Government Gazette

of the State of

New South Wales

Number 27 - Other

Friday, 24 January 2025

The New South Wales Government Gazette is the permanent public record of official NSW Government notices. It can also contain 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 each page of the notice and can be used as a reference for that notice. For example, [NSWGG-2024-10-1].

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

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ISSN 2201-7534

By Authority
Government Printer

Anti-Discrimination
New South Wales

Anti-Discrimination Act 1977

EXEMPTION ORDER

Under the provisions of section 126 of the *Anti-Discrimination Act 1977* (NSW), an exemption is given an exemption is given from sections 8 and 51 of the *Anti-Discrimination Act 1977* (NSW) to Cancer Council Australia.

This exemption is to advertise, designate and recruit an Aboriginal or Torres Strait Islander person in the position of First Nations Cancer Navigation Lead.

This exemption will remain in force for 3 years.

Date: 27 November 2024

Alex Benn
Manager, Governance & Advice
Delegate of the President
Anti-Discrimination NSW

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Anti-Discrimination
New South Wales

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 8 and 51 of the *Anti-Discrimination Act 1977* (NSW) to CDC NSW Pty Ltd.

This exemption is to advertise, designate and recruit up to 10 bus driver positions each year for Aboriginal and Torres Strait Islander people only.

This exemption will remain in force for 5 years.

Date: 12 December 2024

Alex Benn
Manager, Governance & Advice
Delegate of the President
Anti-Discrimination NSW

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ASSOCIATIONS INCORPORATION ACT 2009

Cancellation of registration pursuant to section 80

TAKE NOTICE that **AUSTRALASIAN NEUROSCIENCE NURSES' ASSOCIATION INCORPORATED - Y1371926** became registered under the Corporations Act 2001 as **AUSTRALASIAN NEUROSCIENCE NURSES' ASSOCIATION LTD** - **ACN 682 901 346** a company limited by guarantee, on 06 December 2024, and accordingly its registration under the Associations Incorporation Act 2009 is cancelled as of that date.

Christine Raglus
Delegate of the Commissioner,
NSW Fair Trading
20 January 2025

ASSOCIATIONS INCORPORATION ACT 2009

Cancellation of Registration pursuant to Section 74

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

AUSTRALIAN CHINESE ASSOCIATION OF FILM ART INCORPORATED	INC1700361
CALLALA COMMUNITY CHURCH INCORPORATED	INC9886452
COMPUTER PALS FOR SENIORS, KENSINGTON INCORPORATED	INC9875495
CZECH AUSTRALIAN SOCIETY FOR ARTS & SCIENCES (CASAS) INCORPORATED	INC2300723
FRENCH'S FOREST GARDEN CLUB INCORPORATED	Y1799531
HUIHUA CHINESE SCHOOL INC	INC1901453
HUNTER HERITAGE NETWORK INCORPORATED	INC9885933
LUCY FOR HUMANITY INCORPORATED	INC1601027
NATIONAL SENIORS AUSTRALIA WARRINGAH EVENING BRANCH INC	INC9882252
RESPECT AWARENESS INCORPORATED	Y2702925
SECURITY4WOMEN INCORPORATED	INC9892376
SHARKS AQUATIC SPORTS INCORPORATED	INC1400115
TAMBAR SPRINGS EMPORIUM WELLNESS CENTRE INCORPORATED	INC9876714
TE PAPA WAWATA KI TE MOANA INCORPORATED	INC9890090
TWEED WELCOMES REFUGEES INC	INC2300491
YARRAMALONG VALLEY COMMUNITY INCORPORATED	INC9882625

Cancellation is effective as at the date of gazettal.

Dated this 22nd day of January 2025.

Lynette Viner
Delegate of the Commissioner

NSW Fair Trading

ASSOCIATIONS INCORPORATION ACT 2009

Cancellation of Registration pursuant to Section 76

TAKE NOTICE that the registration of the following associations is cancelled by this notice pursuant to section 76 of the Associations Incorporation Act 2009.

