item. May be billed with MS025/48406 if excision of the distal clavicle is used in conjunction with the stabilisation – e.g. Weaver Dunn procedure. Flag if requested in combination with MR210/47966, MS025/48406 or MS035/48409.
MY055/50112	Cicatricial flexion or extension contraction of joint, correction of, involving tissues deeper than skin and subcutaneous tissue.	Not being a service to which another item in this group applies. Not to be billed with any other **arthroscopic** procedure of the shoulder region. Not to be billed in combination with item MT780/48954. **Flag if billed in combination with any item code for elbow and shoulder surgery.** Implies a release for stiffness after injury or surgery. May occur with other numbers in relation to a large release of a stiff elbow. Three to five item numbers should be in association with an operation that took two to three hours and is usually a revision situation or after serious trauma. The complexity should be reflected in the history of injury, number of prior operations, duration of surgery, complexity of the operation note.
MY065/50115	Joint or joints, manipulation of, performed in the operating theatre of a hospital.	Code used for adhesive capsulitis (frozen shoulder) manipulation under anaesthetic (MAU). Not to be billed for an 'examination' of a joint under general anaesthetic prior to an operation, where the general anaesthetic is for the operation itself. Not being a service associated with a service to which another item in this group applies. **Flag if this item is billed two or more times.**
MY105/50127	Joint or joints, arthroplasty of, by any technique.	Not being a service to which another item applies. Not to be billed in combination with any item for shoulder, elbow or sternoclavicular surgery.

AMA/MBS item number	Descriptor	Clinical indication
	GENERAL	
MP455/47429	Humerus, proximal, treatment of fracture of, by open reduction.	
MP465/47432	Humerus, proximal, treatment of intra-articular fracture of, by open reduction.	
MP485/47438	Humerus, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction.	
MP495/47441	Humerus, proximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by open reduction.	
MR020/47903	Epicondylitis, open operation for.	This is the only item number appropriate for Tennis or Golfers Elbow Debridement (Lateral or Medial Epicondylitis). Can be combined with MS045/48412 where a formal excision of the epicondyle is justified, not just for debridement of epicondyle. Can also be combined with LN810/39330 if ulna nerve neuritis or compression has been diagnosed which requires formal surgical decompression. **Flag if billed in combination with any other item numbers.**
MR100/47924	Buried wire, pin or screw (1 or more inserted for internal fixation purposes), removal of requiring incision and suture – per bone.	Not being a service to which item MR410/47927 or MR120/47930 applies.
MR110/47927	Buried wire, pin or screw, one or more of, which were inserted for internal fixation purposes, removal of, in the operating theatre of a hospital.	This item applies for removal of one or more buried k-wire per bone. Where fixation crosses two or more bones, only one item number is billable.
MR120/47930	Plate, rod or nail and associated wires, pins or screws, one or more of, all of which were inserted for internal fixation purposes, removal of.	Not being a service associated with a service to which items MR100/47924 or MR110/47927 apply - per bone. Where fixation crosses two or more bones, only one item number is claimable.
MR170/47954	Tendon, repair of, as an independent procedure.	Can be billed in treating biceps tenodesis. Can be billed in treating distal biceps tendon rupture (Refer to item MR210/47966 for proximal biceps tenodesis). **Flag if billed with any other item code.**
MR190/47960	Tenotomy, subcutaneous.	Not being a service to which another item in this group applies.

AMA/MBS item number	Descriptor	Clinical indication
MR200/47963	Tenotomy, open, with or without tenoplasty.	Not being a service to which another item in this group applies. Not to be billed for epicondylitis/tennis elbow release." Could be billed in combination with items MT770/48951 or MT800/48960.
MR210/47966	Tendon or ligament, transfer.	As an independent procedure. Could be billed in combination with items MT770/48951 or MT800/48960.
MR220/47969	Tenosynovectomy	Not being a service to which another item in this group applies. Should not be billed for tennis elbow or shoulder surgery. **Flag if billed for shoulder or elbow procedures.**

SCHEDULE D

ADDITIONAL ITEMS USED IN UPPER LIMB SURGERY

This Order adopts the *WorkCover Queensland Upper Limb Surgery Guidelines (November 2017) with minor modifications*. The relevant items from the *WorkCover Queensland Upper Limb Surgery Guidelines* are provided in Schedule D and their use is mandatory when billing for upper limb surgery.

AMA/MBS item number	Descriptor	Clinical indication
EA080 – EA155 / 30024 - 30049	Repair of Wounds	The repair of wound referred to in these items must be undertaken by suture, tissue adhesive resin (such as methyl methacrylate) or clips. These items are not to be billed for the closure of surgical wound, as such closure is part of a surgical procedure and not additional. The term 'superficial' means affecting skin and subcutaneous tissue including fat and the term 'deeper tissue' means all tissues deep to but not including subcutaneous tissue such as fascia and muscle.
EA355/30107	Ganglion or small bursa, excision of.	Not being a service associated with a service to which another item in this Group applies.
MN020 – MN160/ 47003 - 47045	Treatment of upper limb dislocations.	Check AMA Fees List for item descriptions and exclusions of item combinations.
MS055/48415	Humerus, osteotomy or osteectomy, with internal fixation.	Excluding services to which items MR130/47933 or MR140/47936 apply. Not to be billed with item LN810/47903 (tennis elbow release) unless a lateral epicondylectomy is performed. Flag if this item is requested, particularly if requested for tennis elbow surgery.
MY005/50100	Joint, diagnostic arthroscopy of (including biopsy).	Not being a service to which another item in this Group applies and not being a service associated with any other arthroscopic procedure.
MY010/50102	Joint, arthroscopic surgery of	Not being a service to which another item in this Group applies.

WORKERS COMPENSATION (MEDICAL PRACTITIONER FEES) ORDER 2020

under the

Workers Compensation Act 1987

I, Carmel Donnelly, Chief Executive, State Insurance Regulatory Authority, make the following Order pursuant to section 61(2) of the *Workers Compensation Act 1987*.

Dated this 11 day December 2019

Carmel Donnelly
Chief Executive
State Insurance Regulatory Authority

Explanatory Note

Treatment by a Medical Practitioner is medical or related treatment covered under the *Workers Compensation Act 1987*. This Order sets the maximum fees for which an employer is liable under the Act for any medical or related treatment provided to a NSW worker. The fee for the treatment or service must not exceed the maximum fee for the treatment or service as specified in this Order. Workers are not liable for the cost of any medical or related treatment covered by this Order. The effect of this Order is to prevent a Medical Practitioner from recovering from the worker or employer any extra charge for treatments covered by this Order.

Under section 60(2A)(a) of the *Workers Compensation Act 1987,* medical or related treatment requires prior insurer approval unless treatment is provided within 48 hours of the injury happening or treatment is exempt from pre-approval under the *Workers Compensation Act 1987* or the State Insurance Regulatory Authority's *Workers Compensation Guidelines* in effect at the time.

This Order adopts the *List of Medical Services and Fees* issued by the Australian Medical Association (AMA), except where specified in this Order. To bill an AMA item, a Medical Practitioner must be confident they have fulfilled the service requirements as specified in the item descriptor. Medical Specialists must utilise AMA item numbers relevant to the type of consultation undertaken (e.g. a pain medicine specialist cannot bill anaesthesia consultation item numbers for a pain medicine consultation). Where a comprehensive item is used, separate items cannot be claimed for any of the individual items included in the comprehensive service.

The incorrect use of any item referred to in this Order can result in penalties, including the Medical Practitioner being required to repay monies that the Medical Practitioner has incorrectly received.

Consulting Surgeons should also refer to the *Workers Compensation (Surgeon Fees) Order 2020* or, if an Orthopaedic Surgeon, the *Workers Compensation (Orthopaedic Surgeon Fees) Order 2020.*

Workers Compensation (Medical Practitioner Fees) Order 2020

1. Name of Order

This Order is the *Workers Compensation (Medical Practitioner Fees) Order 2020.*

2. Commencement

This Order commences on 1 January 2020.

3. Definitions

In this Order:

the Act means the *Workers Compensation Act 1987.*

the Authority means the State Insurance Regulatory Authority as constituted under section 17 of the *State Insurance and Care Governance Act 2015.*

Aftercare visits are covered by the surgical procedure fee during the first six weeks following the date of surgery or until wound healing has occurred. Unrelated visits or incidental reasons for visits that are not regarded as routine aftercare must be explained with accounts rendered.

AMA List means the document entitled *List of Medical Services and Fees* issued by the Australian Medical Association and dated 1 November 2019 and any subsequent amendments to this List published by the AMA in the period 1 November 2019 – 31 October 2020.

Assistance at Operation means assistance provided by a Medical Practitioner, but only where an assistant's fee is allowed for in the Commonwealth Medical Benefits Schedule (MBS). An assistant fee may only be applicable for surgical procedures EA015 – MY330 and MZ731 to MZ871.

Assistance at Operation is only payable once per eligible item number performed by the principal Surgeon/Medical Practitioner irrespective of the number of Medical Practitioners providing Assistance at Operation.

Note: *Assistance at Operation* fees are not payable to health practitioners who are not a Medical Practitioner e.g. perioperative nurses.

In accordance with NSW Health policy directive *Employment Arrangements for Medical Officers in the NSW Public Health Service* (**Doc No**: PD2019_027), assistant fees cannot be charged for workers compensation cases performed in a public hospital when the assistant is a resident medical officer or registrar. If a resident medical officer or registrar is on rotation to an accredited private hospital, the relevant assistant fee may be charged. Payment of these fees are to be directed into a hospital or departmental trust fund account and the invoice should include details of this account. The Authority reserves the right to conduct an audit of assistant fee payments to ensure their proper distribution into the named trust fund.

Case conference means a face-to-face meeting, video conference or teleconference with any or all of the following parties – worker, employer, workplace

rehabilitation provider, insurer or other treatment practitioner/s delivering services to the worker. Discussion must seek to clarify the worker's capacity for work, barriers to return to work and strategies to overcome these barriers via an open forum to ensure parties are aligned with respect to expectations and direction of the worker's recovery at work/return to suitable employment. If the discussion is with the worker, it must include a third party to be considered a Case conference. Discussions between the worker's nominated treating doctor and other treating practitioners (e.g. allied health practitioners, medical specialists/surgeons) relating to treatment are considered a normal interaction between referring doctor and practitioner. This is not to be charged as a Case conference.

File notes of Case conferences are to be documented in the Medical Practitioner's records indicating the person/s spoken to, details of discussions, duration of the discussion and outcomes. This information may be required for invoicing purposes.

Consulting Surgeon means a Medical Practitioner who is recognised by the Medical Board of Australia or by Medicare Australia as a Specialist Surgeon or Specialist in orthopaedic surgery and who is registered with the Australian Health Practitioner Regulation Authority as a Specialist in surgery in their chosen field. It also includes a Surgeon or Orthopaedic Surgeon who is a staff member at a public hospital providing services at that public hospital. In accordance with section 60(2A)(d) of the Act, the employer will not be liable for the treatment provided if the treatment or service is provided by a Medical Practitioner who is suspended or disqualified from practice under any relevant law or the Medical Practitioner's registration is limited or subject to any condition imposed as a result of a disciplinary process.

General Practitioner is a Medical Practitioner and has the meaning given by subsection 3(1) of the *Health Insurance Act 1973 (Cth).* In accordance with section 60(2A)(d) of the Act, the employer will not be liable for the treatment provided if the treatment or service is provided by a Medical Practitioner who is suspended or disqualified from practice under any relevant law or the Medical Practitioner's registration is limited or subject to any condition imposed as a result of a disciplinary process.

GST means the Goods and Services Tax payable under the GST Law.

GST Law has the same meaning as in the *A New Tax System (Goods and Services Tax) Act 1999 (Cth).*

Insurer means the employer's workers compensation insurer.

Medical Practitioner means a person registered in the medical profession under the *Health Practitioner Regulation National Law (NSW) No.86a*, or equivalent in their jurisdiction with the Australian Health Practitioner Regulation Agency. In accordance with section 60(2A)(d) of the Act, the employer will not be liable for the treatment provided if the treatment or service is provided by a Medical Practitioner who is suspended or disqualified from practice under any relevant law or the Medical Practitioner's registration is limited or subject to any condition imposed as a result of a disciplinary process.

Medical Specialist means a Medical Practitioner recognised as a specialist in accordance with the *Health Insurance Regulations 2018 (Cth)*, Part 2, Division 4, who is remunerated at specialist rates under Medicare. In accordance with section 60(2A)(d) of the Act, the employer will not be liable for the treatment provided if the treatment or service is provided by a Medical Practitioner who is suspended or disqualified from practice under any relevant law or the Medical Practitioner's registration is limited or subject to any condition imposed as a result of a disciplinary process.

Multiple operations or injuries refer to situations that require two or more operations or for the treatment of two or more injuries carried out at the same time. It applies to the AMA items EA015 to MY330 and MZ731 to MZ871, with the exception of items specifically listed as a multiple procedure item in the AMA List, or where Schedules in the Workers Compensation (Orthopaedic Surgeon Fees) Order 2020 or Workers Compensation (Surgeon Fees) Order 2020 prevent combining of items.

Out-of-hours services only apply in an emergency where the clinic is not normally open at that time, and urgent treatment is provided. This fee is not to be utilised in the situation where a consultation is conducted within the advertised hours of a clinic.

4. Application of Order

This Order applies to treatment provided on or after the commencement date of this Order, whether it relates to an injury received before, on, or after that date.

