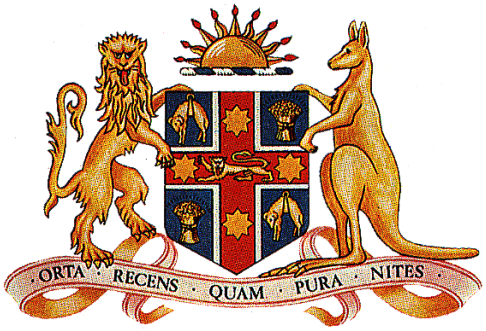


Government Gazette

of the State of

New South Wales

Number 634–Other
Friday, 10 December 2021

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

Each notice in the Government Gazette has a unique reference number that appears in parentheses at the end of the notice and 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 the Gazette page.

ISSN 2201-7534

By Authority
Government Printer

Office of the Minister for Police
SYDNEY, NSW

3 December 2021

MURDER

ONE MILLION DOLLAR ($1,000,000) REWARD

On 29 April 2020, Kalim Saliba, aged 86 years, of Cherrybrook, NSW, was violently attacked by two offenders during a home invasion of his residence. He died as a result of severe and significant head injuries.

Notice is hereby given that a reward of up to one million dollars ($1,000,000) will be paid by the Government of New South Wales for information leading to the arrest and conviction of the person or persons responsible for the murder of Kalim Saliba.

The allocation of this reward will be at the sole discretion of the Commissioner of Police.

The urgent assistance and co-operation of the public is especially sought in the matter. Any information, which will be treated as confidential, may be given at any time of the day or night at any Police Station or by telephone -

Police Headquarters telephone (02) 9281 0000
or Crime Stoppers on 1800 333 000

THE HON. David ELLIOTT, MP
Minister for Police and Emergency Services

FORESTRY ACT 2012

REVOCATION OF DEDICATION

In pursuance of the provisions of clause 7 of Schedule 2 of the *Forestry Act 2012*, I, PAUL TOOLE, Deputy Premier, Minister for Regional New South Wales and Minister for Regional Transport and Roads, being the Minister of the Crown charged with the administration of the *Forestry Act 2012*, having considered a report from the Forestry Corporation of New South Wales, DO HEREBY revoke the dedication as State forest of the hereinafter described land and declare the land is transferred to the Forestry Corporation of New South Wales.

Dated this 11th day of November 2021.

The Hon. Paul Toole, MP
Deputy Premier, Minister for
Regional New South Wales and
Minister for Regional Transport and Roads

Eastern Division

Land District of Taree *LGA of Port Macquarie Hastings*

Central Forestry Region

All that piece or parcel of land situated in the Parish of Johns River, County of Macquarie, being Lot 30 Section B in Deposited Plan 7734 and being part of Kendall State Forest No. 61 Extension No. 2 dedicated 30 October 1942.

[F2013/00211]

WORKERS COMPENSATION (SURGEON AND ORTHOPAEDIC SURGEON FEES) ORDER 2022

under the

Workers Compensation Act 1987

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

Dated this 6 day of December 2021

Adam Dent
Chief Executive
State Insurance Regulatory Authority

Explanatory Note

From 1 July 2022, this Order replaces the *Workers Compensation (Surgeon Fees) Order 2021 No.2* and the *Workers Compensation (Orthopaedic Surgeon Fees) Order 2021 No.2.*

Treatment by a Medical Practitioner who is a Surgeon or 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 a Surgeon or 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 a Surgeon or 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.

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

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

To bill an AMA item number a Surgeon or Orthopaedic Surgeon must 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.

Medical Practitioners cannot bill for any item referred to in this Order in excess of the maximum fee. Recovery may be sought for fees charged in excess of the maximum amount.

Workers Compensation (Surgeon and Orthopaedic Surgeon Fees) Order 2022

1. Name of Order

This Order is the *Workers Compensation (Surgeon and Orthopaedic Surgeon Fees) Order 2022.*

2. Commencement

This Order commences on 1 July 2022.

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.

AMA List means the document entitled *List of Medical Services and Fees* as amended or replaced, from time to time published by the Australian Medical Association, that is the current edition on the AMA website at the date of service delivery.

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 to MZ871. Assistance at Operation fees are to be billed by the Medical Practitioner who provides the assistance (not the Surgeon), using the AMA item code MZ900.

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), Assistance at Operation 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 Assistance at Operation fee may be charged. Paymentof 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 Assistance at Operation fee payments to ensure their proper distribution into the named trust fund.

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 recovery at/return to work plans.

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 refers to situations that require two or more operations or for the treatment of two or more injuries carried out at the same time. The maximum fee payable for multiple operations or injuries is as per Multiple Operations Rule in the AMA List. It applies to the AMA items EA015 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.

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 or Orthopaedic Surgeon and in accordance with privacy principles.

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. 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.

Radiation User Licence means a radiation user licence granted by the Environment Protection Authority (EPA) under Part 2 of the Radiation Control Act 1990 or a similar licence or approval that authorises the holder to use a specified type of radiation source for a specified purpose within the jurisdiction that the service takes place.

Spinal surgical procedures means items MZ731 (MBS 51011) to MZ871 (MBS 51171) and the associated rules and conditions provided in the Medicare Benefits Schedule apply at the time the service was provided.

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 or Orthopaedic 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. Thecost 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 Medical 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 and who is registered with the Australian Health Practitioner Regulation Authority as a Specialist in surgery in their chosen field. It includes a Surgeon who is a staff member at a public hospital providing services at that 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 disciplinaryprocess.

Telehealth means delivery of consultations via video or telephone by a Surgeon or Orthopaedic Surgeon. Consultations would be inclusive of any electronic communication to support the delivery of the consultation service. Surgeons or Orthopaedic Surgeons must consider the appropriateness of this mode of service delivery for each worker on a case-by- case basis and be satisfied worker outcomes are not compromised. Telehealth consultations must be consented to by the worker. Surgeons or Orthopaedic Surgeons. are responsible for delivering Telehealth consultations 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 effectivenessof the service. Telehealth consultations are to be paid in accordance with this Order (noting those items specifically excluded in Clause 7 of the Workers Compensation (Medical Practitioner Fees) Order 2022). Surgeons or Orthopaedic surgeons are to bill for Telehealth consultations using the same AMA Fees List item number normally billed for a face-to-face consultation, with the addition of a 'T' as a suffix to the item number e.g. AC510T (Subsequent consultation and report delivered via telehealth) versus AC510 (Subsequent consultation and report delivered face to face). The fee payable remains the same. No additional fee (e.g. facility fees) can be charged in relation to the consultation.

Workers Compensation (Medical Practitioner Fees) Order means the *Workers Compensation (Medical Practitioner Fees) Order* in force on the date the service is provided.

Workplace Injury Management and Workers Compensation (Medical Examinations and Reports Fees) Order means the Workplace Injury Management and Workers Compensation (Medical Examinations and Reports Fees) Order in force on the date the service is provided.

4. Application of Order

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

5. Maximum fees for treatment by a Surgeon or Orthopaedic Surgeon (Schedule A)

The maximum fee amount for which an employer is liable under the Act for treatment of a worker by a Surgeon or 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 a Surgeon or 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 a Surgeon or Orthopaedic Surgeon seek an exception to the mandatory guidelines, the Surgeon or 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 a Surgeon or Orthopaedic Surgeon seek an exception to the mandatory guidelines, the Surgeon or Orthopaedic Surgeon must provide a written explanation to support the request.

9. Goods and Services Tax (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 or 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 at www.sira.nsw.gov.au.

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: A Medical Practitioner who provides Assistance at Operation is to invoice for their services separately to the principal Surgeon, Orthopaedic Surgeon or 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 or Orthopaedic Surgeon.

SCHEDULE A
MAXIMUM FEES FOR SURGEONS
AND ORTHOPAEDIC SURGEONS

Item	Column 1 Type of service	Column 2 AMA Item(s)	Column 3 Maximum amount
Consultations			
1.	Initial consultation and report (AC500T/AC600T to be utilised when consultation delivered via telehealth)	AC500/AC500T (MBS 104) AC600 /AC600T (MBS 6007)	$340.40
2.	Subsequent consultation and report (AC510T/AC610T to be utilised when consultation delivered via telehealth)	AC510/AC510T (MBS 105) AC610/AC610T (MBS 6009)	$234.50
Procedures			
3.	Surgical procedure(s)	EA015 (MBS 30001) to MZ871 (MBS 51171)	AMA List Fee for the primaryitem number. (For any additional item numbers refer to item 5 of this Schedule).
4.	Assistance at Operation (*Assistance at Operation* fees are only payable to Medical Practitioners, not other health practitioners e.g. perioperative nurses). Assistance at Operation fees are to be billed by the Medical Practitioner who provides the assistance (not the Surgeon or Orthopaedic Surgeon). 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 or Orthopaedic Surgeon's fee, or the amount stated in the AMA List for MZ900, whichever is the greater, for surgical procedure/s performed, but only those surgical procedure/s where an assistant is allowed for in the MBS.

Item	Column 1 Type of service	Column 2 AMA Item(s)	Column 3 Maximum amount
5.	Multiple operations or injuries		Multiple Operations Rule from AMA List applies, with the exception of items specifically listed as a multiple procedure item in the AMA List, or where Schedules in this Fees Order prevent combining of items.
6.	Spinal surgical procedures	MZ731 to MZ871	Rules and conditions provided in the Medicare Benefits Schedule at the time the service was provided apply to spinal surgical items MZ731 (MBS 51011) to MZ871 (MBS 51171).
7.	Aftercare visits (As defined in this Order)		As per AMA List.
Insurer/lawyer requests			
8.	Opinion on file request	WCO009	$234.50
9.	Telephone requests including Case conferences (refer to the definition within the *Workers Compensation (Medical Practitioner Fees) Order)* 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
10.	Lost reports and reprints		$158.90 per report
11.	Surgeon or 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 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 InjuryManagement and Workers Compensation (Medical Examinations and Reports Fees) Order* Schedule 2.
12.	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 provisionof all requested medical records.