3 VILLAGE ART FESTIVAL INCORPORATED	INC1400228
AFRICAN COMMUNITIES COUNCIL OF NSW INCORPORATED	INC1301323
ANATOLIAN SHEPHERD DOG CLUB OF NEW SOUTH WALES INCORPORATED	INC1400042
ARMIDALE COMPUTERBANK INCORPORATED	INC1400422
AUSTRALASIA BANGLADESHI EMERGENCY PHYSICIANS ASSOCIATION INCORPORATED	INC1301549
AUSTRALIA CHINESE TOURISM AND FISHING ASSOCIATION INCORPORATED	INC1400423
AUSTRALIAN CYCLISTS PARTY INC	INC1301582
AUSTRALIAN INSTITUTE OF FUTURE LEADERS INCORPORATED	INC1301189
AUSTRALIAN JIAXING ASSOCIATION INCORPORATED	INC1301358
AUSTRALIAN KYOKUSHIN FEDERATION INCORPORATED	INC1400291
AUSTRALIAN MEDICAL STUDENT JOURNAL ASSOCIATION INCORPORATED	INC1301590
AUSTRALIAN SACRED MUSIC ASSOCIATION INCORPORATED	INC1301425
AUSTRALIAN STUDENTS FILM FESTIVAL INCORPORATED	INC1400433
BAR BEACH SKATEBOARD CLUB INCORPORATED	INC1400503
BAWLEY POINT KIOLOA JUNIOR LIFE SAVING CLUB INCORPORATED	INC1301433
CAN 4 LIFE INCORPORATED	INC1301226
CARE MINISTRIES INTERNATIONAL AUSTRALIA INCORPORATED	INC1301192
CENTRE OF GRAVITY HIGH FUNCTIONING AUTISM & ASPERGER SYNDROME COMMUNITY CENTRE INCORPORATED	INC1301295
CHAMBER OF AUSTRALIAN TURKISH CYPRIOT PROFESSIONALS INCORPORATED	INC1400493
CHAOS SYNDICATE INCORPORATED	INC1301203
CHEER NEPAL INCORPORATED	INC1301461
CHINESE YEARBOOK ASSOCIATION AUSTRALIA INCORPORATED	INC1400397
COASTAL COUNTRY MUSIC EVENTS INCORPORATED	INC1301334
FAKAFOTU INCORPORATED	INC1301391

FEDERATION OF AUSTRALASIAN COMMUNITIES INC	INC1301413
GENERATION PHOENIX INCORPORATED	INC1301349
GLOBAL SHAPERS COMMUNITY - SYDNEY HUB INCORPORATED	INC1400068
GOLD CARRIAGE INCORPORATED	INC1400247
HENTY AND DISTRICT HISTORICAL SOCIETY INCORPORATED	INC1301515
HILLSTON AQUIFER ALLIANCE INCORPORATED	INC1400441
HOI CUU NU SINH TRUNG VUONG SYDNEY UC CHAU INCORPORATED	INC1301193
ILLUMINATI CAR CLUB INCORPORATED	INC1400139
INTERNATIONAL CAMPAIGN FOR HUMANITARIAN RELIEF OF SYRIA INCORPORATED	INC1400457
JESUS GOODNEWS MINISTRIES INCORPORATED	INC1400225
JIANGXI COMMERCE AND INDUSTRY ASSOCIATION OF AUSTRALIA INCORPORATED	INC1301538
JOMNIN INCORPORATED	INC1400405
KATOOMBA FOOTBALL CLUB INCORPORATED	INC1400079
KIAMA YOUNG MUSICIANS ENSEMBLE INCORPORATED	INC1301551
LEELA COMMUNITY INCORPORATED	INC1400421
LEETON DISTRICT CHRISTIAN EDUCATION ASSOCIATION INCORPORATED	INC1301363
MATHOURA FISHING CLASSIC INCORPORATED	INC1400107
MAZI MAS INCORPORATED	INC1400095
MOONBI AMATEUR HACK & HUNTER ASSOCIATION INCORPORATED	INC1301342
NATIONAL INDOOR SPORTS CENTRE ASSOCIATION INCORPORATED	INC1400495
NEWCASTLE ALL ABILITY TOUCH ASSOCIATION INCORPORATED	INC1400458
OLD TYMERS CLUB SYDNEY INCORPORATED	INC1301285
PROSPERITY ASSOCIATION SYDNEY INCORPORATED	INC1400067
ROMI'S MEMORIAL CHILDREN INCORPORATED	INC1301256
RUP COMMUNITY ASSOCIATION IN AUSTRALIA INCORPORATED	INC1301214
SAN REMO TIDY TOWNS GROUP INCORPORATED	INC1300996
SILVER GHOST CRUISING CLUB INCORPORATED	INC1400299
SMALL BUSINESS PARTY OF AUSTRALIA INCORPORATED	INC1400190
SOUTH SUDAN DIASPORA NETWORK INCORPORATED	INC1400359
ST TIMOTHY'S COLLEGE INCORPORATED	INC1400255
STATE BASKETBALL ASSOCIATION INCORPORATED	INC1301522
SYDNEY MOTOR UNDERWRITERS GROUP INCORPORATED	INC1301298

TENTERFIELD MENS SHED INCORPORATED	INC1301157
THE KOREAN CATHOLIC SENIOR ACADEMY INCORPORATED	INC1301233
THE USUAL SUSPECTS PERFORMING ARTS ASSOCIATION INCORPORATED	INC1400206
THE WELL AT SWANSEA INCORPORATED	INC1400038
TONGAN HILLS CHRISTIAN CHURCH INCORPORATED	INC1400394
ULMARRA POOL PRESERVATION ASSOCIATION INCORPORATED	INC1400158
UNDERSTEER RADIO CONTROL CAR CLUB INCORPORATED	INC1400360
UNIT SUPPORT COMMITTEE - TRAINING SHIP AUSTRALIA INCORPORATED	INC1400482
WEST HARBOUR JUNIOR RUGBY UNION DEVELOPMENT ASSOCIATION INCORPORATED	INC1400336
WOLLONGONG BULLDOGS INC	INC1400456
WORD DOMINION CENTRE INCORPORATED	INC1301269
WORLD LITERATUS & ARTISTS JOINT GENERAL ASSOCIATION INCORPORATED	INC1301574
ZAGHWA UNION IN AUSTRALIA (ZUIA) INCORPORATED	INC1301424

Cancellation is effective as at the date of gazettal.