5. Maximum fees for Medical Practitioners

(1) This clause applies to medical and related treatment provided by a Medical Practitioner in respect of which a fee is specified in the AMA List, except:

- Medical services identified in the AMA List by AMA numbers AC500, AC510, AC520, AC530, AC600 and AC610 (Professional Attendances by a Specialist), if these medical services are provided by a Specialist Surgeon;
- Medical services identified in the AMA List by AMA Numbers EA015 to MZ871 (Surgical Operations) if these medical services are provided by a Specialist Surgeon;
- Medical services identified in the AMA List by AMA Number MZ900 (Assistant at Operation fee);
- Medical services identified in the AMA List by AMA numbers OP200 and OP210 (magnetic resonance imaging – MRI).

(2) The maximum amount payable for magnetic resonance imaging (MRI) is:

- OP200 - $700 for one region of the body or two contiguous regions of the body
- OP210 - $1050 for three or more contiguous regions of the body, or two or more entirely **separate** regions of the body (e.g. wrist and ankle).

(3) The maximum amount payable for a certificate of capacity is $48.40. This fee is payable only once per claim for completion of the initial certificate of capacity and is invoiced under payment classification code **WCO001**.

(4) A General Practitioner, Medical Specialist and Consulting Surgeon may be remunerated for time spent in addition to the usual medical management to assist a worker recover at/return to work. This time may include discussions with employers, Case conferences, visits to work sites, time spent reviewing injury management or recovery at/return to work plans and providing additional reports. (where pre-approved by the insurer).

The time taken for these services must be billed under payment classification code **WCO002** (with the exception of some reports – see explanation below) and reflect the time taken (to the nearest 5 minutes) to deliver the service.

The following maximum hourly rates are payable:

- General Practitioner: $296.40 or $24.70 per 5 minutes
- Medical Specialist: $411.60 or $34.30 per 5 minutes
- Consulting Surgeon: $543.60 or $45.30 per 5 minutes.

Note: No fee is payable for liaising with other health providers involved in the treatment of the worker (e.g. Medical Specialists, allied health practitioners) unless the communication is additional to that required for the management of patients with comparable injuries/conditions that are not work related.

Where a report is requested regarding the management of a worker's injury and is additional to any report routinely provided as part of a specialist consultation (refer to clause 6 'Specialist consultations' below) it should be billed under **WCO002** at the above rates. These reports may answer questions to assist the insurer determine prognosis for recovery and timeframes for returning to work. The hourly rate is to be pro-rated into 5 minute blocks to reflect the time taken to prepare the report. The Medical Practitioner requires pre-approval from the insurer for provision of these reports.

If the report is requested as part of a current or potential dispute (for example, when there is lack of agreement regarding liability, causation, capacity for work or treatment between key parties) and the treating Medical Practitioner is requested to provide their opinion, the *Workplace Injury Management and Workers Compensation (Medical Examinations and Reports Fees) Order 2020* applies.

(5) Where medical records are maintained electronically by a Medical Practitioner/practice a flat fee of $60 is payable (for provision of all requested medical records held by the medical practice) inclusive of postage and handling. A Medical Practitioner/practice should not provide or bill for hard copy medical records if they are maintained electronically.

Where medical records are not maintained electronically the maximum fee for providing hard copies of medical records is $38 (for 33 pages or less) and an additional $1.40 per page if more than 33 pages. This fee is inclusive of postage and handling.

Provision of electronic or hard copy medical records is to be billed under State Insurance Regulatory Authority payment classification code **WCO005**.

Where a Medical Practitioner has been requested to provide medical records and the doctor needs to review the records prior to provision (to redact non work-related injury information), the time taken to review the records is to be billed under **WCO002** at the rate specified above at 5(4). The hourly rate is to be pro-rated into 5 minute blocks to reflect the time taken. This fee can be billed in addition to the fees stated above for provision of medical records by hard copy or electronically.

(6) Fees for Assistance at Operation are calculated at 20% of the principal Surgeon/Medical Practitioner's fee for surgical procedure/s performed, but only those surgical procedure/s where an assistance fee is allowed for in the MBS, or $393.20, whichever is the greater. *Assistance at Operation* is only payable once per eligible item number performed by the principal Surgeon irrespective of the number of Medical Practitioners providing Assistance at Operation.

The Medical Practitioner/s providing the *Assistance at Operation* are to invoice for their services separately to the principal Surgeon/Medical Practitioner.

(7) Subject to subclauses (1), (2), (3), (4), (5), (6), (8), (9) and clause 7 (Nil fee for certain medical services) and clause 9 (Nil payment for cancellation or non-attendance) of this Order, the maximum amount for which an employer is liable under the Act for any claim for medical or related treatment is the fee listed, in respect of the medical or related treatment concerned, in the AMA List.

(8) Video consultations are permissible when approved in advance by the insurer. Insurers will consider if the video consultation is appropriate and likely to be effective when making a decision whether to approve these services. Video consultation treatment services are to be paid in accordance with the consultation items in this Order. No additional payment in relation to facility fees can be charged by the Medical Practitioner undertaking the consultation.

(9) Fees for multiple operations or injuries are to be paid in accordance with the AMA List '*Multiple Operations Rule*' with the exception of:

- items specifically listed as a multiple procedure item in the AMA List or where Schedules in the *Workers Compensation (Surgeon Fees) Order 2020* or the *Workers Compensation (Orthopaedic Surgeon Fees) Order 2020* prevent combining of items.
- Medical Practitioners who meet the definition of Surgeon or Orthopaedic surgeon as defined in the *Workers Compensation (Surgeons Fees) Order 2020* or *Workers Compensation (Orthopaedic Surgeons Fees) Order 2020* are to be paid in accordance with the provisions specified in the *Workers Compensation (Surgeon Fees) Order 2020* or, if an Orthopaedic Surgeon, the *Workers Compensation (Orthopaedic Surgeon Fees) Order 2020*.

6. Specialist consultations

The initial Medical Specialist/Consulting Surgeon consultation fee includes the first consultation, the report to the referring Medical Practitioner and copy of the report to the insurer.

The report will contain:

- The worker's diagnosis and present condition;
- An outline of the mechanism of injury;
- The worker's capacity for work;
- The need for treatment or additional rehabilitation; and
- Medical co-morbidities that are likely to impact on the management of the worker's condition (subject to relevant privacy considerations).

A subsequent Medical Specialist/Consulting Surgeon consultation fee includes an attendance with a Medical Specialist/Consulting Surgeon subsequent to the first in a single course of treatment, the report from the subsequent consultation to the referring Medical Practitioner and copy of the report to the insurer.

A subsequent consultation fee is not to be billed if conducted on the same day as surgery or in the normal aftercare that applies following surgery. The cost of these consultations is included in the fee for the surgical procedure.

Consultations with Medical Specialists/Consultant Surgeons require prior approval by the insurer, unless exempt from pre-approval by the Act or the Authority's *Workers Compensation Guidelines*.

7. Nil fee for certain medical services

The AMA List includes items that are not relevant to medical services provided to workers. As such, the fee set for the following items is nil:

- General Practitioner - Urgent attendances after hours item (Medical services identified in the AMA List by AMA number AA007)

- All time based General Practitioner fees items (Medical services identified in the AMA List by AMA numbers AA190 – AA320)

- Enhanced primary care items (Medical services identified in the AMA List by AMA numbers AA501 – AA670, AA850)

- All shared health summary items (Medical services identified in the AMA List by AMA numbers AA340 – AA343)

- Telehealth items (Medical services identified in the AMA List by AMA numbers AA170 – AA210, AA584 – AA670, AF070 – AF180, AF260 – AF370, AJ051 – AJ200, AM210 – AM 240, AP040, and AP050 – AP105).

- Imaging/radiology – Professional attendance items billed in conjunction with imaging /radiology services where an additional interventional procedure/s **has not** been provided by the attending radiologist.

Note: Telephone consultations with workers are discouraged and do not attract a fee.

8. Nil payment for cancellation or non-attendance

No fee is payable for cancellation or non-attendance by a worker for treatment services with a Medical Practitioner/Medical Specialist/Consultant Surgeon.

9. No pre-payment of fees

Pre-payment of fees for reports and services is not permitted.

10. Goods and Services Tax

An amount fixed by this Order is exclusive of GST. An amount fixed by this Order may be increased by the amount of any GST payable in respect of the service to which the cost relates, and the cost so increased is taken to be the amount fixed by this Order. This clause does not permit a Medical Practitioner/Medical Specialist/Consultant Surgeon to charge or recover more than the amount of GST payable in respect of the service to which the cost relates.

11. Requirements for invoices

All invoices should be submitted to the insurer within 30 calendar days of the service provided and must comply with the Authority's itemised invoicing requirements for the invoice to be processed. Refer to the Doctors in workers compensation webpage on the SIRA website - https://www.sira.nsw.gov.au/for-service-providers/A-Z-of-service-providers/doctors-and-other-medical-professionals#Doctors_in_Workers_Comp

WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION (MEDICAL EXAMINATIONS AND REPORTS FEES) ORDER 2020

under the

Workplace Injury Management and Workers Compensation Act 1998

I, Carmel Donnelly, Chief Executive, State Insurance Regulatory Authority, make the following Order pursuant to section 339 of the *Workplace Injury Management and Workers Compensation Act 1998.*

Dated this 11 day December 2019

Carmel Donnelly
Chief Executive
State Insurance Regulatory Authority

Explanatory Note

This Order is not relevant to medical treatment services provided to workers. Please refer to the *Workers Compensation (Medical Practitioner Fees) Order 2020*, *Workers Compensation (Surgeons Fees) Order 2020* and *Workers Compensation (Orthopaedic Surgeons Fees) Order 2020* for medical services fees related to treatment.

Workplace Injury Management and Workers Compensation (Medical Examinations and Reports Fees) Order 2020

Part 1 Preliminary

1. Name of Order

This Order is the *Workplace Injury Management and Workers Compensation (Medical Examinations and Reports Fees) Order 2020*

2. Commencement

This Order commences on 1 January 2020

3. Definitions

In this Order:

the Act means the *Workplace Injury Management and Workers Compensation Act 1998.*

Authority means the State Insurance Regulatory Authority as constituted under section 17 of the *State Insurance and Care Govemance Act 2015.*

Approved Medical Specialist (AMS) has the meaning given by section 319 of the Act. Schedules 3 and 4 of this Order apply to an approved medical specialist.

File Review means a review of the file when the Practitioner is able to provide a report on the basis of a file review alone.

General Practitioner has the meaning given by *subsection 3(1) of the Health Insurance Act 1973 (Cth).* Schedule 1 of this Order applies to a General Practitioner.

GST means the Goods and Services Tax payable under the GST Law.

GST Law has the same meaning as in the *A New Tax System (Goods and Services Tax) Act 1999 (Cth).*

Health Service Provider has the meaning given by section 339 of the Act.

Independent Medical Examiner means an appropriately qualified Medical Practitioner with the expertise to appropriately respond to the questions(s) outlined in the referral. They must have qualifications relevant to the treatment of the worker's injury. If the referral includes a question of causation or treatment, the independent medical examiner is to be in current clinical practice or have recently been in clinical practice, or undertake professional activities such that they are well abreast of clinical practice.

Insurer means the employer's workers compensation insurer.

Medical Examination and Report

i) means an examination and report completed by an Independent Medical Examiner where additional information is required by a party to a current or potential dispute in relation to a claim for workers compensation or work injury damages.

   Video consultations are permissible when requested to provide an opinion in relation to a dispute or potential dispute in respect of a claim made by the worker when approved in advance by the party requesting the service.

   Video consultation examination services are to be paid in accordance with the consultation items in this Order. No additional payment in relation to facility fees can be charged by the Medical Practitioner undertaking the examination;

ii) includes a report prepared by a General Practitioner or a Medical Specialist, who is treating the worker, when requested to provide an opinion in relation to a dispute or potential dispute in respect of a claim made by the worker. For example, when there is lack of agreement regarding liability, causation, capacity for work or treatment between key parties;

iii) does not include reports on the routine management of the worker's injury (these reports are not billable separately as they constitute part of an initial or subsequent specialist consultation (see Clause 6 'Specialist

consultations' in the Workers Compensation (Medical Practitioners Fees) Order 2020));

iv) may be requested to assist decision making on any part of the claim when reports available relating to the management of the worker's injury do not adequately address the issue;

v) are categorised as follows:

a. **Standard Reports** are reports relating solely to a single event or injury in relation to:
   - causation; or
   - capacity for work; or
   - treatment; or
   - simple permanent impairment assessment of one body system.

b. **Moderately Complex Reports are:**

   - reports relating to issues involving a combination of two of the following:
     - causation
     - capacity for work
     - treatment
     - simple permanent impairment assessment of one body system;

   or

   - reports of simple permanent impairment assessment of two body systems or more than one injury to a single body system.

c. **Complex Reports are:**

   - reports relating to issues involving a **combination of three or more** of the following:

     - causation
     - capacity for work
     - treatment
     - simple permanent impairment assessment of one body system;

   or

   - A complex method of permanent impairment assessment on a single body system or multiple injuries involving more than one body system.

Medical Practitioner means a person registered in the medical profession under the *Health Practitioner Regulation National Law (NSW) No 86a,* or equivalent Health Practitioner National Law in their jurisdiction with the Australian Health Practitioner Regulation Agency.

Medical Specialist means a Medical Practitioner recognised as a Specialist in accordance with the *Health Insurance Regulations 2018(Cth), Part 2, Division 4,* who is remunerated at specialist rates under Medicare. Schedule 2 of this Order applies.

Supplementary report means where additional information is provided for review and/or requested, or additional questions are posed. This fee does not apply where the referring party is required to seek clarification because a previous report was ambiguous and/or did not answer questions previously posed.

Unreasonably late attendance means that the worker or interpreter arrives for the scheduled appointment unreasonably late to the degree that a full examination is prevented from being conducted.

Working Days means Monday to Friday (excluding public holidays).

4. Application of Order

This Order applies to an examination and/or report provided on or after the commencement date of this Order, whether it relates to an injury received before, on or after that date.