Item	Column 1 Type of service	Column 2 AMA Item(s)	Column 3 Maximum amount
			held by the medical practice) inclusive of postage and handling. A Medical Practitioner/practice should not provide or bill for hardcopy medical records if they are maintained electronically. Where medical records are not maintained electronically the maximum fee for providing hard copies of medical records (includingSurgeon or 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. 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 or Orthopaedic Surgeon. This item can only be billed in circumstances where a formal nerve block is performed by the Surgeon or 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	Repair of traumatic tear or rupture of tendon, other than a service associated with: (a) a service to which item LN810 applies; or (b) a service to which another item in the List applies if the service described in the other item is for the purpose of repairing peripheral nerve items in the same region	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
MS005/48400	Osteotomy of phalanx or metatarsal of foot, for correction of deformity, excision of accessory bone or sesamoid bone, including any of the following (if performed):	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.

AMA/MBS item number	Descriptor	Reason for decline
	(a) removal of bone (b) excision of surrounding osteophytes (c) synovectomy (d) joint release - one bone	
MS015/48403	Osteotomy of phalanx or metatarsal, osteotomy or osteectomy of first toe of foot, for correction of deformity, with internal fixation, including any of the following (if performed): (a) removal of bone; (b) excision of surrounding osteophytes; (c) synovectomy; (d) joint release; - one bone	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.
OF812/60500, OF816/60503, OF820/60506, OF824/60509 and OF952/61109	FLUOROSCOPY	Fluoroscopy items (OF812 – OF824 and OF952) can only be billed by a medical practitioner who, at the date they deliver the service, holds a relevant Radiation User Licence. *Note:* These items are not billable by more than one provider per occasion of service and only billable by the provider who delivers the service.

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

AMA/MBS item number	Descriptor	Clinical indication
AC510/30105 *Note:* If consultation is undertaken via telehealth, code AC510T applies	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	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by lateral suture	This item is applicable for repair of radial, ulnar or brachial arteries proximal to wrist crease.

AMA/MBS item number	Descriptor	Clinical indication
ET570/33818	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.
LN740/39312	NEUROLYSIS, internal (interfascicular) neurolysis of, using microsurgical techniques, other than a service associated with a service to which EA075 applies	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 or MU410: Wrist carpal tunnel release (division of transverse carpal ligament), unless for a revision procedure. Not billable with EA075 or LN810.
LN750/39315	NERVE TRUNK, nerve graft to, (cable graft) by cable graft, using microsurgical techniques, including any of the following (if performed): (a) harvesting of nerve graft using microsurgical graft; (b) proximal and distal anastomosis of nerve graft; (c) transposition of nerve to facilitate grafting; (d) neurolysis; other than a service associated with a service to which item EA075 or LN810 applies	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 EA075, LN790, LN800, LN804, LN806 or LN810.
LN760/39318	Nerve, digital or cutaneous, nerve graft to, using microsurgical techniques, including either or both of the following (if performed): (a) harvesting of nerve graft from separate donor site; (b) proximal and distal anastomosis of nerve graft. - other than a service associated with a service to which item LN810 applies	This item cannot be billed in conjunction with items LN790, LN800, LN804, LN806 or LN810. This item cannot be billed for prosthetic neural tubes or wraps. In this setting, items LN700 or LN710 are applicable.
LN790/39324	NEURECTOMY or removal of tumour or neuroma from superficial peripheral nerve	This item cannot be billed in conjunction with item LN810.
LN800/39327	NEURECTOMY, NEUROTOMY or removal of tumour from deep 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 items EA075, LN740, LN770, LN804, LN806, LN826, LN829, LN832, LN835, MU402, MX474 or MX475 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 cannot be billed in combination with EA075, LN740, LN770, LN804, LN806, LN826, LN829, LN832, LN835, MU402, MX474 or MX475. This item is not to be billed in conjunction with item MU400 or MU410.However, items LN810

AMA/MBS item number	Descriptor	Clinical indication
		and MU400 can be billed together for combined 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.
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 reimplantation 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,	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

AMA/MBS item number	Descriptor	Clinical indication
	excluding flap for male pattern baldness	advancement flaps where item MH125/45206 is applicable.
ML105/46325	Excisional arthroplasty of CARPOMETACARPAL JOINT OF THUMB, with excision of adjacent trapezoid, including either or both of the following (if performed): (a) ligament and tendon transfers (b) realignment procedures	This item is primarily intended for use in reconstruction for basal thumb arthritis. It is not approved for excision of the pisiform.
ML125/46330	Ligamentous or capsular repair or reconstruction of INTERPHALANGEAL OR METACARPOPHALANGEAL JOINT OF HAND, including any of the following (if performed): (a) arthrotomy (b) joint stabilisation (c) synovectomy; - one joint	This item is only billable for repair of named ligaments where preoperative or intraoperative findings document significant joint instability.
ML135/46333	Ligamentous or capsular repair or reconstruction of INTERPHALANGEAL OR METACARPOPHALANGEAL JOINT OF HAND with graft, using graft or implant, including any of the following (if performed): (a) arthrotomy (b) harvest of graft (c) joint stabilisation (d) synovectomy, other than a service associated with a service to which item MR645, MR650, MR655, MR660 or MR665 apply - one joint	Cannot be billed with MR645, MR650, MR655, MR660 or MR665. 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	Synovectomy of INTERPHALANGEAL, METACARPOPHALANGEAL OR CARPOMETACARPAL JOINT OF HAND, including any of the following (if performed): (a) capsulectomy (b) debridement (c) ligament or tendon realignment (or both), other than a service combined with a service to which item ML705 applies—one 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 or ML705.

AMA/MBS item number	Descriptor	Clinical indication
ML155/46339	Synovectomy of digital flexor tendons at wrist level, for diagnosed inflammatory arthritis, including either or both of the following (if performed): (a) tenolysis (b) release of median nerve and carpal tunnel, other than a service associated with a service to which item EA075, LN810 or MU400 applies—applicable only once per occasion on which the service is performed	Rare in a workers' compensation setting. Not for use for De Quervain's (refer to ML247/46367). 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 ML237/46367 (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	Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed): (a) removal of intratendinous nodules (b) tenolysis (c) tenoplasty, other than a service associated with a service to which item EA075 or ML235 applies	ML185/46348 – 1 digit ML195/46351 – 2 digits ML205/46354 – 3 digits ML215/46357 – 4 digits ML225/46360 – 5 digits Not in combination with EA075, ML235 orML155/46339.
ML235/46363	Trigger finger release, for stenosing tenosynovitis, including either or both of the following (if performed): (a) synovectomy (b) synovial biopsy - one ray	This item is not to be billed in combination with LN810/39330. Item used for Trigger Finger Release.
ML247/46367	De Quervain's release, including any of the following (if performed): (a) synovectomy of extensor pollicis brevis (b) synovectomy of abductor pollicis longus tendons (c) retinaculum reconstruction, other than a service associated with a service to which item ML155 applies	Not to be billed with ML155. De Quervain's tenosynovitis - can only be billed once per side (i.e. includes both APL and EPB tendons).
ML260/46370 – ML340/46395	Dupuytren's contracture, fasciectomy	Flag if this procedure is requested for an acute injury or trauma.
ML405/46414	Insertion of artificial tendon prosthesis in preparation for grafting of tendon of hand or wrist, including tenolysis (if performed), other than a service associated with a service to which item EA075 applies	Tenolysis items ML535/ 46450 and ML545/46453) or EA075 cannot be billed with this item.
ML425/46420	Primary repair of EXTENSOR TENDON OF HAND OR WRIST—one tendon	Item ML425 is 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.

AMA/MBS item number	Descriptor	Clinical indication
ML445/46426	Primary repair of FLEXOR TENDON OF HAND OR WRIST, proximal to A1 pulley, other than a service to repair a tendon of a digit if 2 tendons of the same digit have been repaired during the same procedure - one 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	Primary repair of FLEXOR TENDON OF HAND OR WRIST, distal to A1 pulley, other than a service to repair a tendon of a digit if 2 tendons of the same digit have been repaired during the same procedure - one tendon	This item is only to be billed for acute injuries. This item can only be billed a maximum of twice per digit.
ML535/46450	Tenolysis of EXTENSOR TENDON OF HAND OR WRIST, following tendon injury or graft, other than a service: (a) for acute, traumatic injury; or (b) associated with a service to which item EA075 applies —one ray	This item is applicable for freeing tendons from scar following previous surgery or trauma. It is not indicated in an acute hand injury. Item ML535 cannot be billed in conjunction with release of trigger finger or for release of De Quervians' (see ML235/46363 and ML247/46367). Item ML535 cannot be billed with EA075.
ML545/46453	Tenolysis of FLEXOR TENDON OF HAND OR WRIST, following tendon injury, repair or graft, other than a service: (a) for acute, traumatic injury; or (b) associated with a service to which item EA075 applies	This item is applicable for freeing tendons from scar following previous surgery or trauma. It is not indicated in an acute hand injury. Item ML545 cannot be billed in conjunction with release of trigger finger or for release of De Quervain's (see ML235/46363 and ML247/46367). Item ML545 cannot be billed with EA075.
ML705/46495	Complete excision of one or more ganglia or mucous cysts of INTERPHALANGEAL, METACARPOPHALANGEAL OR CARPOMETACARPAL JOINT OF HAND, including any of the following (if performed): (a) arthrotomy (b) osteophyte resections (c) synovectomy, other than a service associated with a service to which item EA355 or ML145 applies—one joint	Not being a service associated with a service to which item EA355/30107 or ML145/46336 applies.
ML715/46498	Excision of GANGLION OF FLEXOR TENDON SHEATH OF HAND, including any of the following (if performed): (a) flexor tenosynovectomy (b) sheath excision (c) skin closure by any method, other than a service associated with a service to which item EA355 or ML235 applies	Not being a service associated with a service to which item EA355/30107 or ML235/46363 applies.

AMA/MBS item number	Descriptor	Clinical indication
ML725/46500	Excision of GANGLION OF DORSAL WRIST JOINT OF HAND, including any of the following (if performed): (a) arthrotomy (b) capsular or ligament repair (or both) (c) synovectomy, other than a service associated with a service to which item EA355 applies	This item is not to be billed in combination with EA355/30107.
ML735/46501	Excision of GANGLION OF VOLAR WRIST JOINT OF HAND, including any of the following (if performed): (a) arthrotomy (b) capsular or ligament repair (or both) (c) synovectomy, other than a service associated with a service to which item EA355 or ML105 applies	This item is not to be billed in combination with EA355/30107 or ML105/46325.
ML745/46502	Excision of RECURRENT GANGLION OF DORSAL WRIST JOINT OF HAND, including any of the following (if performed): (a) arthrotomy (b) capsular or ligament repair (or both) (c) synovectomy	This item is not to be billed in combination with EA355/30107.
ML755/46503	Excision of RECURRENT GANGLION OF VOLAR WRIST JOINT OF HAND, including any of the following (if performed): (a) arthrotomy (b) capsular or ligament repair (or both) (c) synovectomy, other than a service associated with a service to which item EA355 applies	This item is not to be billed in combination with EA355/30107.
ML765/46504	NEUROVASCULAR ISLAND FLAP, heterodigital, for pulp re-innervation and soft tissue cover	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.
ML795/46513	Removal of nail of finger or thumb—one nail	This item should not be billed in association with nailbed repair (items ML665/46486 or ML675/46489).