Dated this 22nd day of January 2025.

Lynette Viner
Delegate of the Commissioner
NSW Fair Trading

WORKERS COMPENSATION (ACCREDITED EXERCISE PHYSIOLOGY FEES) ORDER 2025

under the

Workers Compensation Act 1987

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

Dated this 21st day of January 2025

Megan Osborne
A/Chief Executive
State Insurance Regulatory Authority

Explanatory Note

Treatment by a remedial medical gymnast is medical or related treatment under the *Workers Compensation Act 1987* (the Act). For the purposes of this Order, the term "remedial medical gymnast" is interchangeable with "Accredited Exercise Physiologist". This Order sets the maximum fees for which an employer is liable under the Act for any Accredited Exercise Physiology treatment related services provided to an injured worker. For clarity, this Order applies to an exempt worker or a worker receiving treatment outside of NSW under the Act.

A Practitioner 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 injury being a "catastrophic injury" as defined under section 87EAA(2) of the Act. Rates for this treatment are to be agreed between the Practitioner and Insurer.

Workers Compensation (Accredited Exercise Physiology Fees) Order 2025

1. Name of Order

This Order is the *Workers Compensation (Accredited Exercise Physiology Fees) Order 2025.*

2. Commencement

This Order commences on 1 February 2025.

3. Definitions

In this Order:

the Act means the *Workers Compensation Act 1987*.

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

Accredited Exercise Physiology services refers to all treatment related services delivered by an Accredited Exercise Physiologist. Each service is to be billed according to Schedule A.

Accredited Exercise Physiologist means an exercise physiologist accredited by Exercise and Sports Science Australia (ESSA) to provide Accredited Exercise Physiology services.

Note: As outlined in the SIRA *Workers compensation guidelines for the approval of treating allied health practitioners*, an Accredited Exercise Physiologist must be approved by the Authority to deliver services in the NSW workers compensation system. The requirement to be approved does not apply to treatment provided interstate or to exempt workers.

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

Allied Health Treatment 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 and must:

- seek to clarify the worker's capacity/fitness 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 Practitioner and any or all of the following:

- the employer
- the workplace rehabilitation provider
- an Injury Management Consultant or Independent 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 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 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 a Practitioner 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.

Catastrophic injury means an injury that meets the criteria for one or more of the kinds of injury specified on clauses 9.1.1 to 9.1.5 of the Workers Compensation Guidelines dated 1 March 2021 as provided for under section 87EAA of the Act.

Consultation C means any treatment consultation related to complex pathology and clinical presentations including, but not limited to:

- three (3) or more entirely separate compensable injuries or conditions
- extensive burns
- complex neurological/orthopaedic/pain/cardio-respiratory conditions.

Consultation C is for the management of workers with complex pathology and clinical presentations who require a matched intensity and relevance of treatment. Only a small number of workers will require treatment within this category. As workers progress in their recovery towards self-management and independence, it is expected there will be a reduction in Consultation C duration time, or transition to a subsequent consultation (EPA002). It is expected that two (2) or more evidence-based risk screening/standardised outcome measures relevant to the clinical presentation are documented to demonstrate the complexities of the case and form the basis for the clinical rationale for delivery of Consultation C. Practitioners are expected to measure and demonstrate effectiveness of Consultation C treatment outcomes.

Exempt worker refers to specific classes of workers set out in Part 19H of Schedule 6 of 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*.

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

Group/class intervention occurs where a Practitioner delivers a common service to more than one (1) person at the same time. Maximum class size is six (6) participants.

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

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

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

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

Initial Allied Health Treatment Request means the first Allied Health Treatment Request completed by a Practitioner and submitted to the Insurer for the claim.

Initial consultation means the first consultation provided by the Practitioner 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 Treatment Request when indicated.

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

Insurer means the employer's workers compensation insurer.

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

Normal practice means a commercial place of business in or from which a Practitioner regularly operates an exercise physiology practice and provides treatment services. It also includes facilities where services may be delivered on a regular or contracted basis, such as a private hospital, hydrotherapy pool or gymnasium.

Practitioner in this Order means an Accredited Exercise Physiologist or remedial medical gymnast who delivers services in accordance with Schedule A of this Order to an injured worker.

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

Subsequent consultation means a treatment consultation provided subsequent to the initial consultation and may include:

- re-assessment
- intervention/treatment
- setting expectations of recovery and return to work
- clinical recording, and

- preparation of an Allied Health Treatment Request when indicated.