Part 2 Fees for medical assessments

5. Maximum fees for medical assessments

The following maximum fees are fixed under section 339 of the Act:

a. Maximum fees for the provision of Medical Examinations and/or Reports by General Practitioners as set out in Schedule 1.

b. Maximum fees for the provision of Medical Examinations and Reports by Medical Specialists as set out in Schedule 2.

c. Maximum fees for the provision of medical assessments by an AMS under Part 7 of Chapter 7 of the Act as set out in Schedule 3,

d. Maximum fees for the provision of services by an AMS on an Appeal Panel constituted under section 328 of the Act to hear an appeal against a medical assessment as set out in Schedule 4.

e. The incorrect use of any item referred to in this Order can result in penalties, including the Medical Practitioner being required to repay monies that the Medical Practitioner has incorrectly received.

6. Goods and Services Tax

An amount fixed by this Order is exclusive of GST. An amount fixed by this Order may be increased by the amount of any GST payable in respect of the service to which the cost relates, and the cost so increased is taken to be the amount fixed by this Order. This clause does not permit a Health Service Provider to charge or recover more than the amount of GST payable in respect of the service to which the cost relates.

7. Procedure for Requesting & Paying for Schedules 1 & 2 Services

(1) The party requesting a Medical Examination and/or Report described in Schedules 1 and 2 is to either:

a. agree the category of report being requested with the Medical Practitioner in advance and confirm the request in writing indicating that payment will be made within 10 business days of receipt of a properly completed report and tax invoice; or

b. pay in accordance with a contractual arrangement between the medical practice/Medical Practitioner/medico-legal organisation and the referring body on receipt of a properly completed report and tax invoice.

(2) Where the Medical Practitioner disagrees with the category of report stated in the referral, the Medical Practitioner must explain the complexity of the Medical Examination and/or Report that is required by reference to the 3 categories of complexity specified in the definition of Medical Examination and/or Report and obtain agreement from the referrer before accepting the referral.

(3) Under section 339(3) of the Act, a Health Service Provider is not entitled to be paid or recover any fee for providing a service that exceeds the maximum fee fixed for the provision of that service by this Order. As such, the contractual arrangement referred to in paragraph 7(1) b. above must not provide for the payment of a fee above the maximum fees prescribed in Schedules 1 and 2 of this Order.

(4) Schedules 1 and 2 apply to Medical Examinations and/or Reports that are requested for the purpose of resolving a dispute in relation to a claim for workers compensation or work injury damages, for example, by proving or disproving an entitlement, or the extent of an entitlement to workers compensation or work injury damages. Schedules 1 and 2 do not apply to medical or related treatment reports. Fees for those reports, which usually contain information to assist the insurer determine prognosis for recovery and timeframes for return to work are fixed under the Workers Compensation (Medical Practitioners Fees) Order 2020.

(5) Schedules 1 and 2 provide the maximum fees allowed for the purposes of Items 4 and 5 of the disbursements regulated by Part 3 of Schedule 6 to *The Workers Compensation Regulation 2016.*

8. Requirements for invoices

All invoices should be submitted within 30 calendar days of the service provided and must comply with the Authority's itemised invoicing requirements for the invoice to be processed. Refer to the independent medical examiners webpage on the SIRA website - https://www.sira.nsw.gov.au/for-service-providers/A-Z-of-service-providers/independent-medical-examiner

9. No pre-payment of fees

Pre-payment of fees for reports and services is not permitted.

Schedule 1

Maximum fees for the provision of Medical Examination and/or Report by General Practitioners

Payment Classification Code	Service description	Fee (excl. GST)
IMG001 or WIG001	Examination and report - Standard Report (see definition of Medical Examination and Report).	$603.50
IMG002 or WIG002	Examination conducted with the assistance of an interpreter and report– Standard Report (see definition of Medical Examination and Report).	$673.70
IMG003 or WIG003	Examination and report - Complex Report (see definition of Medical Examination and Report).	$901.00
IMG004 or WIG004	Examination conducted with the assistance of an interpreter and report – Complex Report (see definition of Medical Examination and Report).	$1,049.70
IMG005 or WIG005	Cancellation with 2 working days' notice or less, nonattendance at scheduled appointment or **unreasonably late attendance**.	$147.10
IMG006 or WIG006	File review and report (see definition of File Review).	$446.60
IMG007 or WIG007	Supplementary report (See definition of Supplementary report).	$297.90
IMG008 or WIG008	Update examination and report of worker previously reviewed, where there is no intervening incident.	$376.30
IMG009 or WIG009	Travel.	Reimbursed in accordance with the "Use of private motor vehicle" set out in Item 6 of Table 1 (Rates and Allowances) to Part B (Monetary Rates) of the *Crown Employees (Public Service Conditions of Employment) Reviewed Award 2009, at the rate effective 1 July 2019.* *Use of private motor vehicle:*

Payment Classification Code	Service description	Fee (excl. GST)
		68 cents per kilometre
WCO005	Fees for providing copies of clinical notes and records.	Where medical records are maintained electronically by a medical practitioner/practice a flat fee of $60 is payable (for provision of all requested medical records held by the medical practice) inclusive of postage and handling. A medical practitioner/practice should not provide or bill for hard copy medical records if they are maintained electronically. Where medical records are not maintained electronically the maximum fee for providing hard copies of medical records is $38 (for 33 pages or less) and an additional $1.40 per page if more than 33 pages. This fee is inclusive of postage and handling. Where a medical practitioner has been requested to provide medical records and the doctor needs to review the records prior to provision (to redact non work-related injury information), the time taken to review the records is to be billed under **WCO002** at the rate specified in the *Workers Compensation (Medical Practitioner Fees) Order 2020.* The hourly rate is to be pro-rated into 5 minute blocks to reflect the time taken. This fee can be billed in addition to the fees stated above for provision of medical records by hard copy or electronically.

Schedule 2

Maximum fees for the provision of Medical Examination and Report by Medical Specialists

Payment Classification Code	Service description	Fee (excl. GST)
IMS001 or WIS001	Examination and report - Standard Report (see definition of Medical Examination and Report).	$815.40
IMS002 or WIS002	Examination conducted with the assistance of an interpreter and report – Standard Report (see definition of Medical Examination and Report).	$1,018.10
IMS003 or WIS003	ENT examination (includes audiological testing) and report - Standard Report (see definition of Medical Examination and Report).	$815.40
IMS031 or WIS031	ENT examination (includes audiological testing) conducted with the assistance of an interpreter and report – Standard Report (see definition of Medical Examination and Report).	$1,018.10
IMS004 or WIS004	Examination and report – Moderately Complex Report (see definition of Medical Examination and Report).	$1,222.20
IMS005 or WIS005	Examination conducted with the assistance of an interpreter and report – Moderately Complex Report (see definition of Medical Examination and Report).	$1,426.40
IMS006 or WIS006	Examination and report – Complex Report including complex psychiatric (see definition of Medical Examination and Report).	$1,621.40
IMS007 or WIS007	Examination conducted with the assistance of an interpreter and report – Complex Report (see definition of Medical Examination and Report).	$2,029.70
IMS008 or WIS008	Examination and report – psychiatric.	$1,426.40
IMS081 or WIS081	Examination conducted with the assistance of an interpreter and report – psychiatric.	$1,785.60

Payment Classification Code	Service description	Fee (excl. GST)
IMS092 or WIS092	Cancellation with 2 working days notice or less, nonattendance at scheduled appointment or **unreasonably late attendance**.	$408.90
IMS010 or WIS010	File review and report (see definition of File Review).	$611.00
IMS011 or WIS011	Supplementary report where additional information is provided and requested, or additional questions are posed. This fee does not apply where the referring party is required to seek clarification because a previous report was ambiguous and/or did not answer questions previously posed. (See definition of Supplementary report).	$407.10
IMS012 or WIS012	Update examination and report of worker previously reviewed, where there is no intervening incident.	$603.60
IMS013 or WIS013	Travel.	Reimbursed in accordance with the "Use of private motor vehicle" & "Flying allowance" set out in Item 6 & 14 of Table 1 (Rates and Allowances) to Part B (Monetary Rates) of the *Crown Employees (Public Service Conditions of Employment) Reviewed Award 2009, at the rate effective 1 July 2019.* *Use of private motor vehicle:* *68 cents per kilometre* *Flying allowance:* *$21.70 per hour This is in addition to actual expenses incurred for air travel e.g airfare, taxi fares.*
IMS014 or WIS014	Consolidation of assessments from different Medical Specialists by Lead Assessor to determine the final degree of permanent	$204.40

Payment Classification Code	Service description	Fee (excl. GST)
	impairment resulting from the individual assessments.	
WCO005	Fees for providing copies of clinical notes and records.	Where medical records are maintained electronically by a medical practitioner/practice a flat fee of $60 is payable (for provision of all requested medical records held by the medical practice) inclusive of postage and handling. A medical practitioner/practice should not provide or bill for hard copy medical records if they are maintained electronically. Where medical records are not maintained electronically the maximum fee for providing hard copies of medical records is $38 (for 33 pages or less) and an additional $1.40 per page if more than 33 pages. This fee is inclusive of postage and handling. Where a medical practitioner has been requested to provide medical records and the doctor needs to review the records prior to provision (to redact non work-related injury information), the time taken to review the records is to be billed under **WCO002** at the rate specified in the *Workers Compensation (Medical Practitioner Fees) Order 2020.* The hourly rate is to be pro-rated into 5 minute blocks to reflect the

Payment Classification Code	Service description	Fee (excl. GST)
		time taken. This fee can be billed in addition to the fees stated above for provision of medical records by hard copy or electronically.

Schedule 3

Maximum Fees for Approved Medical Specialists (AMS)

These are maximum fees payable to an Approved Medical Specialist for the provision of medical assessments on medical disputes referred under subsection 321(1) of the Act.

Service description	**Fee (excl. GST)**
Examination and report in accordance with Workers Compensation Commission standards – standard case.	$1,456.50
Examination and report in accordance with Workers Compensation Commission standards - multiple medical assessments e.g. for permanent impairment and general medical disputes.	$1,951.20
Ear, nose and throat examination, includes audiological testing and report.	$1,707.60
Examination and report in accordance with the Workers Compensation Commission standards – psychiatric.	$2,436.70
Cancellation with less than 7 calendar days notice.	$485.70
Cancellation with 2 working days notice or less, nonattendance at scheduled appointment, or **unreasonably** late attendance by worker or interpreter that prevents full examination being conducted.	$971.10
Consolidation of medical assessment certificates by Lead Assessor.	$485.70
Re-examination + medical assessment certificate or reconsideration at request of Workers Compensation Commission.	$729.10
When interpreter present at examination.	Plus $249.70
Miscellaneous Fee at the discretion of the Registrar or delegate.	$485.70 per hour
Travel.	Reimbursed in accordance with the "Use of private motor vehicle" & "Flying allowance" set out in Item 6 & 14 Table 1 (Rates and Allowances) to Part B (Monetary Rates) of the *Crown Employees (Public Service Conditions of Employment) Reviewed Award 2009, at the rate effective 1 July 2019.* *Use of private motor vehicle:* *68 cents per kilometre* *Flying allowance:* *$21.70 per hour. This is in addition to actual expenses incurred for air travel e.g airfare, taxi fares.*

	Other allowances as outlined in Table 1 (Rates and Allowances) may be claimed when appropriate.

Schedule 4

Rates for Approved Medical Specialists on Appeal Panels

These rates are payable to an Approved Medical Specialist when participating as a member of an Appeal Panel at the Workers Compensation Commission.

Service description	Fee (excl. GST)
Assessment, initial telephone conference and decision on papers.	$971.00
Examination of worker and report by AMS.	Fees as per Schedule 3 applies
Cancellation with less than 7 calendar days notice.	$485.70
Cancellation with 2 working days notice or less, nonattendance at scheduled appointment or **unreasonably** late attendance by worker or interpreter that prevents full examination being conducted.	$971.10
Assessment, telephone conference, appeal hearing and decision.	$2,193.30
Additional hearing or teleconference when convened by Arbitrator.	$408.50 per hour
Travel.	Reimbursed in accordance with the "Use of private motor vehicle" & "Flying allowance" set out in Item 6 & 14 of Table 1 (Rates and Allowances) to Part B (Monetary Rates) of the *Crown Employees (Public Service Conditions of Employment) Reviewed Award 2009, at the rate effective 1 July 2019.* *Use of private motor vehicle:* *68 cents per kilometre* *Flying allowance:* *$21.70 per hour This is in addition to actual expenses incurred for air travel e.g airfare, taxi fares.* *Other allowances as outlined in Table 1 (Rates and Allowances)*

Service description	Fee (excl. GST)
	may be claimed when appropriate.

WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION (INJURY MANAGEMENT CONSULTANTS FEES) ORDER 2020

under the

Workplace Injury Management and Workers Compensation Act 1998

I, Carmel Donnelly, Chief Executive, State Insurance Regulatory Authority, make the following Order pursuant to section 339 of the *Workplace Injury Management and Workers Compensation Act 1998.*

Dated this 11 day of December 2019

Carmel Donnelly
Chief Executive
State Insurance Regulatory Authority

Workplace Injury Management and Workers Compensation (Injury Management Consultants Fees) Order 2020

Part 1 Preliminary

1. Name of Order

This Order is the *Workplace Injury Management and Workers Compensation (Injury Management Consultants Fees) Order 2020.*

2. Commencement

This Order commences on 1 January 2020.

3. Definitions

In this Order:

the Act means the *Workplace Injury Management and Workers Compensation Act 1998.*

the Authority means the State Insurance Regulatory Authority as constituted under section 17 of the *State Insurance and Care Governance Act 2015.*

GST means the Goods and Services Tax payable under the GST Law.