AMA/MBS item number	Descriptor	Clinical indication
ML825/46522	Open operation and drainage of infection for FLEXOR TENDON SHEATH OF FINGER OR THUMB, including either or both of the following (if performed): (a) synovectomy (b) tenolysis, other than a service associated with a service to which item EA075 applies - one digit	This item is applicable only for drainage of suppurative flexor tenosynovitis. It does not apply to washout of flexor sheath in acute injury. ML825 cannot be billed in combination with EA075.
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	Removal of one or more buried wires, pins or screws (inserted for internal fixation purposes) - one 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.
MS025/48406	Osteotomy of fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, for correction of deformity, including any of the following (if performed): (a) removal of bone (b) excision of surrounding osteophytes (c) synovectomy (d) joint release - one bone	This item is <u>not</u> appropriate for simple removal of bone prominence, osteophytes or small quantities of excess bone.
MU400 and MU410	Carpal tunnel release (division of transverse carpal ligament), by any approach (MU400) or endoscopic (MU410) approach	These are the appropriate item numbers for a primary carpal tunnel release. These items cannot be billed together. Either of these items cannot be used in combination with ML155/46339 or EA075/30023. Ultrasound costs are not billable in conjunction with these surgical procedures. Nerve Conduction Studies (NCS) are preferable prior to surgical consideration, other than in acute cases.
MU460/49209	Prosthetic replacement of WRIST or distal radioulnar joint, including either or both of the following (if performed): (a) ligament realignment (b) tendon realignment	Flag if this procedure is requested.
MU462/49210	Revision of total replacement arthroplasty of WRIST or distal radioulnar joint, including any of the following (if performed):	Flag if this procedure is requested.

AMA/MBS item number	Descriptor	Clinical indication
	(a) ligament rebalancing (b) removal of prosthesis (c) tendon rebalancing	
MU470/49212	Arthrotomy of WRIST or distal radioulnar joint, for infection, including any of the following (if performed): (a) joint debridement (b) removal of loose bodies (c) synovectomy	This item is not to be billed in conjunction with excision of primary or recurrent wrist ganglia (items ML725/46500, ML735/46501, ML745/46502 and ML755/46503).
MU480/49215	Reconstruction of single or multiple ligaments or capsules of WRIST, by open procedure, including any of the following (if performed): (a) arthrotomy (b) ligament harvesting and grafting (c) synovectomy (d) tendon harvesting and grafting (e) insertion of synthetic ligament substitute	Including repair of single or multiple ligaments or capsules, including associated arthrotomy.
MU490/49218	WRIST, diagnostic arthroscopy of, including radiocarpal or midcarpal joints, or both (including biopsy)—other than a service associated with another arthroscopic procedure of the wrist joint	Not being a service associated with any other arthroscopic procedure of the wrist joint.
MU500/49221	Treatment of WRIST, by arthroscopic means, including any of the following (if performed): (a) drilling of defect (b) removal of loose bodies (c) release of adhesions (d) synovectomy (e) debridement (f) resection of dorsal or volar ganglia, other than a service associated with a service to which another item in the List applies if the service described in the other item is for the purpose of performing an arthroscopic procedure of the wrist joint	Not being a service associated with any other arthroscopic procedure of the wrist joint.
MU510/49224	Osteoplasty of WRIST, by arthroscopic means, including either or both of the following (if performed): (a) excision of the distal ulna (b) total synovectomy, other than a service associated with a service to which another item in the List applies if the service described in the other item is for the purpose of	Not being a service associated with any other arthroscopic procedure of the wrist.

AMA/MBS item number	Descriptor	Clinical indication
	performing an arthroscopic procedure of the wrist joint—2 or more distinct areas	
MU520/49227	Treatment of WRIST by one of the following: (a) pinning of osteochondral fragment, by arthroscopic means (b) stabilisation procedure for ligamentous disruption (c) partial wrist fusion or carpectomy, by arthroscopic means (d) fracture management, other than a service associated with a service to which another item in the List applies if the service described in the other item is for the purpose of performing an arthroscopic procedure of the wrist joint	Not being a service associated with any other arthroscopic procedure of the wrist joint.

SCHEDULE C

BILLING ITEMS USED IN SHOULDER AND ELBOW SURGERY

This Order adopts the *WorkCover Queensland Upper Limb Surgery Guidelines (July 2021)* 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		
MS025/48406	Osteotomy of fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, for correction of deformity, including any of the following (if performed): (a) removal of bone (b) excision of surrounding osteophytes (c) synovectomy (d) joint release - one bone	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).**
MS035/48409	Osteotomy of fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, for correction of deformity, with internal fixation, including any of the following (if performed): (a) removal of bone (b) excision of surrounding osteophytes (c) synovectomy (d) joint release, - one bone	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).**
MS045/48412	Osteotomy of humerus, without internal fixation	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	SHOULDER, 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	SHOULDER, 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).

AMA/MBS item number	Descriptor	Clinical indication
MT620/48906	SHOULDER, repair of rotator cuff, including excision of coraco-acromial ligament or removal of calcium deposit from cuff, or both - other than a service associated with a service to which Item MT600 applies	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. Note: If MT620/48906 is performed arthroscopically it cannot be billed with item MT770/48951.
MT630/48909	SHOULDER, repair of rotator cuff, including decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination, other than a service associated with a service to which item MT610 applies	Known as open rotator cuff repair with acromioplasty with excision of AC joint. Not being a service to which item MT610/48903 applies. **Not to be 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.
MT650/48915	SHOULDER, Hemi-arthroplasty	Use of this item rarely seen in State Insurance Regulatory Authority claims. Maybe appropriate for shoulder trauma/fractures only.
MT660/48918	Anatomic or reverse total shoulder replacement, including any of the following (if performed): (a) associated rotator cuff repair (b) biceps tenodesis (c) tuberosity osteotomy other than a service associated with a service to which another item in the List applies if the service described in the other item is for the purpose of performing a procedure on the shoulder region by open or arthroscopic means	Use of this item rarely seen in State Insurance Regulatory Authority claims.
MT670/48921	SHOULDER, total replacement arthroplasty, revision of	Use of this item rarely seen in State Insurance Regulatory Authority claims.
MT680/48924	Revision of total shoulder replacement, including either or both of the following (if performed): (a) bone graft to humerus (b) bone graft to scapula	Use of this item rarely seen in State Insurance Regulatory Authority claims.
MT690/48927	Shoulder prosthesis, removal of	Use of this item rarely seen in State Insurance Regulatory Authority claims.
MT730/48939	SHOULDER, arthrodesis of, with synovectomy if performed	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed once or more.**
MT740/48942	Arthrodesis of shoulder, with bone grafting or internal fixation, including	Not to be billed with a service to which item MR645, MR650, MR655, MR660 or MR665

AMA/MBS item number	Descriptor	Clinical indication
	either or both of the following (if performed): (a) removal of prosthesis (b) synovectomy other than a service associated with a service to which item MR645, MR650, MR655, MR660 or MR665 applies	applies Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed once or more.**
MT750/48945	SHOULDER, diagnostic arthroscopy of (including biopsy) - not being a service associated with any other arthroscopic procedure of the shoulder region	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.
MT760/48948	SHOULDER, arthroscopic surgery of, involving any 1 or more of: removal of loose bodies; decompression of calcium deposit; debridement of labrum, synovium or rotator cuff; or chondroplasty - not being a service associated with any other arthroscopic procedure of the shoulder region	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.
MT770/48951	SHOULDER, arthroscopic division of coraco-acromial ligament including acromioplasty - not being a service associated with any other arthroscopic procedure of the shoulder region	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 if MT620 is performed as an open rotator cuff repair procedure.
MT780/48954	Synovectomy of shoulder, performed as an independent procedure, including release of contracture (if performed), other than a service associated with a service to which another item in the List applies if the service described in the other item is for the purpose of performing a procedure on the shoulder region by arthroscopic means	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.**
MT798/48958	Joint stabilisation procedure for multi-directional instability of shoulder, anterior or posterior repair, by open or arthroscopic means, including labral repair or attachment (if performed), excluding bone grafting and removal of hardware. Other than a service associated with a service to which another item in this List applies if the service	If item is requested for recurrent dislocations, it is highly recommended to look at worker history to determine if surgery is to treat the aggravation or a pre-existing condition. Not to be used with any other arthroscopic procedure of the shoulder region.

AMA/MBS item number	Descriptor	Clinical indication
	described in the other item is for the purpose of performing a procedure on the shoulder region by arthroscopic means	
MT800/48960	SHOULDER, reconstruction or repair of, including repair of rotator cuff by arthroscopic, arthroscopic assisted or mini open means; arthroscopic acromioplasty; or resection of acromioclavicular joint by separate approach when performed - not being a service associated with any other procedure of the shoulder region	Not to be billed with any other procedure of the shoulder region. Not to be billed with item **EA365/30111, MT770/48951 or MT798/48958**. **Flag if practitioner requesting a Superior Capsular Reconstruction (SCR) procedure.**
ELBOW		
LN770/39321	Transposition of NERVE, excluding the ulnar nerve at the elbow, other than a service associated with a service to which item LN810 applies	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 or LN730.
MU035/49100	ELBOW, arthrotomy of, involving 1 or more of lavage, removal of loose body or division of contracture	Not to be billed for tennis elbow surgery.
MU055/49106	ELBOW, arthrodesis of, with synovectomy if performed	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed.**
MU065/49109	Elbow, total synovectomy of	Known as **common contracture release**. Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if billed.**
MU075/49112	Radial head replacement of elbow, other than a service associated with a service to which item MU085 applies	Seen with fractures, dislocations and acute trauma. Not to be billed in combination with item MU065/49109 or MU085**.** **Flag if billed.**
MU085/49115	Total or hemi humeral arthroplasty of elbow, excluding isolated radial head replacement and ligament stabilisation procedures, other than a service associated with a service to which item MU075 applies	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if billed.**
MU086/49116	ELBOW, total replacement arthroplasty of, revision procedure, including removal of prosthesis	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if billed.**
MU087/49117	Revision of total replacement arthroplasty of elbow, including bone	Use of this item rarely seen in State Insurance Regulatory Authority claims.