This definition applies to a service provided on an one-to-one basis with the worker for the entire consultation, irrespective of the modality of treatment delivered during the consultation.

Telehealth consultation means delivery of Accredited Exercise Physiology services that use videoconferencing or telephone as an alternative to an in-person consultation in compliance with Part 2 of the *Guidelines for the Provision of Relevant Services (Health and Related Services)*. .

Three (3) or more entirely separate compensable injuries or conditions means three (3) or more distinct 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.

4. Application of Order

This Order applies to treatment provided on or after 1 February 2025, whether it relates to an injury received before, on or after that date.

5. Maximum fees for Accredited Exercise Physiology services

(1) The maximum fee amount for which an employer is liable under the Act for treatment of a worker by a Practitioner, 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 a service of a type specified in any of items EPA001, EPA002, EPA004 and EPA009 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 for travel under item EPA008 at the rate per kilometre in Column 2 of Schedule A. Travel costs cannot be charged:

- where the Practitioner provides services on a regular or contracted basis to facilities such as a private hospital
- where a Practitioner does not have, or is employed by a business that does not have, a normal practice for the delivery of Accredited Exercise Physiology services (eg. 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 claims.

(3) The maximum amount payable for an Initial Allied Health Treatment Request is $44.10 (+ GST). This fee is payable only once (1) per claim for completion of the Initial Allied Health Treatment Request.

(4) Telehealth consultations are to be billed according to the appropriate items EPA301 to EPA302 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 treating 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 the cost price of the facility fee on their invoice and attach a copy of the facility's 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 treating Practitioner, or the treating 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 a 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 Accredited Exercise Physiology services

Item	Column 1 Type of Treatment	Column 2 Maximum Amount ($) (excl GST)
EPA001	Initial consultation	$142.40
EPA301	Initial consultation via telehealth **(requires pre-approval by the Insurer)**	$142.40
EPA002	Subsequent consultation	$96.50
EPA302	Subsequent consultation via telehealth **(requires pre-approval by the Insurer)**	$96.50
EPA009	Consultation C – treatment consultation related to complex pathology and clinical presentations including, but not limited to: • three (3) or more entirely separate compensable injuries or conditions • extensive burns • complex neurological/orthopaedic/pain/cardio-respiratory conditions	$18.70/5 minutes (maximum one hour)
EPA004	Group/class intervention	$65.50/participant
EPA005	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
EPA006	Case conference	$18.70/5 minutes
EPA007	Report writing **(requires pre-approval and must be requested by the Insurer)**	$18.70/5 minutes (maximum one hour)
EPA008	Travel **(requires pre-approval by the Insurer)** As provided in Clause 5(2), the rate per kilometre applies only to the number of kilometres of travel reasonably involved and directly related to the treatment, where this service has been pre-approved by the Insurer.	Reimbursed in accordance with the Australian Taxation Office cents per kilometre method for business and organisations for 2024 - 2025: - *88 cents per kilometre*

WCO005	Fees for providing copies of clinical notes and records. The Practitioner/practice should not provide or bill for hard copy clinical records if they are maintained electronically. Fees are inclusive of postage and handling.	Where clinical records are maintained electronically by a Practitioner/practice, a flat fee of $68.20 is payable for provision of all requested clinical records held by the practice. Where clinical records are not maintained electronically, the maximum fee for providing hard copies of clinical records is $43.30 (for 33 pages or less) and an additional $1.40 per page if more than 33 pages.
OAS003	Submission of an *Initial Allied Health Treatment Request* (AHTR) only. All other AHTRs submitted are not subject to a fee.	$44.10 (Initial AHTR per claim only)

WORKERS COMPENSATION (MASSAGE THERAPY FEES) ORDER 2025

under the

Workers Compensation Act 1987

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

Dated this 21st day of January 2025

Megan Osborne
A/Chief Executive
State Insurance Regulatory Authority

Explanatory Note

Treatment by a "masseur" is medical or related treatment under the *Workers Compensation Act 1987* (the Act). 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 any Massage Therapy services provided to an injured worker. For clarity, this Order applies to an exempt worker or a worker receiving treatment outside of NSW under the Act.

A Massage Therapist 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.

This Order provides that a Massage Therapist must seek pre-approval for treatment services from the relevant workers compensation Insurer unless a specific service is exempt from pre-approval by the Act or the Authority's *Workers Compensation Guidelines.*

Workers Compensation (Massage Therapy Fees) Order 2025

1. Name of Order

This Order is the *Workers Compensation (Massage Therapy Fees) Order 2025.*

2. Commencement

This Order commences on 1 February 2025.

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 Treatment Request means the form used 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
- 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 Treatment Request when indicated.

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

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 is treatment services limited to soft tissue massagetargeting specific musculoskeletal injuries delivered by a Massage Therapist. Each service is to be billed according to Schedule A.