GST Law has the same meaning as in the *A New Tax System (Goods and Services Tax) Act 1999 (Cth).*

Injury Management Consultant is a Medical Practitioner approved by the Authority under section 45A of the Act to perform the functions as outlined in the Authority's *Workers Compensation Guidelines* current at the time.

Medical Practitioner means a person registered in the medical profession under the *Health Practitioner Regulation National Law (NSW) No 86a*, or equivalent Health Practitioner National Law in their jurisdiction with the Australian Health Practitioner Regulation Agency.

Unreasonably late attendance means that the worker or interpreter arrives unreasonably late, to the degree that a full examination is prevented from being conducted.

Working days means Monday to Friday (excluding public holidays).

4. Application of Order

This Order applies to all Injury Management Consultant services provided on or after the commencement date of this Order, whether it relates to an injury received before, on, or after that date.

Part 2 Fees for Injury Management Consultants

5. Maximum Fees for Injury Management Consultants

a. For the purposes of section 339 of the Act, the maximum hourly fee for the provision of services by an Injury Management Consultant in connection with a claim for compensation or work injury damages is as set out in the Schedule to this Order.

b. An Injury Management Consultant may not charge for more than 3 hours of work in the absence of express written agreement in advance from the relevant insurer or the Workers Compensation Commission. Where appropriate, an Injury Management Consultant may request approval for additional time where more than three hours are required to complete the Injury Management Consultation and report.

c. An Injury Management Consultant may charge a cancellation fee specified in item IIN107 where a worker provides 2 working days notice or less of cancellation, fails to attend their scheduled appointment, or the worker (or interpreter) attends **unreasonably** late preventing a full examination being conducted.

d. An Injury Management Consultant's report is to be provided to the referrer within 10 working days of the examination, or in the case where no examination has been conducted, within 10 working days of the request having been received, or within a different timeframe if agreed between the parties at the time of referral.

e. The incorrect use of any item referred to in this Order can result in penalties, including the Medical Practitioner being required to repay monies that the Medical Practitioner has incorrectly received.

6. Goods and Services Tax

An amount fixed by this Order is exclusive of GST. An amount fixed by this Order may be increased by the amount of any GST payable in respect of the service to which the cost relates, and the cost so increased is taken to be the amount fixed by this Order. This clause does not permit an Injury Management Consultant to charge or recover more than the amount of GST payable in respect of the service to which the cost relates.

7. Requirements for invoices

All invoices should be submitted to the insurer within 30 calendar days of the service provided and must comply with the Authority's itemised invoicing requirements for the invoice to be processed. Refer to the injury management consultants page on the SIRA website - https://www.sira.nsw.gov.au/for-service-providers/A-Z-of-service-providers/injury-management-consultants

8. No pre-payment of fees

Pre-payment of fees for reports and services is not permitted.

SCHEDULE 1

Rates for Injury Management Consultants

Payment Classification Code	Service description	Fee (excl. GST)
IIN105	Assessments, examinations, file reviews, discussions and reports.	$407.80 per hour to a maximum of 3 hours (unless authorised in advance by the insurer or Workers Compensation Commission).
IIN107	Cancellation with 2 working days notice or less, nonattendance at scheduled appointment or **unreasonably late attendance.**	$407.80.
IIN108	Examination conducted with the assistance of an interpreter.	$509.80 per hour (examination only). Discussions with other parties and report to be charged under IIN105 at $407.80 per hour.
IIN109	Travel for assessment/consultation at the worker's place of work.	$407.80 per hour.

WORKERS COMPENSATION (PSYCHOLOGY AND COUNSELLING FEES) ORDER 2020

under the

Workers Compensation Act 1987

I, Carmel Donnelly, Chief Executive, State Insurance Regulatory Authority, make the following Order pursuant to section 61(2) of the *Workers Compensation Act 1987*.

Dated this 11 day of December 2019

Carmel Donnelly
Chief Executive
State Insurance Regulatory Authority

Explanatory Note

Treatment by a Psychologist or Counsellor is medical or related treatment as defined in section 59 of the *Workers Compensation Act 1987*. This Order sets the maximum fees for which an employer is liable under the Act for any Psychology or Counselling treatment related services provided to a NSW worker. It must not exceed the maximum fee for the treatment or services as specified in this Order. Workers are not liable for the cost of any medical or related treatment covered by this Order. The effect of this Order is to prevent a Psychologist or Counsellor from recovering from the injured worker or employer any extra charge for Psychologist or Counselling treatments covered by the Order.

This Order provides that pre approval by workers compensation insurers must be sought for certain Psychology/Counselling treatment.

The incorrect use of any item referred to in this Order can result in the Psychologist or Counsellor being required to repay monies that the Psychologist or Counsellor has incorrectly received.

The Authority has not set a maximum amount for any medical or related treatment provided in respect of a worker's work related "Severe injury" as defined in this Order.

The Authority has not set a maximum amount for trauma focused psychological treatment provided to an Emergency service worker employed by a Treasury Managed Fund member agency who has been diagnosed with a work related post-traumatic stress disorder.

Fees for these services are to be negotiated with the insurer prior to the delivery of services. Use of the Allied Health Recovery Request is optional for the request of services for workers with Severe injury.

Workers Compensation (Psychology and Counselling Fees) Order 2020

1. Name of Order

This Order is the *Workers Compensation (Psychology and Counselling Fees) Order 2020*

2. Commencement

This Order commences on 1 January 2020.

3. Definitions

In this Order:
the Act means the *Workers Compensation Act 1987*.

the Authority means the State Insurance Regulatory Authority as constituted under section 17 of the *State Insurance and Care Governance Act 2015*.

Allied Health Recovery Request means the form used to request prior approval for treatment and services and to communicate with the insurer about a worker's treatment, timeframes and anticipated outcomes.

Case conference means a face-to-face meeting, video conference or teleconference with any or all of the following parties – worker, employer, workplace rehabilitation provider, insurer or other treatment practitioner/s delivering services to the worker, including the nominated treating doctor. Discussion must seek to clarify the worker's capacity for work, barriers to return to work and strategies to overcome these barriers via an open forum to ensure parties are aligned with respect to expectations and direction of the worker's recovery at work or return to suitable employment. If the discussion is with the worker, it must involve a third party to be considered a Case conference.

Discussions with Independent consultants are not classified as Case conferencing and are not to be charged. Discussions between treating doctors and practitioners relating to treatment are considered a normal interaction and are not to be charged.

File notes of Case conferences are to be documented in the Psychologist's or Counsellor's records indicating the person/s spoken to, details of discussions, duration of the discussion and outcomes. This information may be required for invoicing or auditing purposes.

Counsellor means a Counsellor who is a full clinical member of the Psychotherapy and Counselling Federation of Australia (PACFA), or Accredited Mental Health Social Worker with the Australian Association of Social Workers (AASW) or an Australian Counsellors Association (ACA) member level 3-4. As outlined in the SIRA Workers Compensation Regulation Guideline for approval of treating allied health practitioners, a Counsellor must be approved by the authority to deliver services in the NSW workers compensation system. The requirement to be approved does not apply to treatment provided interstate or to exempt workers.

Counselling services refer to all treatment related services delivered by a Counsellor. Each service is to be billed according to Schedule B.

Emergency service worker means a worker who is employed by a Treasury Managed Fund member agency as an ambulance officer, a police officer or a fire and rescue officer.

Exempt worker refers to specific classes of workers set out in Part 19H of Schedule 6 of the 1987 Act for which most of the amendments made to the Workers Compensation Acts in 2012 and 2015 do not apply. These classes of workers include police officers, paramedics, fire fighters, coal miners and volunteers prescribed by the *Workers Compensation (Bush Fire, Emergency and Rescue Services) Act 1987.*

Expert guidelines means the *Expert guidelines: Diagnosis and treatment of post-traumatic stress disorder in emergency service workers* endorsed by the Black Dog Institute.

Group/class intervention occurs where a Psychologist or Counsellor delivers a common service to more than one (1) person at the same time, for example: group therapy. Maximum class size is six (6) participants.

GST means the Goods and Services Tax payable under the GST Law.

GST Law has the same meaning as in the *A New Tax System (Goods and Services Tax) Act 1999* of the Commonwealth.

Incidental expenses means items the worker actually takes with them for independent use at home (e.g. relaxation CDs and self-help books). This does not apply to consumables used during a consultation or exercise handouts.

Independent consultant review means a review where barriers to recovery, progress, return to work or active participation are evident, and an independent opinion of allied health treatment will benefit the management of the worker's injury. The review must be completed by an Independent consultant approved by the Authority.

Initial Allied Health Recovery Request means the first Allied Health Recovery Request completed and submitted to the insurer for approval by the Psychologist or Counsellor for the claim.

Initial consultation and treatment means the first session provided by the Psychologist or Counsellor in respect of an injury or the first consultation in a new episode of care for the same injury and may include:

- history taking
- assessment
- diagnostic formulation (Psychologists only)
- goal setting and treatment planning
- treatment/service
- clinical recording
- communication with referrer, insurer and other relevant parties, and
- preparation of an Allied Health Recovery Request when indicated.

The service is provided on a one-to-one basis with the worker for the entire session.

Insurer means the employer's workers compensation insurer.

New episode of care means when a worker has ceased treatment more than three (3) months previously and returns for additional treatment for the same injury with the same or different practitioner.

Normal practice means premises in or from which a practitioner regularly operates a Psychology or Counselling practice and treats patients. It also includes facilities where services may be delivered on a regular or contract basis such as a private hospital or workplace.

Psychologist means a Psychologist registered to provide Psychology services with Australian Health Practitioner Regulation Agency (AHPRA). As outlined in the SIRA Workers Compensation Regulation Guideline for approval of treating allied health practitioners, a Psychologist must be approved by the authority to deliver services in the NSW workers compensation system. The requirement to be approved does not apply to treatment provided interstate or to exempt workers.

Psychology services refers to all treatment related services delivered by a Psychologist. Each service is to be billed according to Schedule A.

Report writing occurs only when the insurer requests a Psychologist or Counsellor compile a written report, other than an Allied Health Recovery Request, providing details of the worker's treatment, progress and work capacity. The insurer must provide pre-approval for such a service.

Severe injury means one or more of the following diagnoses:

- spinal cord injury — acute traumatic lesion of the neural elements in the spinal canal (spinal cord and cauda equina) resulting in permanent sensory deficit, motor deficit or bladder/bowel dysfunction as a result of the workplace injury
- traumatic brain injury — based on evidence of a significant brain injury which results in permanent impairments of cognitive, physical and/or psychosocial functions. A defined period of post traumatic amnesia plus a Functional Independence Measure (FIM) at five or less, or two points less than the age appropriate norm (or equivalent where other assessment tools are used) is required
- multiple amputations (or equivalent loss of function) of the upper and/or lower extremities or single amputations (or equivalent loss of function) involving forequarter amputation or shoulder disarticulation, hindquarter amputation, hip disarticulation or "short" trans femoral amputation involving the loss of 65% or more of the length of the femur
- burns — full thickness burns greater than 40 per cent of the total body surface area or full thickness burns to the hands face or genital area, or inhalation burns causing long term respiratory impairment, plus a FIM score at five or less, or two points less than the age norm (or equivalent where other assessment tools are used)
- permanent traumatic blindness, based on the legal definition of blindness.

Standard consultation and treatment means treatment sessions provided subsequent to the Initial consultation and treatment and includes:

- re-assessment
- intervention/treatment
- clinical recording, and
- preparation of an Allied Health Recovery Request when indicated.

The service is one-to-one for the entire session.

Trauma focused psychological treatment means cognitive behavioural therapy or eye movement desensitisation reprocessing provided by a Psychologist in accordance with the *Expert guidelines* as defined in this Order.

Telehealth services mean video consultations. Practitioners must consider the appropriateness of this mode of service delivery for each worker on a case-by-case basis. Telehealth services require pre-approval from the insurer and must be consented to by all parties – the worker, Psychologist or Counsellor and insurer. Fees are not payable for phone consultations in the NSW workers compensation system. Service providers are responsible for delivering Telehealth services in accordance with the principles of professional conduct and the relevant professional and practice guidelines to ensure that all care is taken to ensure the safety, appropriateness and effectiveness of the service.

Travel rates can be claimed when the most appropriate clinical management of the worker requires the Psychologist or Counsellor to travel away from their Normal practice.

Travel costs do not apply where the Psychologist or Counsellor provides services on a regular or contracted basis to facilities such as a private hospital or workplace. Where multiple workers are being treated in the same visit, the travel charge must be divided evenly between those workers.

4. Application of Order

This Order applies to treatment provided on or after 1 January 2020, whether it relates to an injury received before, on or after that date.

5. Maximum fees for Psychology or Counselling treatment

(1) The maximum fee amount for which an employer is liable under the Act for treatment of a worker by a Psychologist or Counsellor, being treatment of a type specified in Column 1 of Schedule A for Psychologists, and Schedule B for Counsellors to this Order, is the corresponding amount specified in Column 2 of those Schedules.

(2) If it is reasonably necessary for a practitioner to provide treatment of a type specified in any of items PSY001, PSY002, PSY004 or PSY006 (for Psychologists) in Schedule A or COU002, COU003, COU005 or COU007 (for Counsellors) in Schedule B at a place other than the Normal practice, the maximum fee amount for which an employer would otherwise be liable under the Act for that type of treatment is increased by;

a) an amount calculated at the rate per kilometre (for the number of kilometres of travel reasonably involved) specified for item PSY005 (for Psychologists) in Column 2 Schedule A and COU006 (for Counsellors) in Column 2 of Schedule B, where this service has been pre-approved by the insurer.

(3) The maximum amount payable for an Initial Allied Health Recovery Request is $38.00 (+ GST). This fee is payable only once per claim for completion of the Initial Allied Health Recovery Request.