AMA/MBS item number	Descriptor	Clinical indication
	grafting and removal of prosthesis	**Flag if billed.**
MU095/49118	ELBOW, diagnostic arthroscopy of, including biopsy and lavage, not being a service associated with any other arthroscopic procedure of the elbow	Not to be billed with any other **arthroscopic** procedure of the elbow region. Appropriate for use with open elbow surgery.
MU105/49121	Surgery of the elbow, by arthroscopic means, including any of the following (if performed): (a) chondroplasty (b) drilling of defect (c) osteoplasty (d) removal of loose bodies (e) release of contracture or adhesions (f) treatment of epicondylitis, other than a service associated with a service to which another item in the List applies if the service described in the other item is for the purpose of an arthroscopic procedure of the elbow	Not to be billed with any other **arthroscopic** procedure of the elbow.
OTHER		
EA365/30111	Bursa (large) including olecranon, calcaneum or patella, excision of	**Flag if used in combination with any shoulder surgery.** Not to be billed in combination with item MT800/48960 or MU108/49124.
LN810/39330	Neurolysis by open operation without transposition, other than a service associated with a service to which Item EA075, LN770, LN804, LN806, LN826, LN829, LN832, LN835, MU402, MX474 or MX475 applies	Not being a service associated with a service to which item LN740/39312 EA075, LN770, LN804, LN806, LN826, LN829, LN832, LN835, MU402, MX474 or MX475 applies. Can be billed in combination with elbow surgery (e.g.: 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.**
OTHER JOINTS		
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 9 Surgical Operations applies	Not being a service to which another item in group 9 Surgical Operations 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.**

AMA/MBS item number	Descriptor	Clinical indication
		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.
MY065/50115	Manipulation of one or more joints, excluding spine, other than a service associated with a service to which another item in group 9 Surgical Operations applies	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 Group 9, Surgical operations applies. **Flag if this item is used two or more times.**
GENERAL		
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.**
MR110/47927	Removal of one or more buried wires, pins, or screws (inserted for internal fixation purposes) - one bone	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. Cannot be billed in combination with MR100/47924.
MR170/47954	Repair of traumatic tear or rupture of tendon, other than a service associated with: (a) a service to which item LN810 applies; or (b) a service to which another item in the List applies if the service described in the other item is for the purpose of repairing peripheral nerve items in the same region	Cannot be billed in combination with LN810 or a service to which another item in the List applies if the service described in the other item is for the purpose of repairing peripheral nerve items in the same region. **Flag if billed with any other item code.**

SCHEDULE D

ADDITIONAL ITEMS USED IN UPPER LIMB SURGERY

This Order adopts the *WorkCover Queensland Upper Limb Surgery Guidelines (July 2021) 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
EA075/30023 – EA155/30049	Repair of Wounds	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 repair of wound referred to in these items must be undertaken by suture, tissue adhesive resin (such as methyl methacrylate) or clips. 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, other than a service associated with a service to which an item in this Group applies	Not being a service associated with a service to which another item in this Group applies.
MS055/48415	Humerus, osteotomy, with internal fixation	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.

WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION (INDEPENDENT CONSULTANTS FEES) ORDER 2022

under the

Workplace Injury Management and Workers Compensation Act 1998

I, Adam Dent, 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 7th day of December 2021

Adam Dent
Chief Executive
State Insurance Regulatory Authority

---

1. Name of Order

This Order is the *Workplace Injury Management and Workers Compensation (Independent Consultants Fees) Order* 2022.

2. Commencement

This Order commences on 1 January 2022.

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.

Telehealth services means delivery of examinations video or telephone by Independent Consultants. Consultations would be inclusive of any electronic communication to support the delivery of the treatment service. Independent Consultants must consider the appropriateness of this mode of service delivery for each worker on a case-by-case basis and be satisfied client outcomes are not compromised. Telehealth services must be consented to by all parties – the worker, Independent Consultant and insurer. Independent Consultants are responsible for delivering telehealth services in accordance with the principles of professional conduct and the relevant professional and practice guidelines to ensure the safety, appropriateness and effectiveness of the service.

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 independent chiropractic, osteopathy, physiotherapy or psychology 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.

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 Personal Injury 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.

(4) Telehealth services are to be billed according to the appropriate items IIN310 and IIN311.

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.	$235.80 per hour
IIN111	Independent Consultation where referral initiated by the treating practitioner. May include file review, discussions, interview, examination and report.	$235.80 per hour
IIN310	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. Delivered by telehealth.	$235.80 per hour
IIN311	Independent Consultation where referral initiated by the treating practitioner. May include file review, discussions, interview, examination and report. Delivered by telehealth.	$235.80per 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.	$235.80
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 2020.* *Use of private motor vehicle:* - *72 cents per kilometre*

WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION (INJURY MANAGEMENT CONSULTANTS FEES) ORDER 2022

under the

Workplace Injury Management and Workers Compensation Act 1998

I, Adam Dent, 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 7th day of December 2021

Adam Dent
Chief Executive
State Insurance Regulatory Authority

Workplace Injury Management and Workers Compensation (Injury Management Consultants Fees) Order 2022

Part 1 Preliminary

1. Name of Order

This Order is the *Workplace Injury Management and Workers Compensation (Injury Management Consultants Fees) Order 2022.*

2. Commencement

This Order commences on 1 January 2022.

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 *Workers Compensation Guidelines* current at the time.

Telehealth means delivery of examinations via video or telephone by an Injury Management Consultant approved by the Authority. Injury Management Consultants must consider the appropriateness of this mode of service delivery for each worker on a case-by-case basis and be satisfied worker outcomes are not compromised. Telehealth services must be consented to by the worker. Injury Management Consultants are responsible for delivering Telehealth services in accordance with the principles of professional conduct and the relevant professional and practice guidelines to ensure the safety, appropriateness and effectiveness of the service. No additional fee (e.g. facility fees) can be charged in relation to the examination.

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 for the scheduled appointment unreasonably late (or for a telehealth appointment joins the 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 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 Personal Injury 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/join their telehealth consultation, or the worker (or interpreter) attends/joins the telehealth consultation **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 Injury Management Consultant being required to repay monies that the Injury Management Consultant 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 at www.sira.nsw.gov.au

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	$415.10 per hour to a maximum of 3 hours (unless additional time authorised in advance by the insurer or Personal Injury Commission).
IIN305	Examination conducted via telehealth	$415.10 per hour (examination only). Discussions with other parties and report to be charged under IIN105.
IIN107	Cancellation with 2 working days notice or less, worker or interpreter fails to attend the scheduled appointment/join the Telehealth appointment, or the worker or interpreter attends the appointment/joins the Telehealth appointment **unreasonably late**	$415.10

Payment Classification Code	Service description	Fee (excl. GST)
	preventing a full examination being conducted	
IIN108	Examination conducted with the assistance of an interpreter	$519.00 per hour (examination only). Discussions with other parties and report to be charged under IIN105 at $415.10 per hour.
IIN308	Examination conducted via telehealth with the assistance of an interpreter	$519.00 per hour (examination only). Discussions with other parties and report to be charged under IIN105 at $415.10 per hour.
IIN109	Travel for assessment/consultation at the worker's place of work	$415.10 per hour

WORKERS COMPENSATION (PSYCHOLOGY AND COUNSELLING FEES) ORDER 2022

under the

Workers Compensation Act 1987

I, Adam Dent, Chief Executive, State Insurance Regulatory Authority, make the followingOrder pursuant to section 61(2) of the *Workers Compensation Act 1987*.

Dated this 7th day of December 2021

Adam Dent
Chief Executive
State Insurance Regulatory Authority

Explanatory Note

Treatment by a Psychologist or Counsellor is medical or related treatment covered under the *Workers Compensation Act 1987* (the Act). 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. For clarity this Order applies to an exempt worker or a worker receiving treatment under the Act outside of NSW.

Psychologists or Counsellors cannot bill for services set out in schedule A in excess of the maximum fee, recovery may be sought for fees charged in excess of the maximum amount.

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. Rates for this treatment are negotiated between the practitioner and insurer.

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. Rates for this treatment are negotiated between the Psychologist and insurer.

Workers Compensation (Psychology and Counselling Fees) Order 2022

1. Name of Order

This Order is the *Workers Compensation (Psychology and Counselling Fees) Order 2022.*

2. Commencement

This Order commences on 1 January 2022.

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 (including a support person, if requested by the worker), employer, workplace rehabilitation provider, insurer or other treatment provider/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 or return to suitable employment. If the discussion you have is with the worker either with or without their chosen support person, it must include another third party (apart from the worker's support person) to be considered a case conference.

Discussions during independent consultant reviews are not classified as case conferencing. Discussions between treating doctors and practitioners relating to treatment are considered a normal interaction and not case conferencing.

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.
Note: 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 to the 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.

First subsequent Certificate of Capacity means the first of any subsequent Certificate of Capacity issued by the worker's treating Psychologist (approved by the Authority in accordance with any requirement under the *Workers Compensation Regulation 2016* (the Regulation)) and submitted to the insurer for the claim. This would apply after the first Certificate of Capacity has been issued by the nominated treating doctor.

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)
tailored goal setting and treatment planning
setting expectations of recovery and return to work
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.

Practitioner in this Order means a Psychologist or Counsellor who delivers services in accordance Schedules A or B of this Order to a NSW worker.

Psychologist means a Psychologist who has general registration to provide psychology services with Australian Health Practitioner Regulation Agency (AHPRA).
Note: 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.

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

re-assessment
intervention/treatment
setting expectations of recovery and return to work
clinical recording, and
preparation of an Allied Health Recovery Request when indicated.

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

Subsequent Certificate of Capacity means the form approved by the Authority, issued by the worker's treating Psychologist approved by the Authority as prescribed in the Regulation.

Telehealth consultations means delivery of consultations via video or telephone by a Psychologist or Counsellor. Consultations would be inclusive of any electronic communication to support the delivery of the treatment service. No additional fee (e.g. facility fees) can be charged in relation to the consultation.

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.

Travel rates can be claimed when the most appropriate clinical management of the worker requires a Psychologist or Counsellor to travel away from their commercial place of business.