4. Application of Order

This Order applies to treatment provided on or after 1 February 2025, whether it relates to an injury received before, on or after that date.

5. Maximum fees for Massage Therapy services

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 code that is relevant to NSW Massage Therapists, as defined in Schedule A in the column headed ***"Item"*** of this Order.

7. 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.

SCHEDULE A

Maximum fees for Massage Therapy services

Item	Column 1 Type of Treatment	Column 2 Maximum Amount (excl GST)
RMA001	Consultation and treatment (60 minutes duration)	$95.10
RMA002	Consultation and treatment (45 minutes duration)	$71.30
RMA003	Consultation and treatment (30 minutes duration)	$47.70
WCO005	Fees for providing copies of clinical notes and records. A Massage Therapist/practice should not provide or bill for hard copy clinical records if they are maintained electronically. Fees are inclusive of postage and handling.	Where clinical records are maintained electronically by a Massage Therapist/practice, a flat fee of $68.20 is payable (for provision of all requested clinical records held by the practice). Where clinical records are not maintained electronically, the maximum fee for providing hard copies of clinical records is $43.30 (for 33 pages or less) and an additional $1.40 per page if more than 33 pages.

WORKERS COMPENSATION (MEDICAL PRACTITIONER FEES) ORDER 2025

under the

Workers Compensation Act 1987

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

Dated this 21st day of January 2025

Megan Osborne
A/Chief Executive
State Insurance Regulatory Authority

Explanatory Note

Treatment by a Medical Practitioner is medical or related treatment 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 medical or related treatment provided to an injured worker. For clarity, this Order applies to an exempt worker or a worker receiving treatment outside of NSW under the Act.

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 Act, 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 Act or the 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 Fees List 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 must not 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 2025

1. Name of Order

This Order is the *Workers Compensation (Medical Practitioner Fees) Order 2025*.

2. Commencement

This Order commences on 1 February 2025.

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 Fees 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 or Orthopaedic Surgeon), using the AMA Fees List item code MZ900.

Assistance at Operation is only payable once per eligible item 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.

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

- seek to clarify the worker's capacity/fitness 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 or Independent 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 Medical 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.

Certificate of Capacity means the certificate given by the Medical Practitioner under s44B(3)(a) of the Act in the form approved by the Authority.

General Practitioner means a Medical Practitioner and has the meaning given by subsection 3(1) of the *Health Insurance Act 1973 (Cth).*

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 ServicesTax) 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.

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.

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, except for items specifically listed as a multiple procedure item in the AMA Fees 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.

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.

Radiation User Licence means a radiation user licence granted by the Environment Protection Authority (EPA) under Part 2 of the *Protection from Harmful Radiation Act 1990* (NSW) 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.

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 Agency 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.

Telehealth consultation means delivery of Medical Practitioner services that use videoconferencing or telephone as an alternative to an in-person consultation in compliance with Part 2 of the *Guidelines for the Provision of Relevant Services (Health and Related Services)*.

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 1 February 2025, whether it relates to an injury received before, on, or after that date.

5. Maximum fees for Medical Practitioner services

(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 Fees List, except:

- Medical services identified in the AMA Fees 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 Fees 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 - $1,050 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) 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.

(4) The maximum amount payable for a Certificate of Capacity is $56.20. This fee is payable only once per claim for completion of the initial Certificate of Capacity and is invoiced under payment classification code **WCO001**.

(5) 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: $28.10 per 5 minutes
- Medical Specialist: $39.10 per 5 minutes
- Surgeon or Orthopaedic Surgeon: $51.50 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.

(6) Where medical records are maintained electronically by a Medical Practitioner/practice a flat fee of $68.20 is payable for the 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 $43.30 (for 33 pages or less) and an additional $1.40 per page if more than 33 pages. This fee is inclusive of postage and handling.

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

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

(7) 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**.

(8) 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.

(9) Fees for Multiple operations or injuries are to be paid in accordance with the AMA Fees List 'Multiple Operations Rule' with the exception of items specifically listed as a multiple procedure item in the AMA Fees List or where Schedules in the *Workers Compensation (Surgeon and Orthopaedic Surgeon Fees) Order* prevent combining of items.

(10) Subject to subclauses 5(1), 5(2), 5(3), 5(4), 5(5), 5(6), 5(7), 5(8), 5(9) and clause 7 (Nil fee for certain medical services) 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 Fees 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 a 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 a 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 a Medical Specialist/Surgeon/Orthopaedic Surgeon require prior approval by the Insurer, unless exempt from pre-approval by the Act or the Authority's *Workers Compensation Guidelines.*

7. Nil fee for certain medical services

The AMA Fees 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 Fees List by AMA number AA007)
- All time-based General Practitioner fees items (Medical services identified in the AMA Fees List by AMA numbers AA220 – AA323)
- Enhanced primary care items (Medical services identified in the AMA Fees List by AMA numbers AA501 – AA670, and AA850)
- All shared health summary items (Medical services identified in the AMA Fees List by AMA numbers AA340 – AA343)
- Telehealth and case conference items (Medical services identified in the AMA Fees List by AMA numbers AA170, AA584 – AA670, AF070 – AF180, AF260 – AF370, AJ051 – AJ200, AM210 – AM240, and AP050 – AP278), noting SIRA specific items exist for the provision of telehealth and case conferencing services.
- 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 Fees 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. 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.