(4) Telehealth services are to be billed according to the appropriate items PSY001 to PSY002 (for Psychologists) in Schedule A and items COU002 to COU003 (for Counsellors) in Schedule B and require insurer pre-approval.

6. Treatment provided interstate or to exempt workers

Psychologists or Counsellors approved by the authority must submit their SIRA approval number when invoicing for treatment delivered under the NSW workers compensation system in a State/Territory other than NSW, or to exempt workers.

When an Psychologist or Counsellor is not approved by the Authority and delivering treatment under the NSW workers compensation system in a State/Territory other than NSW or to exempt workers, the service provider number for that service provided:

- interstate is INT0000
- to an exempt worker is EXT0000

and the payment classification code is the one that is relevant to the Psychologist or Counsellor as defined in Schedule A and B item column of this Order.

7. Nil fee for cancellation or non-attendance

No fee is payable for cancellation or non-attendance by a worker for treatment services with a Psychologist or Counsellor.

8. Goods and Services Tax

(1) Psychology treatment services provided by a Psychologist directly to the worker are GST free.

(2) Counselling services provided by a Counsellor directly to the worker are subject to GST.

(3) Case conference, Report writing, Travel services and the Initial Allied Health Recovery Request (AHRR) provided by a Psychologist or Counsellor in relation to treatment of a worker are subject to GST.

(4) An amount fixed by this Order is exclusive of GST. An amount fixed by this Order may be increased by the amount of any GST payable in respect of the service to which the cost relates, and the cost so increased is taken to be the amount fixed by this Order. This clause does not permit a Psychologist or Counsellor to charge or recover more than the amount of GST payable in respect of the service to which the cost relates.

9. Requirements for invoices

All invoices should be submitted within 30 calendar days of the service provided and must be itemised in accordance with Schedule A or B of this Order and comply with the Authority's itemised requirements for the invoice to be processed. Refer to the relevant provider page on the SIRA website - *https://www.sira.nsw.gov.au/for-service-providers/A-Z-of-service-providers*

10. No pre-payment of fees

Pre-payment of fees for reports and services is not permitted.

Schedule A

Maximum fees for Psychologists services

Psychologists **Item**	**Column 1** **Type of Treatment**	**Column 2** **Maximum Amount ($) (excl GST)**
PSY001	Initial consultation and treatment	$234.30
PSY002	Standard consultation and treatment	$195.60
PSY003	Report writing (only when requested by the insurer)	$16.30/ 5 minutes $195.60/hour (maximum 1 hour)
PSY004	Case conference	$16.30/ 5 minutes $195.60/ hour
PSY005	Travel (requires pre-approval by the insurer)	Reimbursed in accordance with the "Use of private motor vehicle" set out in Item 6 of Table 1 (Rates and Allowances) to Part B (Monetary Rates) of the *Crown Employees (Public Service Conditions of Employment) Reviewed Award 2009, at the rate effective 1 July 2019.* *Use of private motor vehicle:* - *68 cents per kilometre*
PSY006	Group/class intervention	$58.50/ participant
PSY007	Trauma focused psychological treatment (for a worker who has been diagnosed with a work-related post traumatic stress disorder).	Must be pre-approved by the insurer. Rates to be negotiated between the practitioner and insurer. Only to be used where treatment is provided to an emergency service worker employed by a Treasury Managed Fund member agency.
OAD001	Incidental expenses e.g. relaxation CD's, books, etc.	Cost price
WCO005	Fees for providing copies of clinical notes and records.	Where clinical records are maintained electronically by an allied health practitioner /practice, a flat fee of $60 is payable (for provision of all requested clinical records held by the practice) inclusive of postage and handling. An allied health practitioner/practice should not provide or bill for hard copy clinical records if they are maintained electronically. Where clinical records are not maintained electronically, the maximum fee for providing hard copies of clinical records is $38 (for 33 pages or less) and an additional $1.40 per page if more than 33 pages. This fee includes postage and handling.

OAS003	Submission of an Initial Allied Health Recovery Request (AHRR) only.	$38.00 (Initial AHRR per claim only) All other Allied Health Recovery Requests submitted are not subject to a fee.

Schedule B

Maximum fees for Counsellors services

Counsellors Item	**Column 1 Type of Treatment**	**Column 2 Maximum Amount ($) (excl GST)**
COU002	Initial consultation and treatment	$174.50
COU003	Standard consultation and treatment	$156.00
COU004	Report writing (only when requested by the insurer)	$13.00/ 5 minutes $156.00/ hour (maximum 1 hour)
COU005	Case conference	$13.00/ 5 minutes $156.00/ hour
COU006	Travel (requires pre-approval from the insurer)	Reimbursed in accordance with the "Use of private motor vehicle" set out in Item 6 of Table 1 (Rates and Allowances) to Part B (Monetary Rates) of the *Crown Employees (Public Service Conditions of Employment) Reviewed Award 2009, at the rate effective 1 July 2019.* *Use of private motor vehicle:* - *68 cents per kilometre*
COU007	Group/class intervention	$49.50/ participant
OAD001	Incidental expenses e.g. relaxation CD's, books, etc	Cost price
WCO005	Fees for providing copies of clinical notes and records.	Where clinical records are maintained electronically by an allied health practitioner /practice, a flat fee of $60 applies for provision of all requested clinical records held by the practice. Where clinical records are not maintained electronically, the maximum fee for providing hard copies of clinical records is $38 (for 33 pages or less) and an additional $1.40 per page if more than 33 pages. This fee includes postage and handling.
OAS003	Submission of an Initial Allied Health Recovery Request (AHRR) only.	$38.00 (Initial AHRR per claim only) All other Allied Health Recovery Requests submitted are not subject to a fee.

(n2019-4069)

WORKERS COMPENSATION (MASSAGE THERAPY FEES) ORDER 2020

under the

Workers Compensation Act 1987

I, Carmel Donnelly, Chief Executive, State Insurance Regulatory Authority, make the following Order pursuant to section 61(2) of the *Workers Compensation Act 1987*.

Dated this 11 day of December 2019

Carmel Donnelly
Chief Executive
State Insurance Regulatory Authority

Explanatory Note

Treatment by a "masseur" is medical or related treatment covered under the *Workers Compensation Act 1987*. For the purposes of this Order, the term "masseur" is interchangeable with "Massage Therapist". This Order sets the maximum fees for which an employer is liable under the Act, for reasonably necessary treatment by a Massage Therapist of a worker's work-related injury.

Any Massage Therapy treatment related services provided to a NSW worker must not exceed the maximum fee for the treatment or service as specified in this Order. Workers are not liable for the cost of any medical or related treatment covered by this Order

The effect of this Order is to prevent a Massage Therapist from recovering from the injured worker or employer any extra charge for treatments covered by the Order.

This Order provides that pre-approval by workers compensation insurers must be sought for certain Massage Therapy services.

The incorrect use of any item referred to in this Order can result in the Massage Therapist being required to repay monies that the Massage Therapist has incorrectly received.

Workers Compensation (Massage Therapy Fees) Order 2020

1. Name of Order

This Order is the *Workers Compensation (Massage Therapy Fees) Order 2020*

2. Commencement

This Order commences on 1 January 2020.

3. Definitions

In this Order:

the Act means the *Workers Compensation Act 1987*.

the Authority means the State Insurance Regulatory Authority as constituted under section 17 of the *State Insurance and Care Governance Act 2015*.

Allied Health Recovery Request (AHRR) means the form to be used by the practitioner to request prior approval for treatment and services and to communicate to the insurer about a worker's treatment, timeframes and anticipated outcomes.

Consultation and treatment includes:

- history taking
- assessment/re-assessment
- goal setting and treatment planning
- treatment/service
- clinical recording
- communication with referrer, insurer and other relevant parties, and
- preparation of an Allied Health Recovery Request when indicated.

GST means the Goods and Services Tax payable under the GST Law.

GST Law has the same meaning as in the *A New Tax System (Goods and Services Tax) Act 1999* of the Commonwealth.

Insurer means the employer's workers compensation insurer

Massage Therapist means any person providing Massage Therapy services.

For the purposes of this Order, the term "masseur" is interchangeable with "Massage Therapist".

Massage Therapy services refers to treatment services limited to soft tissue massage targeting specific musculoskeletal injuries. Each service is to be billed according to Schedule A.

4. Application of Order

This Order applies to treatment provided on or after 1 January 2020, whether it relates to an injury received before, on or after that date.

5. Maximum fees for Massage Therapy

The maximum fee amount for which an employer is liable under the Act for treatment of a worker by a Massage Therapist, being treatment of a type specified in Column 1 of Schedule A to this Order, is the corresponding amount specified in Column 2 of that Schedule.

6. Treatment provider number

The service provider number to be used is INT0000 and the payment classification code is the one that is relevant to NSW Massage Therapists, as defined in Schedule A in the column headed ***"Item"*** of this Order.

7. Nil fees for cancellation or non-attendance

No fee is payable for cancellation or non-attendance by a worker for treatment services with a Massage Therapist.

8. Goods and Services Tax (GST)

(1) Massage Therapy services are subject to GST.

(2) An amount fixed by this Order is exclusive of GST. An amount fixed by this Order may be increased by the amount of any GST payable in respect of the service to which the cost relates, and the cost so increased is taken to be the amount fixed by this Order. This clause does not permit a Massage Therapist to charge or recover more than the amount of GST payable in respect of the service to which the cost relates.

9. Requirements for invoices

All invoices should be submitted within 30 calendar days of the service provided and must be itemised in accordance with Schedule A and comply with the Authority's requirements for the invoice to be processed. Refer to the relevant provider page on the SIRA website - *https://www.sira.nsw.gov.au/for-service-providers/A-Z-of-service-providers*

10. No pre-payment of fees

Pre-payment of fees for reports and services is not permitted.

Schedule A

Maximum fees for Massage Therapists (including interstate practitioners)

Item	Column 1 Type of Treatment	Column 2 Maximum Amount (excl GST)
RMA001	Consultation and treatment (60 minutes duration)	$85.70
RMA002	Consultation and treatment (45 minutes duration)	$64.20
RMA003	Consultation and treatment (30 minutes duration)	$43.00
WCO005	Fees for providing copies of clinical notes and records.	Where clinical records are maintained electronically by an allied health practitioner /practice, a flat fee of $60 is payable (for provision of all requested clinical records held by the practice) inclusive of postage and handling. An allied health practitioner/practice should not provide or bill for hard copy clinical records if they are maintained electronically. Where clinical records are not maintained electronically, the maximum fee for providing hard copies of clinical records is $38 (for 33 pages or less) and an additional $1.40 per page if more than 33 pages. This fee includes postage and handling.

WORKERS COMPENSATION (ACCREDITED EXERCISE PHYSIOLOGY FEES) ORDER 2020

under the

Workers Compensation Act 1987

I, Carmel Donnelly, Chief Executive, State Insurance Regulatory Authority, make the following Order pursuant to section 61(2) of the *Workers Compensation Act 1987*.

Dated this 11 day of December 2019

Carmel Donnelly
Chief Executive
State Insurance Regulatory Authority

Explanatory Note

Treatment by a remedial medical gymnast is medical or related treatment as defined in section 59 of the *Workers Compensation Act 1987*. For the purposes of this Order, the term "remedial medical gymnast" is interchangeable with "Accredited Exercise Physiologist". This Order sets the maximum fees for which an employer is liable under the Act for any Accredited Exercise Physiology treatment related services provided to a NSW worker. It must not exceed the maximum fee for the treatment or service as specified in this Order. Workers are not liable for the cost of any medical or related treatment covered by this Order. The effect of this Order is to prevent an Accredited Exercise Physiologist from recovering from the injured worker or employer any extra charge for Accredited Exercise Physiology treatments covered by the Order.

This Order provides that pre-approval by workers compensation insurers must be sought for certain Accredited Exercise Physiology treatment.

The incorrect use of any item referred to in this Order can result in the Accredited Exercise Physiologist being required to repay monies that the Accredited Exercise Physiologist has incorrectly received.

The Authority has not set a maximum amount for any medical or related treatment provided in respect of a worker's work related "Severe injury" as defined in this Order. Fees for this treatment are to be negotiated with the insurer prior to the delivery of the treatment. Use of the Allied Health Recovery Request is optional for the request of treatment for workers with Severe injury.

Workers Compensation (Accredited Exercise Physiology Fees) Order 2020

1. Name of Order

This Order is the *Workers Compensation (Accredited Exercise Physiology Fees) Order 2020*.

2. Commencement

This Order commences on 1 January 2020.

3. Definitions

In this Order:

the Act means the Workers Compensation Act 1987.

the Authority means the State Insurance Regulatory Authority as constituted under section 17 of the *State Insurance and Care Governance Act 2015.*

Accredited Exercise Physiology treatment related services refers to clinical exercise prescription, instruction and supervision, health education and exercise-based lifestyle and behaviour modification services. Each service is to be billed according to Schedule A.

Accredited Exercise Physiologist means an exercise physiologist accredited by Exercise and Sports Science Australia (ESSA) to provide Accredited Exercise Physiology services. As outlined in the SIRA Workers Compensation Regulation Guideline for approval of treating allied health practitioners, an Accredited Exercise Physiologist must be approved by the authority to deliver services in the NSW workers compensation system. The requirement to be approved does not apply to treatment provided interstate or to exempt workers.

For the purposes of this Order, the term "remedial medical gymnast" is interchangeable with "Accredited Exercise Physiologist.

Allied Health Recovery Request means the form used to request prior approval for treatment and services and to communicate with the insurer about a worker's treatment, timeframes and anticipated outcomes.

Case conference means a face-to-face meeting, video conference or teleconference with any or all of the following parties – worker, employer, workplace rehabilitation provider, insurer or other treatment practitioner/s delivering services to the worker, including the nominated treating doctor. Discussion must seek to clarify the worker's capacity for work, barriers to return to work and strategies to overcome these barriers via an open forum to ensure parties are aligned with respect to expectations and direction of the worker's recovery at work or return to suitable employment. If the discussion is with the worker, it must involve a third party to be considered a Case conference.