4. Application of Order

This Order applies to treatment provided on or after 1 January 2022, 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 and PSY002 and PSY004 (for Psychologists) in Schedule A or COU002, and COU003 and COU005 (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 an amount calculated at the rate per kilometre (for the number of kilometres of travel involved). The rate per kilometre applies only to the number of kilometres of travel reasonably involved and directly related to the treatment. The rate per kilometre is specified in item PSY005 (for Psychologists) in Column 2 of Schedule A and COU006 (for Counsellors) in Column 2 of Schedule B, where this service has been pre-approved by the insurer. Travel costs cannot be charged:

where the practitioner provides services to facilities such as a private hospital
where a practitioner does not have (or is employed by a business that does not have) a commercial place of business for the delivery of psychological or counselling treatment services (e.g. mobile practice).

Where multiple workers are being treated in the same visit to a facility or in the same geographical area on the same day, the reasonable travel charge must be divided evenly between those workers.

(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) The maximum amount payable for the first Subsequent Certificate of Capacity is $38.00 (+GST). This fee is payable only once (1) per claim for completion of the first subsequent Certificate of Capacity.

(5) Telehealth consultations are to be billed according to the appropriate items PSY301 to PSY302 (for Psychologists) in Schedule A and items COU302 to COU303 (for Counsellors) in Schedule B. No additional payment in relation to facility fees can be charged by the practitioner undertaking the consultation.

6. Goods and Services Tax

(1) 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.

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	$119.25/30 mins (maximum 60 minutes) (Pro-rata rates in units of 30 minutes apply)
PSY301	Initial consultation and treatment via telehealth	$119.25/30 minutes (maximum 60 minutes) (Pro-rata rates in units of 30 minutes apply)
PSY002	Subsequent consultation and treatment	$99.55/30 minutes (maximum 60 minutes) (Pro-rata rates in units of 30 minutes apply)
PSY302	Subsequent consultation and treatment via telehealth	$99.55/30 minutes (maximum 60 minutes) (Pro-rata rates in units of 30 minutes apply)
PSY003	Report writing (requires pre-approval and must be requested by the insurer)	$16.60/5 minutes (maximum 60 minutes)
PSY004	Case conference	$16.60/5 minutes
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 2020.* *Use of private motor vehicle:* - *72 cents per kilometre*
PSY006	Group/class intervention	$59.60/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 Psychologist and insurer. Only to be used where treatment is provided to an emergency service worker employed by a Treasury Managed Fund member agency.
PSY020	Incidental expenses e.g. relaxation CD's, books, etc.	Cost price, including postage/freight

WCO005	Fees for providing copies of clinical notes and records	Where clinical records are maintained electronically by a Psychologist/practice, a flat fee of $60 is payable (for provision of all requested clinical records held by the practice) inclusive of postage and handling. A Psychologist/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	$38.70 (Initial AHRR per claim only) Subsequent Allied Health Recovery Requests cannot be billed.
OAS004	Submission of a first subsequent Certificate of Capacity only	$38.70 (first subsequent Certificate of Capacity only) All other Certificate of Capacity submissions 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	$88.80/30 minutes (maximum 60 minutes) (Pro-rata rates in units of 30 minutes apply)
COU302	Initial consultation and treatment via telehealth	$88.80/30 minutes (maximum 60 minutes) (Pro-rata rates in units of 30 minutes apply)
COU003	Subsequent consultation and treatment	$79.40/30 minutes (maximum 60 minutes) (Pro-rata rates in units of 30 minutes apply)
COU303	Subsequent consultation and treatment via telehealth	$79.40/30 minutes (maximum 60 minutes) (Pro-rata rates in units of 30 minutes apply)
COU004	Report writing (only when requested by the insurer)	$13.20/5 minutes (maximum 60 minutes)
COU005	Case conference	$13.20/5 minutes
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 2020.* *Use of private motor vehicle:* - *72 cents per kilometre*
COU007	Group/class intervention	$50.40/participant
COU020	Incidental expenses e.g. relaxation CD's, books, etc.	Cost price, including postage/freight
WCO005	Fees for providing copies of clinical notes and records.	Where clinical records are maintained electronically by a Counsellor/practice, a flat fee of $60 applies for provision of all requested clinical records held by the practice. A Counsellor/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.	$38.70 (Initial AHRR per claim only) Subsequent Allied Health Recovery Requests cannot be billed.

WORKERS COMPENSATION (MEDICAL PRACTITIONER FEES) ORDER 2022

under the

Workers Compensation Act 1987

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

Dated this 6 day of December 2021

Adam Dent
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 otherwise specified in this Order. To bill an AMA item, a Medical Practitioner must have fulfilled the service requirements as specified in the item descriptor. Medical Specialists must utilise AMA item numbers relevant to the type of consultation/service provided (e.g. a dually qualified Pain medicine specialist/anaesthetist cannot bill time based anaesthetic item numbers where pain medicine consultations/services apply). Where a comprehensive item is used, separate items cannot be claimed for any of the individual items included in the comprehensive service.

Medical Practitioners cannot bill for any item referred to in this Order in excess of the maximum fee. Recovery may be sought for fees charged in excess of the maximum amount.

Surgeons and Orthopaedic Surgeons should also refer to the *Workers Compensation (Surgeon and Orthopaedic Surgeon Fees) Order.*

Workers Compensation (Medical Practitioner Fees) Order 2022

1. Name of Order

This Order is the *Workers Compensation (Medical Practitioner Fees) Order 2022.*

2. Commencement

This Order commences on 1 July 2022.

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* as amended or replaced, from time to time, published by the Australian Medical Association, that is the current edition on the AMA website at the date of service delivery.

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 to MZ871. Assistance at Operation fees are to be billed by the Medical Practitioner who provides the assistance (not the Surgeon), using the AMA item code MZ900.

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), Assistance at Operation 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 Assistance at Operation 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 Assistance at Operation fee payments to ensure their proper

distribution into the named trust fund.

Case conference means a face-to-face meeting, video conference or teleconference and must:

- seek to clarify the worker's capacity for work, barriers to return to work, and strategies to overcome these barriers
- be an open forum to ensure parties share the same expectations about the worker's recovery at work or return to suitable employment.

A case conference can be between a medical practitioner and any or all of the following:

- the employer
- the workplace rehabilitation provider
- an injury management consultant
- the insurer; and/or
- other treatment practitioner/s delivering services to the worker (including the nominated treating doctor).

A case conference can be between the worker (including a support person, if requested by the worker) and the medical practitioner but must also include a person from the list above.

The following are not considered a case conference and are not to be charged as such:

- discussions between a medical practitioner and the worker (and their support person, if requested by the worker), which are not attended by a person from the list above
- discussions between treating doctors and treating practitioners relating to treatment. These are considered a normal interaction between referring doctor and practitioner.

The practitioner is to retain file notes of the case conference, including date, duration, participants, topics and outcomes. This information may be required for invoicing or auditing purposes.

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.

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 refers 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 MZ871, with the exception of items specifically listed as a multiple procedure item in the AMA List, or where Schedules in the *Workers Compensation (Surgeon and Orthopaedic Surgeon Fees) Order* prevent combining of items.

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. 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.

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.

Pain medicine specialist means a Medical Practitioner registered as a Pain Medicine Specialist with the Australian Health Practitioner Regulation Agency and is a Fellow of the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists.

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 and who is registered with the Australian Health Practitioner Regulation Authority as a Specialist in surgery in their chosen field. It includes a Surgeon who is a staff member at a public hospital providing services at that 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.

Telehealth means delivery of consultations via video or telephone by a Medical Practitioner. Consultations would be inclusive of any electronic communication to support the delivery of the consultation service. Medical Practitioners must consider the appropriateness of this mode of service delivery for each worker on a case-by-case basis and be satisfied worker outcomes are not compromised. Telehealth consultations must be consented to by the worker. Medical Practitioners are responsible for delivering Telehealth consultations 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. Telehealth consultations are to be paid in accordance with this Order (noting those items specifically excluded in Clause 7 of this Order). Medical Practitioners are to bill for Telehealth consultations using the same AMA List item number normally billed for a face-to-face consultation, with the addition of a 'T' as a suffix to the item number e.g. AA020T (Level B consultation delivered via telehealth) versus AA020 (Level B consultation delivered face to face). The fee payable remains the same. No additional fee (e.g. facility fees) can be charged in relation to the consultation.

Workers Compensation (Surgeon and Orthopaedic Surgeon Fees) Order means the *Workers Compensation (Surgeon and Orthopaedic Surgeon Fees) Order* in force on the date the service is provided.

Workplace Injury Management and Workers Compensation (Medical Examinations and Reports Fees) Order means the *Workplace Injury Management and Workers Compensation (Medical Examinations and Reports Fees) Order* in force on the date the service is provided.

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/AC500T, AC510/AC510T, AC600/AC600T and AC610/AC610T (Professional Attendances by a Specialist), if these medical services are provided by a Surgeon or Orthopaedic Surgeon;
- 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).

Note: The definitions of OP200 and OP210 apply regardless of whether MRI

scans are all performed on one day or, for any reason, over several days. The entire episode of care is classified as one service under one medical practitioner request, for which either payment classification code OP200 or OP210 apply and therefore can only be invoiced once per medical practitioner request to cover the complete service.

(3) The maximum amount payable for a certificate of capacity is $49.30. This fee is payable only once per claim for completion of the initial certificate ofcapacity and is invoiced under payment classification code **WCO001**.

(4) A General Practitioner, Medical Specialist and Surgeon or Orthopaedic 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 rates are payable:

- General Practitioner: $24.70 per 5 minutes
- Medical Specialist: $34.30 per 5 minutes
- Surgeon or Orthopaedic Surgeon: $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/Surgeons, 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 5-minute pro-rata rates to reflect the time taken to prepare the report. These reports may answer questions to assist the insurer determine prognosis for recovery and timeframes for returning to work. 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* 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) andan

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 pro-rata rates specified above at 5(4). This fee can be billed in addition to the fees stated above for provision of medical records by hard copy or electronically.

(6) Assistance at Operation is only payable for those surgical procedure/s where an assistance fee is allowed for in the MBS, and only once per eligible item number performed by the principal Surgeon irrespective of the number of Medical Practitioners providing Assistance at Operation. Maximum fees for Assistance at Operation are calculated at 20% of the principal Surgeon/Medical Practitioner's fee for the surgical procedure/s performed, or the amount stated in the AMA Fees List for MZ900, whichever is the greater.