WORKERS COMPENSATION (PHYSIOTHERAPY, CHIROPRACTIC AND OSTEOPATHY FEES) ORDER 2025

under the

Workers Compensation Act 1987

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

Dated this 21st day of January 2025

Megan Osborne
A/Chief Executive
State Insurance Regulatory Authority

Explanatory Note

Treatment by a Physiotherapist, Chiropractor or Osteopath is medical or related treatment 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 an injured worker. For clarity, this Order applies to an exempt worker or a worker receiving treatment outside of NSW under the Act.

A Practitioner 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 injury being a "catastrophic injury" as defined under section 87EAA(2) of the Act. Rates for this treatment are to be agreed between the Practitioner and Insurer.

Workers Compensation (Physiotherapy, Chiropractic and Osteopathy Fees) Order 2025

1. Name of Order

This Order is the *Workers Compensation (Physiotherapy, Chiropractic and Osteopathy Fees) Order 2025.*

2. Commencement

This Order commences on 1 February 2025.

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 Treatment 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 and must:

- seek to clarify the worker's capacity/fitness 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 Practitioner and any or all of the following:

- the employer
- the workplace rehabilitation provider
- an Injury Management Consultant or Independent 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 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 the 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 a Practitioner 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.

Catastrophic injury means an injury that meets the criteria for one or more of the kinds of injury specified on clauses 9.1.1 to 9.1.5 of the Workers Compensation Guidelines dated 1 March 2021 as provided for under section 87EAA of the Act.

Certificate of Capacity means the certificate given by the nominated treating doctor or treating Physiotherapist in accordance with any requirement under the *Workers Compensation Regulation 2016* (the Regulation) and under the following circumstances:

(a) ***Initial Certificate of Capacity*** means the first certificate given by the nominated treating doctor in the form approved by the Authority in accordance with any requirement under the Regulation.

(b) ***First subsequent Certificate of Capacity*** means the first Certificate of Capacity issued by the worker's treating Physiotherapist subsequent to the *Initial Certificate of Capacity* issued by the nominated treating doctor. The Physiotherapist must be approved by the Authority in accordance with any requirement under the Regulation.

(c) ***Subsequent Certificate of Capacity*** means any Certificate of Capacity issued by the worker's treating Physiotherapist after the *First Subsequent Certificate of Capacity*. The Physiotherapist must be approved by the Authority in accordance with any requirement under the Regulation.

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 guidelines for the 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 consultation provided by the Practitioner in respect of an injury or the first consultation in a new episode of care for the same injury.

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

Consultation A - Subsequent means a Consultation A treatment provided after the initial consultation and treatment.

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

Consultation B - Initial means the first consultation provided by the Practitioner 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 a Consultation B treatment provided after the initial consultation and treatment 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 means any treatment consultation related to complex pathology and clinical presentations including, but not limited to:

- three (3) or more entirely separate compensable injuries or conditions
- 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,
- extensive burns
- complex neurological/orthopaedic/pain/cardio-respiratory or lymphoedema conditions.

Consultation C is for the management of workers with complex pathology and clinical presentations who require a matched intensity and relevance of treatment. Only a small number of workers will require treatment within this category. As workers progress towards self-management and independence, it is expected there will be a reduction in Consultation C duration time, or transition to the lower-level intensity consultation of Consultation B or Consultation A. It is expected that two (2) or more evidence-based risk screening/standardised outcome measures relevant to the clinical presentation are documented to demonstrate the complexities of the case and form the basis for the clinical rationale for delivery of Consultation C. Practitioners are expected to measure and demonstrate effectiveness of Consultation C treatment outcomes.

Exempt worker refers to specific classes of workers set out in Part 19H of Schedule 6 of 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*.

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

Group/class intervention occurs where a Practitioner delivers a common service to more than one (1) person at the same time. Maximum class size is six (6) participants.

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

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

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. The review must be completed by an Independent Consultant approved by the Authority.

Initial Allied Health Treatment Request means the first Allied Health Treatment Request completed by a Practitioner and submitted to the Insurer for the claim.

Initial consultation means the first consultation provided by the Practitioner 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 Treatment Request when indicated.

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

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 a commercial place of business in or from which a Practitioner regularly operates a Physiotherapy, Chiropractic or Osteopathy practice and provides treatment services. 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 guidelines for the 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 guidelines for the 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 refers 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 with Schedule A of this Order to a NSW worker.