Discussions with Independent consultants are not classified as Case conferencing and are not to be charged. Discussions between treating doctors and practitioners relating to treatment are considered a normal interaction and are not to be charged.

File notes of Case conferences are to be documented in the Accredited Exercise Physiologist's records indicating the person/s spoken to, details of discussions, duration of the discussion and outcomes. This information may be required for invoicing or auditing purposes.

Exempt worker refers to specific classes of workers set out in Part 19H of Schedule 6 of the 1987 Act for which most of the amendments made to the Workers Compensation Acts in 2012 and 2015 do not apply. These classes of workers include police officers, paramedics, fire fighters, coal miners and volunteers prescribed by the *Workers Compensation (Bush Fire, Emergency and Rescue Services) Act 1987*.

External facility means an external facility such as a gymnasium or pool, where the facility is not owned or operated by the treatment provider or where the provider does not contract their services to the facility.

Group/class intervention occurs where an Accredited Exercise Physiologist delivers the same service that is, the same exercise and instruction, to more than one person at the same time. Maximum class size is six (6) participants.

GST means the Goods and Services Tax payable under the GST Law.

GST Law has the same meaning as in the *A New Tax System (Goods and Services Tax) Act 1999* of the Commonwealth.

Incidental expenses means items the worker actually takes with them for independent use at home (e.g. strapping tape, theraband, exercise putty, disposable electrodes, walking stick). This does not apply to consumables used during a consultation or exercise handouts.

Independent consultant review means a review where barriers to recovery, progress, return to work or active participation are evident, and an independent opinion of allied health treatment will benefit the management of the worker's injury. The review must be completed by an Independent consultant approved by the Authority.

Initial Allied Health Recovery Request means the first Allied Health Recovery Request completed and submitted to the insurer for the claim.

Initial consultation and treatment means the first session, provided by the Accredited Exercise Physiologist in respect of an injury, or the first consultation in a new episode of care for the same injury and may include:

- history taking
- physical assessment
- goal setting and treatment planning
- treatment/service

- clinical recording
- communication with referrer, insurer and other relevant parties, and
- preparation of an Allied Health Recovery Request when indicated.

The service is provided on a one-to-one basis with the worker for the entire session. It is a maximum of one hour duration, or where less than one hour should be pro-rated into 5 minute blocks to reflect the time taken.

Insurer means the employer's workers compensation insurer.

New episode of care means when a worker has ceased treatment more than three (3) months previously and returns for additional treatment for the same injury with the same or a different practitioner.

Normal practice means premises in or from which an Accredited Exercise Physiologist regularly operates an exercise physiology practice and treats patients. It also includes facilities where services may be delivered on a regular basis or as a contracted service, such as a private hospital, hydrotherapy pool or gymnasium.

Reduced supervision treatment occurs where an Accredited Exercise Physiologist delivers a service, which may or may not be the exact same exercise and instruction, to more than one person at the same time. Maximum number of persons per session is three (3), with the Accredited Exercise Physiologist to worker ratio being one-to-one for at least 30% of the session time.

Report writing occurs only when the insurer requests an Accredited Exercise Physiologist compile a written report, other than an Allied Health Recovery Request, providing details of the worker's treatment, progress and work capacity. The insurer must provide pre-approval for such a service.

Severe injury means one or more of the following diagnoses:

- spinal cord injury — acute traumatic lesion of the neural elements in the spinal canal (spinal cord and cauda equina) resulting in permanent sensory deficit, motor deficit or bladder/bowel dysfunction as a result of the workplace injury
- traumatic brain injury — based on evidence of a significant brain injury which results in permanent impairments of cognitive, physical and/or psychosocial functions. A defined period of post traumatic amnesia plus a Functional Independence Measure (FIM) at five or less, or two points less than the age appropriate norm (or equivalent where other assessment tools are used) is required
- multiple amputations (or equivalent loss of function) of the upper and/or lower extremities or single amputations (or equivalent loss of function) involving forequarter amputation or shoulder disarticulation, hindquarter amputation, hip disarticulation or "short" trans femoral amputation involving the loss of 65% or more of the length of the femur
- burns — full thickness burns greater than 40 per cent of the total body surface area or full thickness burns to the hands, face or genital area, or inhalation burns causing long term respiratory impairment, plus a FIM score at five or less, or two points less than the age norm (or equivalent where other assessment tools are used)
- permanent traumatic blindness, based on the legal definition of blindness.

Standard consultation and treatment means treatment provided subsequent to the initial consultation and treatment and includes:

- re-assessment
- intervention/treatment
- clinical recording
- preparation of an Allied Health Recovery Request when indicated.

The services are provided on a one-to-one basis with the worker for the entire session. They are a maximum of one hour duration, or where less than one hour should be pro-rated into 5 minute blocks to reflect the time taken.

Telehealth services mean video consultations. Accredited Exercise Physiologists must consider the appropriateness of this mode of service delivery for each worker on a case-by-case basis. Telehealth services require pre-approval from the insurer and must be consented to by all parties – the worker, Accredited Exercise Physiologist and insurer. Phone consultations are not payable in the NSW workers compensation system. Service providers are responsible for delivering Telehealth services in accordance with the principles of professional conduct and the relevant professional and practice guidelines to ensure that all care is taken to ensure the safety, appropriateness and effectiveness of the service.

Travel rates can be claimed when the most appropriate clinical management of the worker requires the Accredited Exercise Physiologist to travel away from their Normal practice.

Travel costs do not apply where the Accredited Exercise Physiologist provides services on a regular or contracted basis to facilities such as a private hospital, hydrotherapy pool, or gymnasium. Where multiple workers are being treated in the same visit, the travel charge must be divided evenly between those workers.

4. Application of Order

This Order applies to treatment provided on or after 1 January 2020, whether it relates to an injury received before, on or after that date.

5. Maximum fees for Accredited Exercise Physiologists

(1) The maximum fee amount for which an employer is liable under the Act for treatment of a worker by an Accredited Exercise Physiologist, being treatment of a type specified in Column 1 of Schedule A to this Order, is the corresponding amount specified in Column 2 of that Schedule.

(2) If it is reasonably necessary for an Accredited Exercise Physiologist to provide a service of a type specified in any of items EPA001 to EPA004 in Schedule A at a place other than the Normal practice, the maximum fee amount for which an employer would otherwise be liable under the Act for that type of service is increased by;

a) an amount calculated at the rate per kilometre (for the number of kilometres of travel reasonably involved) specified for item EPA008 in Column 2 of Schedule A, where this service has been pre-approved by the insurer.

(3) The maximum amount payable for an Initial Allied Health Recovery Request is $38.00 (+ GST). This fee is payable only once (1) per claim for completion of the Initial Allied Health Recovery Request.

(4) Telehealth services are to be billed according to the appropriate items EPA001 to EPA004 in Schedule A and require insurer pre-approval.

6. Treatment provided interstate or to exempt workers

Accredited Exercise Physiologists approved by the authority must submit their SIRA approval number when invoicing for treatment delivered under the NSW workers compensation system in a State/Territory other than NSW, or to exempt workers.

When an Accredited Exercise Physiologist is not approved by the Authority and delivering treatment under the NSW workers compensation system in a State/Territory other than NSW or to exempt workers, the service provider number for that service provided:

- interstate is INT0000
- to an exempt worker is EXT0000

and the payment classification code is the one that is relevant to the Accredited Exercise Physiologist as defined in Schedule A item column of this Order.

7. External facility fees

In the exceptional circumstance where approval is given for treatment to be provided at an external facility, the facility (and not the service provider) is to invoice the insurer directly under code OTT007. Where this is not possible, the service provider must clearly state the name, location and charge the cost price of the facility on their invoice and attach a copy of the facilities invoice to their account.

External facility fees only apply to the cost for the worker's entry. Fees payable for the entry of the Accredited Exercise Physiologist are a business cost and cannot be charged to the insurer.

An entry fee will not be paid where the facility is owned or operated by the treatment provider or the provider contracts their services to the facility.

8. Nil fees for cancellation or non-attendance

No fee is payable for cancellation or non-attendance by a worker for treatment services with an Accredited Exercise Physiologist.

9. Goods and Services Tax

(1) Accredited Exercise Physiology services are subject to GST.

(2) Case conferences, Report writing, Travel services and the Initial Allied Health Recovery Request (AHRR) provided by an Accredited Exercise Physiologist in relation to treatment of a worker are subject to GST.

(3) An amount fixed by this Order is exclusive of GST. An amount fixed by this Order may be increased by the amount of any GST payable in respect of the service to which the cost relates, and the cost so increased is taken to be the amount fixed by this Order. This clause does not permit an Accredited Exercise Physiologist to charge or recover more than the amount of GST payable in respect of the service to which the cost relates.

10. Requirements for invoices

All invoices should be submitted within 30 calendar days of the service provided and must be itemised in accordance with Schedule A of this Order and comply with the Authority's itemised invoicing requirements for the invoice to be processed.Refer to the relevant provider page on the SIRA website - *https://www.sira.nsw.gov.au/for-service-providers/A-Z-of-service-providers*

11. No pre-payment of fees

Pre-payment of fees for reports and services is not permitted.

Schedule A

Maximum fees for Accredited Exercise Physiologists services

Item	Column 1 Type of Treatment	Column 2 Maximum Amount ($) (excl GST)
EPA001	Initial consultation and treatment	$13.10/ 5 minutes $157.20/ hour (maximum 1 hour)
EPA002	Standard consultation and treatment	$13.10/ 5 minutes $157.20/ hour (maximum 1 hour)
EPA003	Reduced supervision treatment	$68.50
EPA004	Group/class intervention	$49.90/participant
EPA005	Incidental expenses e.g. strapping tape, theraband, exercise putty, etc. **Note:** This code does not apply to external facility fees	Cost price
EPA006	Case conference	$13.10/ 5 minutes $157.20/ hour
EPA007	Report writing (only when requested by the insurer)	$13.10/ 5 minutes $157.20/ hour (maximum 1 hour)
EPA008	Travel (requires pre-approval by the insurer)	Reimbursed in accordance with the "Use of private motor vehicle" set out in Item 6 of Table 1 (Rates and Allowances) to Part B (Monetary Rates) of the *Crown Employees (Public Service Conditions of Employment) Reviewed Award 2009, at the rate effective 1 July 2019.* *Use of private motor vehicle:* - *68 cents per kilometre*
WCO005	Fees for providing copies of clinical notes and records.	Where clinical records are maintained electronically by an allied health practitioner /practice, a flat fee of $60 (is payable for provision of all requested clinical records held by the practice). Inclusive of postage and handling. An allied health practitioner/practice should not provide or bill for hard copy clinical records if they are maintained electronically. Where clinical records are not maintained electronically, the maximum fee for providing hard copies of clinical records is $38 (for 33 pages or less) and an additional $1.40 per page if more than 33 pages. This fee includes postage and handling.
OAS003	Submission of an Initial Allied Health Recovery Request (AHRR) only.	$38.00 (Initial AHRR per claim only) All other Allied Health Recovery Requests submitted are not subject to a fee.

(n2019-4071)

WORKERS COMPENSATION (PHYSIOTHERAPY, CHIROPRACTIC AND OSTEOPATHY FEES) ORDER 2020

under the

Workers Compensation Act 1987

I, Carmel Donnelly, Chief Executive, State Insurance Regulatory Authority, make the following Order pursuant to section 61(2) of the *Workers Compensation Act 1987*.

Dated this 11 day of December 2019

Carmel Donnelly
Chief Executive
State Insurance Regulatory Authority

Explanatory Note

Treatment by a Physiotherapist, Chiropractor or Osteopath is medical or related treatment covered under the *Workers Compensation Act 1987*. This Order sets the maximum fees for which an employer is liable under the Act for any Physiotherapy, Chiropractic and Osteopathy treatment related services provided to an NSW worker. It must not exceed the maximum fee for the treatment or service as specified in this Order. Workers are not liable for the cost of any medical or related treatment covered by this Order. The effect of this Order is to prevent a Physiotherapist, Chiropractor or Osteopath from recovering from the injured worker or employer any extra charge for Physiotherapy, Chiropractic and Osteopathy treatment covered by the Order.

This Order provides that pre- approval by workers compensation insurers must be sought for certain Physiotherapy, Chiropractic and Osteopathy treatment.

The incorrect use of any item referred to in this Order can result in the Physiotherapist, Chiropractor or Osteopath being required to repay monies that the Physiotherapist, Chiropractor or Osteopath has incorrectly received.

The Authority has not set a maximum amount for any medical or related treatment provided in respect of a worker's work related "Severe injury" as defined in this Order. Fees for this treatment are to be negotiated with the insurer prior to the delivery of services. Use of the Allied Health Recovery Request is optional for the request of treatment for workers with Severe injury.

Workers Compensation (Physiotherapy, Chiropractic and Osteopathy Fees) Order 2020

1. Name of Order

This Order is the *Workers Compensation (Physiotherapy, Chiropractic and Osteopathy Fees) Order 2020*

2. Commencement

This Order commences on 1 January 2020.

3. Definitions

In this Order:

The Act means the *Workers Compensation Act 1987*.

the Authority means the State Insurance Regulatory Authority as constituted under section 17 of the *State Insurance and Care Governance Act 2015*.

Allied Health Recovery Request means the form used to request prior approval for treatment and services and to communicate with the insurer about a worker's treatment, timeframes and anticipated outcomes.