The Medical Practitioner providing the Assistance at Operation is to invoice for their services separately to the principal Surgeon/Medical Practitioner using AMA item number **MZ900**.

(7) Telehealth consultations are to be paid in accordance with this Order (noting those items specifically excluded in Clause 7 of this Order). Medical Practitioners are to bill for Telehealth consultations using the same AMA Fees List item number normally billed for a face-to-face consultation, with the addition of a 'T' as a suffix to the item number e.g. AA020T (Level B consultation delivered via telehealth) versus AA020 (Level B consultation delivered face to face). The fee payable remains the same. No additional fee (e.g. facility fees) can be charged in relation to the consultation.

(8) 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 and Orthopaedic Surgeon Fees) Order* prevent combining of items.

(9) Subject to subclauses (1), (2), (3), (4), (5), (6), (7), (8) and clause 7 (Nil fee for certain medical services) and clause 8 (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.

6. Specialist consultations

The initial Medical Specialist/Surgeon/Orthopaedic 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/Surgeon/Orthopaedic Surgeon consultation fee includes a consultation with a Medical Specialist/Surgeon/Orthopaedic 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**.**

Professional attendances for pain medicine services are not to be billed using time based anaesthetic AMA items CA002 – CA008. Pain Medicine Specialists are to bill using AMA items AF010 – AF050.

Specialist Anaesthetists who are not Pain Medicine Specialists are to use items AC500 or AC510 for the purpose of a pain medicine professional attendance.

Professional attendances for pain medicine services provided by a Medical Specialist other than a Pain Medicine Specialist are billed using the Professional Attendance AMA items relevant to their specialty.

Consultations with Medical Specialist/Surgeon/Orthopaedic Surgeon require prior approval bythe 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 byAMA 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, AM180 – AM 240, AP040, and AP050 – AP105).

- Imaging/radiology – Professional attendance items billed in conjunction with imaging /radiology services where an interventional procedure/s has not been

provided by the attending radiologist.

- Subsequent specialist consultations (Medical services identified in the AMA List by AMA numbers AC510, AC530, AC610, AC630, AC640, AD020, AD040, AE125, AE145, AF020, AF050, AG015, AG035, AJ020 and AJ040) conducted on the same day as delivery of a planned surgical procedure, therapeutic procedure, or interventional pain medicine procedure.

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/Surgeon/Orthopaedic 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/Surgeon/Orthopaedic 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* webpageon the SIRA website at www.sira.nsw.gov.au.

Anti-Discrimination Act 1977

EXEMPTION ORDER

Under the provisions of section 126 of the *Anti-Discrimination Act 1977* (NSW), an exemption is given from sections 25 and 51 of the *Anti-Discrimination Act 1977* (NSW) to Hanson Construction Materials Pty Ltd to advertise, designate and recruit up to 20 truck driver positions per year for women only.

This exemption will remain in force for 2 years.

Dated this 3 of December 2021

Jackie Lyne
Manager, Governance & Advice
Delegate of the President
Anti-Discrimination NSW

WORKERS COMPENSATION (MASSAGE THERAPY FEES) ORDER 2022

under the

Workers Compensation Act 1987

I, Adam Dent, Chief Executive, State Insurance Regulatory Authority, make the followingOrder pursuant to section 61(2) of the *Workers Compensation Act 1987*.

Dated this 7th day of December 2021

Adam Dent
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 2022

1. Name of Order

This Order is the *Workers Compensation (Massage Therapy Fees) Order 2022.*

2. Commencement

This Order commences on 1 January 2022.

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 2022, 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)	$87.20
RMA002	Consultation and treatment (45 minutes duration)	$65.40
RMA003	Consultation and treatment (30 minutes duration)	$43.80
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 (PHYSIOTHERAPY, CHIROPRACTIC AND OSTEOPATHY FEES) ORDER 2022

under the

Workers Compensation Act 1987

I, Adam Dent, Chief Executive, State Insurance Regulatory Authority, make the followingOrder pursuant to section 61(2) of the *Workers Compensation Act 1987*.

Dated this 7th day of December 2021

Adam Dent
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* (the Act). 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 a NSW worker. For clarity this Order applies to an exempt worker or a worker receiving treatment under the Act outside of NSW.

Physiotherapists, Chiropractors and Osteopaths cannot bill for services set out in schedule A in excess of the maximum fee, recovery may be sought for fees charged in excess of the maximum amount.

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. Rates for this treatment are negotiated between the practitioner and insurer.

Workers Compensation (Physiotherapy, Chiropractic and Osteopathy Fees) Order 2022

1. Name of Order

This Order is the *Workers Compensation (Physiotherapy, Chiropractic and Osteopathy Fees) Order 2022*

2. Commencement

This Order commences on 1 January 2022.

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 (including a support person, if requested by the worker),

employer, workplace rehabilitation provider, insurer or other treatment provider/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 or return to suitable employment. If the discussion you have is with the worker either with or without their chosen support person, it must include another third party (apart from the worker's support person) to be considered a case conference.

Discussions during Independent consultant reviews are not classified as case conferencing. Discussions between treating doctors and practitioners relating to treatment are considered a normal interaction and not case conferencing.

Chiropractor means a Chiropractor who has general registration to provide chiropractic services with the Australian Health Practitioner Regulation Agency.
Note: 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.

Consultation A - Initial 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.

Consultation A – Subsequent means treatment sessions provided after the initial consultation and treatment.

Consultation B - Initial means the first session provided by the Physiotherapist, Chiropractor or Osteopath in respect of an injury where the clinical presentation includes:

- two (2) entirely separate compensable injuries or conditions. Where assessment and treatment applied to one of the injuries or conditions is separate to the treatment required for the other injury e.g. neck condition plus post fracture wrist. A compensable injury with referred symptoms to another body area does not constitute more than one injury, or
- complicated hand injuries involving multiple fingers, joints or tissues.

See Initial consultation for full definition of initial assessment and treatment.

Consultation B - Subsequent means treatment sessions provided subsequent to Consultation B Initial where the clinical presentation includes:

- two (2) entirely separate compensable injuries or conditions. Where assessment and treatment applied to one of the injuries or conditions is separate to the treatment required for the other injury e.g. neck condition plus post fracture wrist. A compensable injury with referred symptoms to another body area does not constitute more than one injury, or
- complicated hand injuries involving multiple fingers, joints or tissues.

See Subsequent consultation for full definition of subsequent assessment and treatment.

Consultation C – *may include Initial* or subsequent consultation, in respect of an injury where the clinical presentation includes:

- three (3) or more entirely separate compensable injuries or conditions. Where assessment and treatment required for any one of the injuries or conditions is separate to the treatment required for any of the other injuries. e.g. treatment required for a neck condition, treatment for a wrist post-fracture, plus treatment for a knee ligament injury. A compensable injury with referred symptoms to another body area does not constitute more than one injury, or
- a major hand injury (Modified Hand Injury Severity Score > 100) where assessment and treatment is provided by an Australian Hand Therapy Association Accredited Hand Therapist, or
- extensive burns.

Provision of Consultation C – See Initial consultation or Subsequent consultation for full definition of initial or subsequent assessment and treatment.

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 practitioner or where the practitioner does not contract their services to the facility.

First subsequent Certificate of Capacity means the first of any subsequent Certificates of Capacity issued by the worker's treating Physiotherapist (approved by the Authority in accordance with any requirement under the *Workers Compensation Regulation 2016* (the Regulation)) and submitted to the insurer for the claim. This would apply after the first Certificate of Capacity has been issued by the nominated treating doctor.

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 to enable treatment of the worker.

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. Independent consultant review means a review 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 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
- tailored goal setting and treatment planning
- setting expectations of recovery and return to work
- treatment/service
- clinical recording
- communication with referrer, insurer and other relevant parties, and preparation of an Allied Health Recovery Request when indicated

This definition applies to a service provide on a one-to-one basis with the worker for the entire session.

Insurer means the employer's workers compensation insurer.

Major hand injury means a hand injury which is assessed in accordance with the Modified Hand Injury Severity Score (MHISS) and scores > 100.

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 who has general registration to provide osteopathy services with the Australian Health Practitioner Regulation Agency.
Note: 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 who has general registration to provide physiotherapy services with the Australian Health Practitioner Regulation Agency.
Note: 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.

Practitioner in this Order means a Physiotherapist, Chiropractor or Osteopath who delivers services in accordance Schedules A of this Order to a NSW worker.

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.

Subsequent Certificate of Capacity means the form approved by the Authority, issued by the worker's treating physiotherapist approved by the Authority as prescribed in the Regulation.

Subsequent consultation means treatment sessions provided after the Initial consultation and treatment, and includes:

- re-assessment
- intervention/treatment
- setting expectations of recovery and return to work
- clinical recording, and
- preparation of an Allied Health Recovery Request when indicated.

The subsequent 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, dry needling and aquatic therapy/hydrotherapy.

Telehealth consultations means delivery of consultations via video or telephone by a Physiotherapist, Chiropractor or Osteopath. Consultations would be inclusive of any electronic communication to support the delivery of the treatment service. No additional fee (e.g. facility fee) can be charged in relation to the consultation.

Three (3) or more distinct areas means three (3) or more entirely separate compensable injuries or conditions. Where assessment and treatment required for any one of the injuries or conditions is separate to the treatment required for any of the other injuries. e.g. treatment required for a neck condition, treatment for a wrist post-fracture, plus treatment for a knee ligament injury. A compensable injury with referred symptoms to another body area does not constitute more thanone injury.

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

Two (2) distinct areas means two (2) entirely separate compensable injuries or conditions. Where assessment and treatment applied to one of the injuries or conditions is separate to the treatment required for the other injury e.g. neck condition plus post fracture wrist. A compensable injury with referred symptoms to another body area does not constitute more than one injury.

4. Application of Order

This Order applies to treatment provided on or after 1 January 2022 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 and PTA015 (for Physiotherapy), CHA005, CHA006, CHA071, CHA072, CHA073 and CHA015 (for Chiropractic) or OSA007 to OSA011 and OSA015 (for Osteopathy) 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 treatment is increased by an amount calculated at the rate per kilometre (for the number of kilometres of travel reasonably involved). The rate per kilometre applies only to the number of kilometres of travel reasonably involved and directly related to the treatment. The rate per kilometre is 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. Travel costs cannot be charged:

- where the practitioner provides services to facilities such as a private hospital
- where a practitioner does not have (or is employed by a business that does not have) a commercial place of business for the delivery of Physiotherapy, Chiropractic and Osteopathy treatment services (e.g. mobile practice).