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

Subsequent consultation means a treatment consultation provided subsequent to the initial consultation and may include:

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

This definition applies to a service provided on a one-to-one basis with the worker for the entire consultation, irrespective of the modality of treatment delivered during the consultation.

Telehealth consultation means delivery of Physiotherapy, Chiropractic or Osteopathy services that use videoconferencing or telephone as an alternative to an in-person consultation in compliance with Part 2 of the *Guidelines for the Provision of Relevant Services (Health and Related Services)*.

Three (3) or more entirely separate compensable injuries or conditions means three (3) or more distinct 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.

Two (2) entirely separate compensable injuries or conditions means two (2) distinct 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 treatment for a wrist post-fracture). 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 February 2025 whether it relates to an injury received before, on or after that date.

5. Maximum fees for Physiotherapy, Chiropractic or Osteopathy services

(1) The maximum fee amount for which an employer is liable under the Act for treatment of a worker by a Practitioner, 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 a service 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 for travel under PTA014, CHA009 or OSA014 at the rate per kilometre in Column 2 of Schedule A. Travel costs cannot be charged:

- where the Practitioner provides services on a regular or contracted basis to facilities such as a private hospital
- where a Practitioner does not have, or is employed by a business that does not have, a normal practice for the delivery of Physiotherapy, Chiropractic and Osteopathy 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 claims.

(3) The maximum amount payable for an Initial Allied Health Treatment Request is $44.10 (+ GST). This fee is payable only once (1) per claim for completion of the Initial Allied Health Treatment Request.

(4) The maximum amount payable for the First subsequent Certificate of Capacity is $44.10 (+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 treating 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 fee on their invoice and attach a copy of the facility's 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 treating Practitioner, or the treating 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 a 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

Physiotherapy Item	***Chiropractic Item***	***Osteopathy Item***	***Column 1 Type of Treatment***	***Column 2 Maximum Amount ($) (excl GST)***
Normal Practice	**Normal Practice**	**Normal Practice**		
PTA001	CHA001	OSA001	Consultation A - Initial	$142.40
PTA301	CHA301	OSA301	Consultation A - Initial via telehealth	$142.40
PTA002	CHA002	OSA002	Consultation A - Subsequent	$96.50
PTA302	CHA302	OSA302	Consultation A - Subsequent via telehealth	$96.50
PTA003	CHA031	OSA003	Consultation B - Initial • Two (2) entirely separate injuries or conditions • Complicated hand injuries	$207.40
PTA303	CHA303	OSA303	Consultation B - Initial via telehealth • Two (2) entirely separate injuries or conditions • Complicated hand injuries	$207.40
PTA004	CHA032	OSA004	Consultation B - Subsequent • Two (2) entirely separate injuries or conditions • Complicated hand injuries	$142.90
PTA304	CHA304	OSA304	Consultation B - Subsequent via telehealth • Two (2) entirely separate injuries or conditions • Complicated hand injuries	$142.90
PTA005	CHA033	OSA005	Consultation C – treatment consultation related to complex pathology and clinical presentations including, but not limited to: • three (3) or more entirely separate injuries or conditions • major hand injury (Modified Hand Injury Severity Score >100) where assessment and treatment is provided by an Australian Hand Therapy Association Accredited Hand Therapist • extensive burns • complex neurological/orthopaedic/pain/cardio-respiratory or lymphoedema conditions	$18.70 / 5 minutes (maximum one hour)
PTA006	CHA010	OSA006	Group/class intervention	$65.50 / participant
N/A	CHA004	N/A	Spine X-rays performed by a Chiropractor	$174.00

Home Visit	**Home Visit**	**Home Visit**		
PTA007	CHA005	OSA007	Consultation A - Initial	$142.40
PTA008	CHA006	OSA008	Consultation A - Subsequent	$112.10
PTA009	CHA071	OSA009	Consultation B - Initial • Two (2) entirely separate injuries or conditions • Complicated hand injuries	$207.40
PTA010	CHA072	OSA010	Consultation B - Subsequent • Two (2) entirely separate injuries or conditions • Complicated hand injuries	$174.10
PTA011	CHA073	OSA011	Consultation C – treatment session related to complex pathology and clinical presentations including, but not limited to: • three (3) or more entirely separate injuries or conditions • major hand injury (Modified Hand Injury Severity Score > 100) where assessment and treatment is provided by an Australian Hand Therapy Association Accredited Hand Therapist • extensive burns • complex neurological/orthopaedic/pain/cardio-respiratory or lymphoedema conditions	$18.70 / 5 minutes (maximum one hour)
Other	**Other**	**Other**		
PTA014	CHA009	OSA014	Travel costs **(requires pre-approval by the Insurer)**. As provided in Clause 5(2), the rate per kilometre applies only to the number of kilometres of travel reasonably involved and directly related to the treatment, where this service has been pre-approved by the Insurer.	Reimbursed in accordance with the Australian Taxation Office cents per kilometre method for businesses and organisations for 2024 - 2025: - 88 cents per kilometre
PTA015	CHA015	OSA015	Case conference	$18.70 (+GST) / 5 minutes
PTA016	CHA016	OSA016	Report writing **(requires pre-approval, and must be requested by the Insurer)**	$18.70 (+GST) / 5 minutes (maximum one 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. A Practitioner/practice should not provide or bill for hard copy clinical records if they are maintained electronically. Fees are inclusive of postage and handling.	Where clinical records are maintained electronically by a Practitioner/practice, a flat fee of $68.20 is payable (for provision of all requested clinical records held by the practice). Where clinical records are not maintained electronically, the maximum fee for providing hard copies of clinical records is $43.30 (for 33 pages or less) and an additional $1.40 per page if more than 33 pages.
OAS003	OAS003	OAS003	Submission of an *Initial Allied Health Treatment Request* (AHTR) only. All other AHTRs submitted are not subject to a fee.	$44.10 (Initial AHTR per claim only)
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. All other subsequent Certificate of Capacity submitted are not subject to a fee.	$44.10 (First subsequent Certificate of Capacity only)