Case conference means a face-to-face meeting, video conference or teleconference with any or all the following parties – worker, employer, workplace rehabilitation provider, insurer or other treatment practitioner/s delivering services to the worker, including the nominated treating doctor. Discussion must seek to clarify the worker's capacity for work, barriers to return to work and strategies to overcome these barriers via an open forum to ensure parties are aligned with respect to expectations and direction of the worker's recovery at work or return to suitable employment. If the discussion is with the worker, it must involve a third party to be considered a Case conference.

Discussions with Independent consultants are not classified as Case conferencing and are not to be charged. Discussions between treating doctors and practitioners relating to treatment are considered a normal interaction and are not to be charged.

File notes of Case conferences are to be documented in the Physiotherapist's, Chiropractor's or Osteopath's records indicating the person/s spoken to, details of discussions, duration of the discussion and outcomes. This information may be required for invoicing or auditing purposes.

Chiropractor means a Chiropractor registered with Australian Health Practitioner Regulation Agency. As outlined in the SIRA Workers Compensation Regulation Guideline for approval of treating allied health practitioners, a Chiropractor must be approved by the authority to deliver services in the NSW workers compensation system. The requirement to be approved does not apply to treatment provided interstate or to exempt workers.

Chiropractic services refer to all treatment related services delivered by a Chiropractor. Each service is to be billed in accordance with Schedule A.

Complex treatment means treatment related to complex pathology and clinical presentation including extensive burns, complicated hand injuries involving multiple joints or tissues and some complex neurological conditions, spinal cord injuries, head injuries and major trauma. Provision of complex treatment requires pre-approval from the insurer. It is expected that only a small number of claimants will require treatment falling within this category.

Exempt worker refers to specific classes of workers set out in Part 19H of Schedule 6 of the 1987 Act for which most of the amendments made to the Workers Compensation Acts in 2012 and 2015 do not apply. These classes of workers include police officers, paramedics, fire fighters, coal miners and volunteers prescribed by the *Workers Compensation (Bush Fire, Emergency and Rescue Services) Act 1987.*

External facility means an external facility such as a gymnasium or pool, where the facility is not owned or operated by the treatment provider or where the provider does not contract their services to the facility.

Group/class intervention occurs where a Physiotherapist, Chiropractor or Osteopath delivers a common service to more than one person at the same time. Examples are education, exercise groups, aquatic classes/hydrotherapy. Maximum class size is six (6) participants.

GST means the Goods and Services Tax payable under the GST Law.

GST Law has the same meaning as in the *A New Tax System (Goods and Services Tax) Act 1999* of the Commonwealth.

Home visit applies in cases where, due to the effects of the injury sustained, the worker is unable to travel. The home visit must be the best and most cost-effective option allowing the practitioner to travel to the worker's home to deliver treatment. Provision of home visit treatment requires pre-approval from the insurer.

Incidental expenses means items the worker actually takes with them for independent use at home (e.g. strapping tape, theraband, exercise putty, disposable electrodes, walking stick). This does not apply to consumables used during a consultation or exercise handouts.

Independent consultant review means a review where barriers to recovery, progress, return to work or active participation are evident, and an independent opinion of allied health treatment

will benefit the management of the worker's injury. The review must be completed by an Independent consultant approved by the Authority.

Initial Allied Health Recovery Request means the first Allied Health Recovery Request completed and submitted to the insurer for the claim.

Initial consultation and treatment means the first session provided by the Physiotherapist, Chiropractor or Osteopath in respect of an injury or the first consultation in a new episode of care for the same injury and may include:

- history taking
- physical assessment
- diagnostic formulation
- goal setting and treatment planning
- treatment/service
- clinical recording
- communication with referrer, insurer and other relevant parties, and
- preparation of an Allied Health Recovery Request when indicated.

The service is provided on a one to one basis with the worker for the entire session.

Insurer means the employer's workers compensation insurer.

New episode of care means when a worker has ceased treatment more than three (3) months previously and returns for additional treatment for the same injury with the same or a different practitioner.

Normal practice means premises in or from which a practitioner regularly operates a Physiotherapy, Chiropractic or Osteopathy practice and treats patients. It also includes facilities where services may be delivered on a regular or contracted basis such as a private hospital, hydrotherapy pool or gymnasium.

Osteopath means an Osteopath registered with Australian Health Practitioner Regulation Agency. As outlined in the SIRA Workers Compensation Regulation Guideline for approval of treating allied health practitioners, an Osteopath must be approved by the authority to deliver services in the NSW workers compensation system. The requirement to be approved does not apply to treatment provided interstate or to exempt workers.

Osteopathy services refer to all treatment related services delivered by an Osteopath. Each service is to be billed in accordance with Schedule A.

Physiotherapist means a Physiotherapist registered with Australian Health Practitioner Regulation Agency. As outlined in the SIRA Workers Compensation Regulation Guideline for approval of treating allied health practitioners, a Physiotherapist must be approved by the authority to deliver services in the NSW workers compensation system. The requirement to be approved does not apply to treatment provided interstate or to exempt workers.

Physiotherapy services refer to all treatment related services delivered by a Physiotherapist. Each service is to be billed in accordance with Schedule A.

Report writing occurs only when the insurer requests a Physiotherapist, Chiropractor or Osteopath compile a written report, other than the Allied Health Recovery Request, providing details of the worker's treatment, progress and work capacity. The insurer must provide pre-approval for such a service.

Severe injury means one or more of the following diagnoses:

- spinal cord injury — acute traumatic lesion of the neural elements in the spinal canal (spinal cord and cauda equina) resulting in permanent sensory deficit, motor deficit or bladder/bowel dysfunction as a result of the workplace injury
- traumatic brain injury — based on evidence of a significant brain injury which results in permanent impairments of cognitive, physical and/or psychosocial functions. A defined period of post traumatic amnesia plus a Functional Independence Measure (FIM) at five or less, or two points less than the age appropriate norm (or equivalent where other assessment tools are used) is required

- multiple amputations (or equivalent loss of function) of the upper and/or lower extremities or single amputations (or equivalent loss of function) involving forequarter amputation or shoulder disarticulation, hindquarter amputation, hip disarticulation or "short" trans femoral amputation involving the loss of 65% or more of the length of the femur
- burns — full thickness burns greater than 40 per cent of the total body surface area or full thickness burns to the hands, face or genital area, or inhalation burns causing long term respiratory impairment, plus a FIM score at five or less, or two points less than the age norm (or equivalent where other assessment tools are used)
- permanent traumatic blindness, based on the legal definition of blindness.

Standard consultation and treatment means treatment sessions provided subsequent to the Initial consultation and treatment and includes:

- re-assessment
- intervention/treatment
- clinical recording, and
- preparation of an Allied Health Recovery Request when indicated.

The standard consultation rate is to be billed by the Physiotherapist, Chiropractor or Osteopath irrespective of the modality of treatment delivered during the consultation, provided it is on a one-to-one basis with the worker. Treatment may include but is not limited to manual therapy, education regarding self-management strategies, exercise prescription, acupuncture and aquatic therapy/hydrotherapy.

Telehealth services mean video consultations. Practitioners must consider the appropriateness of this mode of service delivery for each worker on a case-by-case basis. Telehealth services require pre-approval from the insurer and must be consented to by all parties – the worker, practitioner and insurer. Phone consultations are not payable in the NSW workers compensation system. Service providers are responsible for delivering Telehealth services in accordance with the principles of professional conduct and the relevant professional and practice guidelines to ensure that all care is taken to ensure the safety, appropriateness and effectiveness of the service.

Travel rates can be claimed when the most appropriate clinical management of the worker requires the Physiotherapist, Chiropractor or Osteopath to travel away from their Normal practice.

Travel costs do not apply where the Physiotherapist, Chiropractor or Osteopath provides services on a regular or contracted basis to facilities such as a private hospital, hydrotherapy pool or gymnasium. Where multiple workers are being treated in the same visit, the travel charge must be divided evenly between those workers.

Two (2) distinct areas means where two (2) entirely separate compensable injuries or conditions are assessed and treated and where treatment applied to one condition does not affect the symptoms of the other injury e.g. neck condition plus post fracture wrist. It does not include a condition with referred symptoms to another area.

Work related activity assessment consultation and treatment means a session provided on a one-to-one basis for work related activity, for a maximum of one hour duration, or where less than one hour should be pro-rated into 5 minute blocks to reflect the time taken. This includes:

- assessment/reassessment
  - assessment of current condition including functional status
  - review of previous treatment
- goal setting and treatment/work related activity planning
- delivery of intervention/treatment
  - clinical recording
  - communication with key parties
  - preparation of an Allied Health Recovery Request when indicated.

Note: aquatic therapy/hydrotherapy is not considered work related activity and cannot be billed using this code.

4. Application of Order

This Order applies to treatment provided on or after 1 January 2020 whether it relates to an injury received before, on or after that date.

5. Maximum fees for Physiotherapy, Chiropractic or Osteopathy treatment

(1) The maximum fee amount for which an employer is liable under the Act for treatment of a worker by a Physiotherapist, Chiropractor or Osteopath, being treatment of a type specified in Column 1 of Schedule A to this Order, is the corresponding amount specified in Column 2 of that Schedule.

(2) If it is reasonably necessary for a practitioner to provide treatment of a type specified in any of items PTA007 to PTA011 (for Physiotherapy), CHA005, CHA006, CHA071, CHA072 or CHA073 (for Chiropractic) or OSA007 to OSA011 (for Osteopathy) in Schedule A at a place other than the Normal practice (including the worker's home), the maximum fee amount for which an employer would otherwise be liable under the Act for that type of treatment is increased by:

a) an amount calculated at the rate per kilometre (for the number of kilometres of travel reasonably involved) specified for item PTA014 (Physiotherapy), CHA009 (Chiropractic), or OSA014 (Osteopathy) in Column 2 of Schedule A, where this service has been pre-approved by the insurer.

(3) The maximum amount payable for an Initial Allied Health Recovery Request is $38.00 (+ GST). This fee is payable only once (1) per claim for completion of the Initial Allied Health Recovery Request.

(4) Telehealth services are to be billed according to the appropriate items PTA001 to PTA006 (for Physiotherapy); CHA001, CHA002, CHA031, CHA032, CHA033 or CHA010 (for Chiropractic) and OSA001 to OSA006 (for Osteopathy) in Schedule A and require insurer pre-approval.

6. Treatment provided interstate or to exempt workers

Physiotherapists, Chiropractors and Osteopaths approved by the authority must submit their SIRA approval number when invoicing for treatment delivered under the NSW workers compensation system in a State/Territory other than NSW, or to exempt workers.

When a Physiotherapist, Chiropractor or Osteopath is not approved by the Authority and delivering treatment under the NSW workers compensation system in a State/Territory other than NSW or to exempt workers, the service provider number for that treatment provided:

- interstate is INT0000
- to an exempt worker is EXT0000

and the payment classification code is the one that is relevant to the Physiotherapist, Chiropractor or Osteopath as defined in Schedule A item column of this Order.

7. External facility fees

In the exceptional circumstance where approval is given for treatment to be provided at an external facility, the facility (and not the service provider) is to invoice the insurer directly under code OTT007. Where this is not possible, the service provider must clearly state the name, location and charge cost price of the facility on their invoice and attach a copy of the facilities invoice to their account.

External facility fees only apply to the cost for the worker's entry. Fees payable for the entry of the practitioner are a business cost and cannot be charged to the insurer.

An entry fee will not be paid where the facility is owned or operated by the treatment practitioner or the treatment practitioner contracts their services to the facility.

8. Nil fee for cancellation or non-attendance

No fee is payable for cancellation or non-attendance by a worker for treatment services with a Physiotherapist, Chiropractor or Osteopath.

9. Goods and Services Tax

(1) Physiotherapy, Chiropractic or Osteopathy treatment services provided by a practitioner directly to a worker are GST free.

(2) Case conferences, Report writing, Travel services and the Initial Allied Health Recovery Request (AHRR) provided by a Physiotherapist, Chiropractor or Osteopath in relation to treatment of a worker are subject to GST.

(3) An amount fixed by this Order is exclusive of GST. An amount fixed by this Order may be increased by the amount of any GST payable in respect of the service to which the cost relates, and the cost so increased is taken to be the amount fixed by this Order. This clause does not permit an allied health practitioner to charge or recover more than the amount of GST payable in respect of the service to which the cost relates.

10. Requirements for invoices

All invoices should be submitted within 30 calendar days of the service provided and must be itemised in accordance with Schedule A of this Order and comply with the Authority's invoicing requirements for the invoice to be processed. Refer to the relevant provider page on the SIRA website - https://www.sira.nsw.gov.au/for-service-providers/A-Z-of-service-providers

11. No pre-payment of fees

Pre-payment of fees for reports and services is not permitted.