Where multiple workers are being treated in the same visit to a facility or in the same geographical area on the same day, the reasonable travel charge must be divided evenly between those workers.

(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) The maximum amount payable for the First subsequent Certificate of Capacity is $38.00 (+GST). This fee is payable only once (1) per claim for completion of the First subsequent Certificate of Capacity.

(5) Telehealth consultations are to be billed according to the appropriate items PTA301 to PTA304 (for Physiotherapy); CHA301 to CHA304, (for Chiropractic) and OSA301 to OSA304 (for Osteopathy) in Schedule A. No additional payment in relation to facility fees can be charged by the practitioner undertaking the consultation.

6. 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 practitioner) is to invoice the insurer directly under code OTT007. Where this is not possible, the practitioner must clearly state the name, location and charge cost price of the facility usage 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.

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 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.

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	Consultation A - Initial	$125.00
PTA301	CHA301	OSA301	Consultation A - Initial via telehealth	$125.00
PTA002	CHA002	OSA002	Consultation A - Subsequent	$84.80
PTA302	CHA302	OSA302	Consultation A - Subsequent via telehealth	$84.80
PTA003	CHA031	OSA003	Consultation B - Initial Two (2) distinct areas Complicated hand injuries	$188.30
PTA303	CHA303	OSA303	Consultation B - Initial via telehealth of Two (2) distinct areas Complicated hand injuries	$188.30
PTA004	CHA032	OSA004	Consultation B - Subsequent Two (2) distinct areas Complicated hand injuries	$125.50
PTA304	CHA304	OSA304	Consultation B - Subsequent via telehealth Two (2) distinct areas Complicated hand injuries	$125.50
PTA005	CHA033	OSA005	Consultation C – Initial or subsequent Three (3) or more distinct areas Major hand injury (Modified Hand Injury Severity Score > 100) Extensive burns	$16.40 /5 minutes $196.80/hour (maximum)
PTA006	CHA010	OSA006	Group/class intervention	$60.10/participant
N/A	CHA004	N/A	Spine X-rays performed by a Chiropractor	$152.80
Home Visit	**Home Visit**	**Home Visit**		
PTA007	CHA005	OSA007	Consultation A - Initial	$125.00
PTA008	CHA006	OSA008	Consultation A - Subsequent	$98.50
PTA009	CHA071	OSA009	Consultation B - Initial Two (2) distinct areas Complicated hand injuries	$188.30
PTA010	CHA072	OSA010	Consultation B - Subsequent Two (2) distinct areas Complicated hand injuries	$152.90
PTA011	CHA073	OSA011	Consultation C – Initial or subsequent Three (3) or more distinct areas Major hand injury (Modified Hand Injury Severity Score >	$16.40 /5 minutes $196.80/hour (maximum)

Other	Other	Other		
PTA014	CHA009	OSA014	Travel costs (requires pre-approval by the insurer).	Use of private motor vehicle: - 72 cents per kilometre - 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 2020.
PTA015	CHA015	OSA015	Case conference	$16.40 (+GST)/ 5 minutes
PTA016	CHA016	OSA016	Report writing (only when requested by the insurer)	$16.40 (+GST)/ 5 minutes (maximum 1 hour)
PTA020	CHA020	OSA020	Incidental expenses e.g. strapping, tape, theraband, exercise putty, etc. Note: This code does not apply to external facility fees	Cost price, including postage/freight.
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

OAS003	OAS003	OAS003	Submission of an Initial Allied Health Recovery Request (AHRR) only.	$38.70 (Initial AHRR per claim only) All other Allied Health Recovery Requests submissions do not attract a fee. For Initial Consultation A, B and C when indicated.
OAS004	Nil	Nil	Submission of a first subsequent Certificate of Capacity only. Note: Must be a SIRA approved Physiotherapist to issue a Certificate of Capacity	$38.70 (First subsequent Certificate of Capacity only) All other Certificate of Capacity submissions do not attract a fee.

WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION (MEDICAL EXAMINATIONS AND REPORTS FEES) ORDER 2022

under the

Workplace Injury Management and Workers Compensation Act 1998

I, Adam Dent, 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 7th day of December 2021

Adam Dent
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*, *Workers Compensation (Surgeons Fees) Order and Workers Compensation (Orthopaedic Surgeons Fees) Order for* medical services fees related to treatment.

Workplace Injury Management and Workers Compensation (Medical Examinations and Reports Fees) Order 2022

Part 1 Preliminary

1. Name of Order

This Order is the *Workplace Injury Management and Workers Compensation (Medical Examinations and Reports Fees) Order 2022.*

2. Commencement

This Order commences on 1 January 2022.

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 Governance Act 2015.*

File Review means a review of the file when the Medical 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 current 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 examinations are permissible in limited and special circumstances 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. A pandemic, such as the outbreak of COVID-19 (Coronavirus) is considered a special circumstance.

   Video examination services are to be coded and paid in accordance with the examination items in this Order. The fee payable remains the same. No additional payment fee (e.g. facility fees) can be charged in relation to 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);

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 (or for video examination, joins the appointment unreasonably late) to the degree that a full examination is prevented from being conducted.

Workers Compensation (Medical Practitioner Fees) Order means the Workers Compensation (Medical Practitioner Fees) Order in force on the date the service is provided.

Workers Compensation (Orthopaedic Surgeon Fees) Order means the Workers Compensation (Orthopaedic Surgeon Fees) Order in force on the date the service is provided.

Workers Compensation (Surgeon Fees) Order means the Workers Compensation (Surgeon Fees) Order in force on the date the service is provided.

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. 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*.

(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 Doctors in workers compensation webpage on the SIRA website – www.sira.nsw.gov.au

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)	$614.40
IMG301 or WIG301	Video examination and report - Standard Report (see definition of Medical Examination and Report)	$614.40
IMG002 or WIG002	Examination conducted with the assistance of an interpreter and report– Standard Report (see definition of Medical Examination and Report)	$685.80
IMG302 or WIG302	Video examination conducted with the assistance of an interpreter and report– Standard Report (see definition of Medical Examination and Report)	$685.80
IMG003 or WIG003	Examination and report - Complex Report (see definition of Medical Examination and Report)	$917.20
IMG303 or WIG303	Video examination and report - Complex Report (see definition of Medical Examination and Report)	$917.20
IMG004 or WIG004	Examination conducted with the assistance of an interpreter and report – Complex Report (see definition of Medical Examination and Report)	$1,068.60
IMG304 or WIG304	Video examination conducted with the assistance of an interpreter and report – Complex Report (see definition of Medical Examination and Report)	$1,068.60
IMG005 or WIG005	Cancellation with 2 working days notice or less, worker or interpreter fails to attend the scheduled appointment/join the video appointment, or the worker or interpreter attends the appointment/joins the	$149.70

Payment Classification Code	Service description	Fee (excl. GST)
	video appointment **unreasonably late** preventing a full examination being conducted.	
IMG006 or WIG006	File review and report (see definition of File Review)	$454.60
IMG007 or WIG007	Supplementary report (See definition of Supplementary report).	$303.30
IMG008 or WIG008	Update examination and report of worker previously reviewed, where there is no intervening incident	$383.10
IMG308 or WIG308	Update video examination and report of worker previously reviewed, where there is no intervening incident	$383.10
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 2020.* *Use of private motor vehicle: 72 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.

Payment Classification Code	Service description	Fee (excl. GST)
		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.* 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)	$830.10
IMS301 or WIS301	Video examination and report - Standard Report (see definition of Medical Examination and Report)	$830.10
IMS002 or WIS002	Examination conducted with the assistance of an interpreter and report – Standard Report (see definition of Medical Examination and Report)	$1,036.40
IMS302 or WIS302	Video examination conducted with the assistance of an interpreter and report – Standard Report (see definition of Medical Examination and Report)	$1,036.40
IMS003 or WIS003	ENT examination (includes audiological testing) and report - Standard Report (see definition of Medical Examination and Report)	$830.10
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)	$1,036.40
IMS004 or WIS004	Examination and report – Moderately Complex Report (see definition of Medical Examination and Report)	$1,244.20
IMS304 or WIS304	Video examination and report – Moderately Complex Report (see definition of Medical Examination and Report)	$1,244.20
IMS005 or WIS005	Examination conducted with the assistance of an interpreter and report – Moderately Complex Report (see definition of Medical Examination and Report)	$1,452.10

Payment Classification Code	Service description	Fee (excl. GST)
IMS305 or WIS305	Video examination conducted with the assistance of an interpreter and report – Moderately Complex Report (see definition of Medical Examination and Report)	$1,452.10
IMS006 or WIS006	Examination and report – Complex Report including complex psychiatric (see definition of Medical Examination and Report)	$1,650.60
IMS306 or WIS306	Video examination and report – Complex Report including complex psychiatric (see definition of Medical Examination and Report)	$1,650.60
IMS007 or WIS007	Examination conducted with the assistance of an interpreter and report – Complex Report (see definition of Medical Examination and Report)	$2,066.20
IMS307 or WIS307	Video examination conducted with the assistance of an interpreter and report – Complex Report (see definition of Medical Examination and Report)	$2,066.20
IMS008 or WIS008	Examination and report – psychiatric	$1,452.10
IMS308 or WIS308	Video examination and report – psychiatric	$1,452.10
IMS081 or WIS081	Examination conducted with the assistance of an interpreter and report – psychiatric	$1,817.70
IMS381 or WIS381	Video examination conducted with the assistance of an interpreter and report – psychiatric	$1,817.70
IMS092 or WIS092	Cancellation with 2 working days notice or less, worker or interpreter fails to attend the scheduled appointment/join the video appointment, or the worker or interpreter attends the appointment/joins the video appointment **unreasonably late** preventing a full examination being conducted.	$416.30
IMS010 or WIS010	File review and report (see definition of File Review)	$622.00
IMS011 or WIS011	Supplementary report where additional information is provided and requested, or additional questions are posed. This fee does	$414.40

Payment Classification Code	Service description	Fee (excl. GST)
	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).	
IMS012 or WIS012	Update examination and report of worker previously reviewed, where there is no intervening incident.	$614.50
IMS312 or WIS312	Update video examination and report of worker previously reviewed, where there is no intervening incident.	$614.50
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 2020.* *Use of private motor vehicle:* *72 cents per kilometre* *Flying allowance:* *$21.80 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 impairment resulting from the individual assessments.	$208.10
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

Payment Classification Code	Service description	Fee (excl. GST)
		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.* 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.