Schedule A

Maximum fees for Physiotherapy, Chiropractic and Osteopathy services

Physiotherapists Item	*Chiropractors Item*	*Osteopaths Item*	*Column 1 Type of Treatment*	*Column 2 Maximum Amount ($) (excl GST)*
Normal Practice	**Normal Practice**	**Normal Practice**		
PTA001	CHA001	OSA001	Initial consultation and treatment	$98.30
PTA002	CHA002	OSA002	Standard consultation and treatment	$83.30
PTA003	CHA031	OSA003	Initial consultation and treatment of two (2) distinct areas	$148.30
PTA004	CHA032	OSA004	Standard consultation and treatment of two (2) distinct areas	$125.50
PTA005	CHA033	OSA005	Complex treatment	$166.30
PTA006	CHA010	OSA006	Group/class intervention	$59.00/participant
N/A	CHA004	N/A	Spine X-rays performed by a Chiropractor	$150.10
Home Visit	**Home Visit**	**Home Visit**		
PTA007	CHA005	OSA007	Initial consultation and treatment	$121.00
PTA008	CHA006	OSA008	Standard consultation and treatment	$96.80
PTA009	CHA071	OSA009	Initial consultation and treatment of two (2) distinct areas	$178.60
PTA010	CHA072	OSA010	Standard consultation and treatment of two (2) distinct areas	$152.90
PTA011	CHA073	OSA011	Complex treatment	$196.80
Other	**Other**	**Other**		
PTA012	CHA081	OSA012	Case conference Report writing (only when requested by the insurer)	$16.40/ 5 minutes $196.80/ hour (maximum 1 hour)
PTA013	CHA082	OSA013	Work Related Activity assessment, consultation and treatment (cannot be used for aquatic therapy/hydrotherapy)	$16.40/ 5 minutes $196.80/ hour (maximum 1 hour)
PTA014	CHA009	OSA014	Travel (requires pre-approval by the insurer).	Reimbursed in accordance with the "Use of private motor vehicle" set out in Item 6 of Table 1 (Rates and Allowances) to Part B (Monetary Rates) of the *Crown Employees (Public Service Conditions of Employment) Reviewed Award 2009, at the rate effective 1 July 2019.* *Use of private motor vehicle:* - *68 cents per kilometre*
OAD001	OAD001	OAD001	Incidental expenses e.g. strapping, tape, theraband, exercise putty, etc. **Note:** This code does not apply to external facility fees	Cost price

WCO005	WCO005	WCO005	Fees for providing copies of clinical notes and records.	Where clinical records are maintained electronically by an allied health practitioner /practice, a flat fee of $60 is payable (for provision of all requested clinical records held by the practice) inclusive of postage and handling. An allied health practitioner/practice should not provide or bill for hard copy clinical records if they are maintained electronically. Where clinical records are not maintained electronically, the maximum fee for providing hard copies of clinical records is $38 (for 33 pages or less) and an additional $1.40 per page if more than 33 pages. This fee includes postage and handling".
OAS003	OAS003	OAS003	Submission of an Initial Allied Health Recovery Request (AHRR) only.	$38.00 (Initial AHRR per claim only) All other Allied Health Recovery Requests submissions are not subject to a fee.

WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION (INDEPENDENT CONSULTANTS FEES) ORDER 2020

under the

Workplace Injury Management and Workers Compensation Act 1998

I, Carmel Donnelly, Chief Executive, State Insurance Regulatory Authority, make the following Order pursuant to section 339 of the *Workplace Injury Management and Workers Compensation Act 1998*.

Dated this 11 day of December 2019

Carmel Donnelly
Chief Executive
State Insurance Regulatory Authority

---

1. Name of Order

This Order is the *Workplace Injury Management and Workers Compensation (Independent Consultants Fees) Order* 2020.

2. Commencement

This Order commences on 1 January 2020.

3. Definitions

In this Order:

the Act means the *Workplace Injury Management and Workers Compensation Act 1998*.

the Authority means the State Insurance Regulatory Authority as constituted under section 17 of the *State Insurance and Care Governance Act 2015*.

GST means the Goods and Services Tax payable under the GST Law.

GST Law has the same meaning as in the *A New Tax System (Goods and Services Tax) Act 1999 (Cth)*.

Independent Consultant means a chiropractor, osteopath, physiotherapist or psychologist approved by the Authority to provide an Independent Consultation in the NSW workers compensation system.

Independent Consultation includes a:

i. review where the treating allied health practitioner requests specialised or expert assistance from an Independent Consultant.

ii. Stage 1 review of the treatment/management provided by the allied health practitioner for the purpose of determining whether treatment/service provision is reasonably necessary. Consultation with the treating practitioner is not required for a Stage 1 review.

iii. Stage 2 review of the treatment/management provided by the allied health practitioner for the purpose of determining whether treatment/service provision is reasonably necessary. Consultation with the treating allied health practitioner is required for a Stage 2 review.

iv. Stage 3 review of the treatment/management provided by the allied health practitioner for the purpose of determining whether treatment/service provision is reasonably necessary. Examination of the worker and consultation with the treating allied health practitioner is required for a Stage 3 review.

Unreasonably late attendance means that the worker or interpreter arrives **unreasonably** late, to the degree that a full examination is prevented from being conducted.

Working days means Monday to Friday (excluding public holidays).

4. Application of Order

This Order only applies to independent chiropractic, osteopathy, physiotherapy or psychology consultant services provided on or after 1 January 2020, whether it relates to an injury received before, on or after that date.

5. Maximum Fees for Independent Consultants

(1) For the purposes of section 339 of the Act, the maximum hourly fee for the provision of services by an Independent Consultant in connection with a claim for compensation or an appearance as a witness in proceedings before the Workers Compensation Commission or a court in connection with a claim for compensation is as set out in Schedule A.

(2) An Independent Consultant may charge a cancellation fee specified in item IIN112 where a worker provides 2 working days' notice or less of cancellation, fails to attend their scheduled appointment, or the worker (or interpreter) attends **unreasonably** late preventing a full examination being conducted.

(3) The incorrect use of any item referred to in this Order can result in the Independent Consultant being required to repay monies that the Independent Consultant has incorrectly received.

6. Goods and Services Tax (GST)

(1) Services provided by an Independent Consultant are subject to GST.

(2) An amount fixed by this Order is exclusive of GST. An amount fixed by this Order may be increased by the amount of any GST payable in respect of the service to which the cost relates, and the cost so increased is taken to be the amount fixed by this Order. This clause does not permit an Independent Consultant to charge or recover more than the amount of GST payable in respect of the service to which the cost relates.

7. Requirements for invoices

All invoices should be submitted within 30 calendar days of the service provided and must be itemised in accordance with Schedule A and comply with the Authority's requirements for the invoice to be processed. Refer to the relevant provider page on the SIRA website - *https://www.sira.nsw.gov.au/for-service-providers/A-Z-of-service-providers*

8. No pre-payment of fees

Pre-payment of fees for reports and services is not permitted.

Schedule A

Rates for Independent Consultants

Item	Service description	Maximum Amount ($) (excl GST)
IIN110	Independent Consultation where referral initiated by a party other than the treating practitioner i.e. insurer, employer, Workplace Rehabilitation Provider, worker. May include file review, discussions, interview, examination and report.	$231.60 per hour
IIN111	Independent Consultation where referral initiated by the treating practitioner. May include file review, discussions, interview, examination and report	$231.60 per hour
IIN112	Cancellation with 2 working days or less notice, non-attendance at scheduled appointment or **unreasonably** late attendance by worker or interpreter that prevents full examination being conducted	$231.60
IIN113	Travel for assessment / consultation outside of consulting rooms.	Reimbursed in accordance with the "Use of private motor vehicle" set out in Item 6 of Table 1 (Rates and Allowances) to Part B (Monetary Rates) of the *Crown Employees (Public Service Conditions of Employment) Reviewed Award 2009, at the rate effective 1 July 2019.* *Use of private motor vehicle:* - *68 cents per kilometre*

(n2019-4073)

WORKERS COMPENSATION (HEARING AID FEES) ORDER 2020

under the

***Workers Compensation Act* 1987**

I, Carmel Donnelly, Chief Executive, State Insurance Regulatory Authority, make the following Order pursuant to section 61(2) of the *Workers Compensation Act* 1987.

Dated this 11 day of December 2019

Carmel Donnelly
Chief Executive
State Insurance Regulatory Authority

Explanatory Note

Treatment by a hearing service provider is a category of medical or related treatment as defined in section 59 of the of the *Workers Compensation Act* 1987 (the Act). This Order sets the maximum fees for which an employer is liable under the Act for provision of reasonably necessary medical or related treatment and a hearing aid by a hearing service provider to an injured worker who, as a result of a work-related injury, has suffered hearing loss.

The effect of this Order is to prevent a hearing service provider from recovering from the injured worker or employer any extra charge for treatments covered by the Order.

Workers are not liable for the cost of any medical or related treatment covered by this Order. Employers are liable for the cost of medical or related treatment up to the maximum amounts set out in this Order.

The incorrect use of any item referred to in this Order can result in the hearing service provider being required to repay monies that the hearing service provider has incorrectly received.

Workers Compensation (Hearing Aid Fees) Order 2020

1. Name of Order

This Order is the Workers Compensation (Hearing Aid Fees) Order 2020

2. Commencement

This Order commences on 1 January 2020.

3. Definitions

In this Order:

The Act means the *Workers Compensation Act* 1987.

Audiologist is a university graduate with tertiary qualifications in audiology who specialises in the assessment, prevention and non-medical management of hearing impairment and associated disorders of communication. An audiologist is required to be a full/ordinary member or be eligible for full/ordinary membership of either Audiology Australia or full/ordinary membership of the Australian College of Audiology (ACAud).

Audiometrist holds a qualification from a registered training organisation such as TAFE NSW followed by on-the-job training. An audiometrist also specialises in the non-medical assessment and management of communication difficulties caused by hearing loss. An audiometrist is required to be a full/ordinary member or be eligible for full/ordinary membership of the Australian College of Audiology (ACAud) or full/ordinary membership of the Audiometrist Society of Australia (HAASA).

Audiology Entity is a registered business or company that provides reasonably necessary medical or related treatment and a hearing aid to a worker who, as a result of a work-related injury, has suffered hearing loss.

Ear, Nose and Throat specialist (ENT) means a Medical Practitioner who is recognised by the Medical Board of Australia or by Medicare Australia as a Specialist in otolaryngology (ear, nose and throat) head and neck surgery and who is registered with the Australian Health Practitioner Regulation Agency as a Specialist in otolaryngology head and neck surgery.

Exempt worker refers to specific classes of workers set out in Part 19H of Schedule 6 of the 1987 Act for which most of the amendments made to the Workers Compensation Acts in 2012 and 2015 do not apply. These classes of workers include police officers, paramedics, fire fighters, coal miners and volunteers prescribed by the *Workers Compensation (Bush Fire, Emergency and Rescue Services) Act 1987*.

GST has the same meaning as in the *New Tax System (Goods and Services Tax) Act 1999 (Cth)*.

Hearing needs assessment includes obtaining a clinical history, hearing assessment as per Australian/New Zealand Standard 1269.4:2014, determination of communication goals, recommendation of hearing aid and clinical rationale for hearing aid.

Hearing aid is a non-implantable electronic instrument designed and manufactured to provide amplification for people with a hearing loss.

Hearing service provider refers to either an Ear, Nose and Throat medical specialist or an Audiology entity qualified to provide treatment and supply hearing aids to injured workers. A Hearing Service Provider must be approved by the authority to deliver services in the NSW workers compensation system. The requirement to be approved does not apply to treatment provided interstate or to exempt workers.

Hearing rehabilitation includes education of the injured worker in appropriate use of the hearing aid to meet their needs.

Insurer means an insurer within the meaning of the *Workers Compensation Act 1987* and the *Workplace Injury Management and Workers Compensation Act 1998* and includes Scheme agents, self-insurers and specialised insurers.

the Authority means the State Insurance Regulatory Authority.

4. Application of the Order

This Order applies to the provision of medical or related treatment and a hearing aid, made on or after the date of commencement of this Order, whether it relates to an injury received before, on or after that date.

5. Maximum Fees for an approved hearing service provider

(1) The maximum fee amount for which an employer is liable under the Act for provision of medical or related treatment and a hearing aid by an Authority approved hearing service provider to an injured worker on or after 1 January 2020 is listed in Schedule A.

(2) No fee is payable by or on behalf of an employer for treatment or a hearing aid provided by a person who is not an Authority-approved hearing service provider. The requirement to be an approved hearing service provider does not apply to those providing services interstate or to exempt workers.

6. Treatment provided interstate or to exempt workers

Hearing service providers approved by the authority must submit their SIRA approval number when invoicing for treatment delivered under the NSW workers compensation system in a State/Territory other than NSW, or to exempt workers.

When a Hearing Service Provider is not approved by the Authority and delivering treatment under the NSW workers compensation system in a State/Territory other than NSW or to exempt workers, the service provider number for that service provided:

- interstate is INT0000
- to an exempt worker is EXT0000

and the payment classification code is the one that is relevant to the Hearing Service Provider as defined in Schedule A item column of this Order.

7. Goods and Services Tax

An amount fixed by this Order is exclusive of GST. An amount fixed by this Order may be increased by the amount of any GST payable in respect of the service to which the cost relates, and the cost so increased is taken to be the amount fixed by this Order. This clause does not permit a hearing service provider to charge or recover more than the amount of GST payable in respect of the service to which the cost relates.

8. Requirements for an invoice

All invoices should be submitted within 30 calendar days of the service provided and must be itemised in accordance with Schedule A of this Order and comply with the Authority's itemised invoicing requirements for the invoice to be processed. Refer to the relevant provider page on the SIRA website - *https://www.sira.nsw.gov.au/for-service-providers/A-Z-of-service-providers*

9. No pre-payment of fees

Under section 60(3), pre-payment of fees for a hearing aid and services is not permitted.

SCHEDULE A

Item	*Service description*	*Maximum amount (excl GST)*
AID002	Hearing needs assessment – Audiologist	$214.20
AID002	Hearing needs assessment – Audiometrist	$176.60
AID003	Supply of hearing aid (including remote control)	Wholesale price of hearing aid to maximum of $2500.00 per aid
AID002	Handling fee (monaural or binaural hearing aid/s) payable upon supply of hearing aid	$315.20
AID002	Fitting of hearing aid including: • Fitting • Trial of hearing aid for up to 30 days • All necessary hearing rehabilitation for the injured worker within the first 12 months following supply and fitting • Maintenance as per the manufacturer's warranty.	$756.20 (monaural) $1238.10 (binaural)
AID002	Hearing aid repairs *Payable only if a copy of manufacturer's invoice for repairs is provided*	Up to $416.00
AID002	Hearing aid review/minor maintenance *Only applicable 12 months after supply*	$151.30
AID003	12 months hearing aid battery/consumables supply	$126.10 per hearing aid

(n2019-4074)