WORKERS COMPENSATION (HEARING AID FEES) ORDER 2022

under the

***Workers Compensation Act* 1987**

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

Dated this 7th day of December 2021

Adam Dent
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 has a work-related injury hearing loss. For clarity this Order applies to an exempt worker or a worker receiving treatment under the Act outside of NSW.

Hearing service providers cannot bill for services set out in schedule A in excess of the maximum fee, recovery may be sought for fees charged in excess of the maximum amount.

Workers Compensation (Hearing Aid Fees) Order 2022

1. Name of Order

This Order is the *Workers Compensation (Hearing Aid Fees) Order 2022.*

2. Commencement

This Order commences on 1 January 2022.

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*.

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 an Audiology Australia Accredited Audiologist or a full/ordinary member 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 Hearing Aid Audiology Society of Australia (HAASA).

Audiology Entity is a registered business or company that provides reasonably necessary medical or related treatment (hearing services) to a worker who has a work-related injury hearing loss.

Cost price means the price that a store or business pays for goods that are bought directly from the supplier. This is different to 'retail price' which is charged to consumers.

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

Hearing aid accessories supplement the use of a hearing aid to assist listening, communication and functioning in different environments.

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, clinical rationale for hearing aid, hearing aid accessories (where required) and rehabilitation plan appropriate to the worker and the device.

Hearing rehabilitation includes the assessment, planning and delivery of tailored best practice hearing rehabilitation for the worker, encompassing all necessary education, hearing rehabilitation and counselling to facilitate effective hearing and for the worker to achieve their communication goals.

Hearing Service Provider refers to an Audiology Entity appropriately qualified to provide treatment and supply hearing aids to injured workers.

Insurer means the employer's workers compensation insurer.

Telehealth services means delivery of services via video or telephone by a Hearing Service Provider. Consultations would be inclusive of any electronic communication to support the delivery of the treatment service. No additional fee (e.g. facility fees) can be charged in relation to the services.

4. Application of the Order

This Order applies to the provision of medical or related treatment and a hearing aid, made on or after 1 January 2022, 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 is listed in Schedule A.

(2) The maximum fee for telehealth services are to be billed according to the appropriate item AID309 and AID310 in Schedule A.

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 hearing service provider to charge or recover more than the amount of GST payable in respect of the service to which the cost relates.

SCHEDULE A

Maximum fees for a hearing aid and services provided on or after 1 January 2022

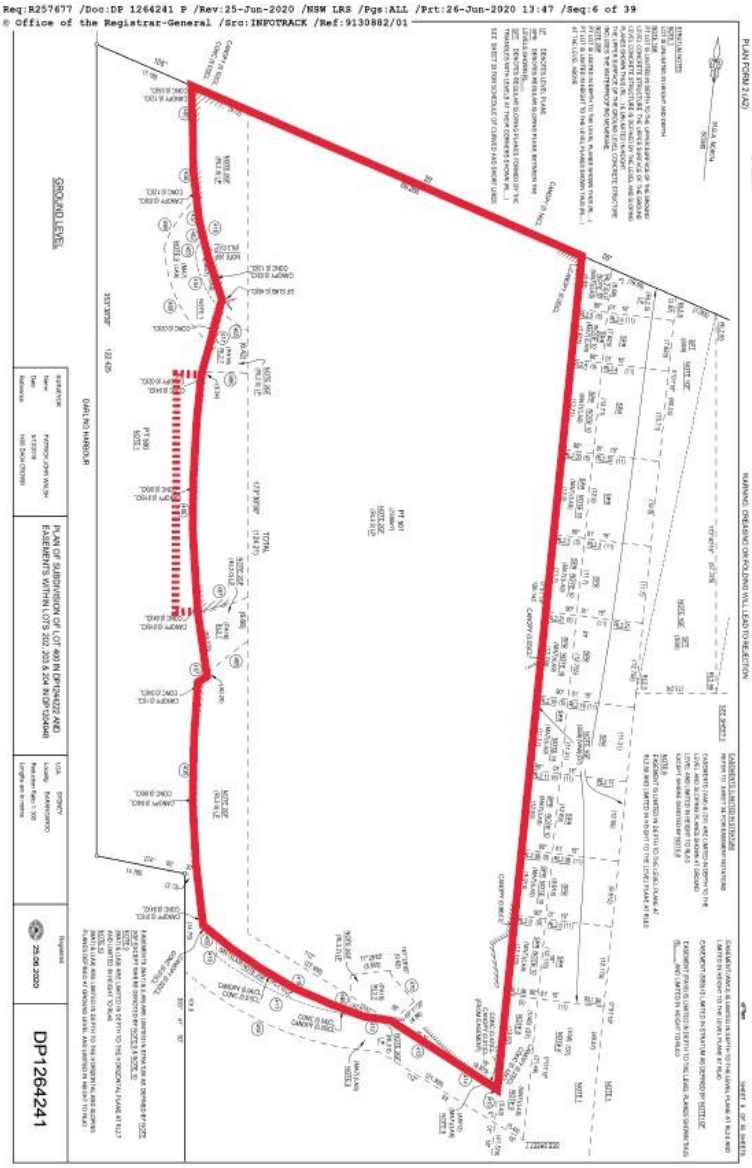
Item	*Service description*	*Maximum amount (excl GST)*
AID004	Hearing needs assessment – Audiologist	$218.10
AID005	Hearing needs assessment – Audiometrist	$179.80
AID006	Supply of hearing aid/s (including remote control and charger if required) 'Supply' includes the: • ordering and delivery of the aid/s to the hearing service provider, and • provision of a 30-day trial of the aid by the worker and • supply of batteries and consumables for the first 12 months.	Cost price of hearing aid/s, including remote control, charger, batteries and consumables to maximum of $2500.00 per aid
AID007	Hearing aid/s accessories Note: does not include remote control or charger.	Cost price, including postage/freight to the provider.
AID008	Handling fee for hearing aid/s (monaural or binaural) and accessories, payable upon supply of hearing aid/s and accessories Note: only one handling fee is billable per hearing aid/s at the time of supply whether they are supplied with accessories or not. The handling fee is not applicable once the hearing aid/s are supplied or for requests of accessories only.	$320.90
AID009 (in person) AID309 (telehealth)	Fitting of device A fitting fee is payable upon supply of hearing aid/s (monaural or binaural). This fee covers: • fitting of the hearing aid/s and assessment that the device is suited to the worker • instructions and education on use of the device and accessories, tailored to the needs of the worker • provision of a device management plan outlining life expectancy, warranty, servicing recommendations, emergency support availability and battery requirements including the need for a charger if appropriate Note: Only one fitting fee is billable per hearing aid/s whether it be provided in person or via telehealth.	$630.30
AID010 (in person) AID310 (telehealth)	Hearing rehabilitation Assess, plan and deliver tailored best practice hearing rehabilitation for the worker, encompassing all necessary education, hearing rehabilitation and counselling to facilitate effective hearing and for the worker to achieve their communication goals.	$630.30

AID011	New batteries/consumables 12 months' supply of hearing aid/s battery and consumables, as requested by the worker. Note**:** Cannot be supplied until 12 months after the initial supply of the hearing aid/s.	$131.30 per hearing aid
AID012	Hearing aid/s review/minor maintenance Audiological services provided for hearing aid/s adjustment, maintenance and rehabilitation for optimal use. **Note**: Cannot be supplied until 12 months after the initial fitting of the hearing aid.	$39.40/ 15 mins Maximum 1 hour
AID013	Hearing aid repairs by manufacturer Note: Payable only if a copy of manufacturer's invoice for repairs is provided.	Up to $423.50

CASINO CONTROL ACT 1992

SECTION 89(3) ORDER

I, Victor Dominello, Minister for Customer Service, pursuant to section 89(3) of the *Casino Control Act 1992*, **DO HEREBY ORDER**, that the premises within the area depicted by red broken lines in the map below, being part of Lot 500 in DP1264241 are to be considered to form part of a casino for the purposes of section 89 of that Act for the period of 17 to 18 December 2021 inclusive.



Dated 6 / 12/ 2021

Victor Dominello MP
Minister for Customer Service

ASSOCIATIONS INCORPORATION ACT 2009

Cancellation of incorporation pursuant to section 74

TAKE NOTICE that the incorporation of the following associations is cancelled by this notice pursuant to section 74 of the Associations Incorporation Act, 2009.

ROTARY CLUB OF FRENCHS FOREST INC	**Y0862810**
STOCKTON HOSPITAL WELFARE ASSOCIATION INC	**Y1742131**
CROUDACE BAY PUPPY PLAYGROUP INCORPORATED	**INC9894253**
SPRINGWOOD SENIORS DANCE CLUB INCORPORATED	**Y2511444**
ROTARY DISTRICT 9670 YOUTH EXCHANGE COMMITTEE INCORPORATED	**Y1994438**
AUSTRALIAN FOOD TRUCKS ASSOCIATION INCORPORATED	**INC1500345**

Cancellation is effective as at the date of gazettal.

Dated this 9th day of December 2021

Megan Green
Delegate of the Commissioner for Fair Trading
Department of Customer Service

ASSOCIATIONS INCORPORATION ACT 2009

Cancellation of registration pursuant to section 80

TAKE NOTICE that **WITMORE ENTERPRISES INCORPORATED - Y2254728** became registered under the Corporations Act 2001 as **WHITMORE LTD** - **ACN 655 533 412,** a company limited by guarantee, on 23 November 2021, and accordingly its registration under the Associations Incorporation Act 2009 is cancelled as of that date.

Terri McArthur
Delegate of the Commissioner,
NSW Fair Trading
8 December 2021

ASSOCIATIONS INCORPORATION ACT 2009

Cancellation of registration pursuant to section 80

TAKE NOTICE that **MINIMBAH CHALLENGE INCORPORATED - Y1729706** became registered under the Corporations Act 2001 as **MINIMBAH DISABILITY SUPPORT SERVICES LIMITED - ACN 655 244 401,** a company limited by guarantee, on 17 November 2021, and accordingly its registration under the Associations Incorporation Act 2009 is cancelled as of that date.

Terri McArthur
Delegate of the Commissioner,
NSW Fair Trading
08 December 2021