Workers Compensation (Private Hospital Maximum Rates) Order 2025

under the

Workers Compensation Act 1987

I, Megan Osborne, A/Chief Executive, State Insurance Regulatory Authority, pursuant to section 62 (1A) of the *Workers Compensation Act* 1987 make the following Order.

Dated this 21st day of January 2025

Megan Osborne
A/Chief Executive
State Insurance Regulatory Authority

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1. Name of Order

This Order is the *Workers Compensation (Private Hospital Maximum Rates) Order 2025.*

2. Commencement

This Order commences on 1 February 2025.

3. Application of Order

This Order applies to the hospital treatment of a worker at a private hospital, being treatment of a type referred to in clause 5 and provided on or after the date of commencement of this Order, whether the treatment relates to an injury that is received before, on, or after that date. This Order sets the maximum fees for which an employer is liable under the *Workers Compensation Act 1987* for any treatment provided by a Private Hospital with respect to an injured worker.

For clarity, this Order applies to treatment provided to exempt workers and to injured workers receiving treatment under the Act outside of NSW.

4. 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*.

Admitted patient means a patient who undergoes a hospital's admission process to receive treatment and/or care. This treatment and/or care is provided over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients).

Electroconvulsive therapy (ECT) means treatment involving the delivery of brief, carefully controlled electric currents through the brain.

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 record means a record of the health information of an individual.

Health Information has the same meaning as in the *Health Records and Information Privacy Act 2002.*

Insurer means the employer's workers compensation insurer.

Intensive care (level 1 or level 2) has the same meaning as clause 6(h) of the *Private Health Facilities Regulation 2017* and must meet the licensing standards in the *Private Health Facilities Regulation 2017*. When invoicing the Insurer for intensive care services, the fee is to be based on the highest licensed level of the facility as approved and published by NSW Health at the time the service is provided and is to be charged in accordance with PTH007 of this Order.

Non-admitted patient means a patient who does not undergo a hospital's formal admission process. There are three categories of non-admitted patient:

- emergency department patient
- outpatient and
- other non-admitted patient (treated by hospital employees off the hospital site – includes community/outreach services).

Private hospital means a hospital or licensed private health facility (as defined in the *Private Health Facilities Act 2007*) but excludes a public hospital.

Same day patient means an admitted patient who is admitted and discharged on the same date.

5. Fees for private hospital patient services generally

(1) An employer is not liable under the Act to pay any amount for hospital treatment provided to a worker at a facility that is not a public hospital or a private hospital as defined.

(2) Where the service is a taxable supply for the purposes of the GST Law, the amount in the last column of the attached Table should be increased by the amount of GST payable.

(3) The theatre fees include the costs of consumable and disposable items. Only in exceptional circumstances will additional fees be paid for high-cost consumable and disposable items on provision of evidence from the hospital that the item is reasonably necessary.

(4) There are Medical Benefits Schedule item numbers on the National Procedure Banding List that change the band to be applied dependent on the provision of a complexity certificate. If the procedure involves one or more of the indicators of high cost or complexity listed on the certificate, the higher banding is payable. A certificate of complexity must accompany the invoice claiming a higher banding level.

(5) The facility fees also include the cost of pharmaceutical items provided during the admission. Only pharmaceutical items provided at discharge may be charged separately.

(6) The overnight facility fees also include the cost of all allied health services provided during the admission except for overnight Rehabilitation patients. For overnight Rehabilitation patients, allied health services are to be charged in accordance with the relevant Workers Compensation Fees Order for that professional discipline. Where services are provided by allied health disciplines with no relevant Fees Order, these providers must bill using the relevant payment classification code for their discipline e.g. OAS002 for occupational therapists, OTT002 for speech pathologists and OTT006 for all other therapies and treatments, at the equivalent rate for Physiotherapists under the Workers Compensation (Physiotherapy, Chiropractic, Osteopathy Fees) Order (applicable at the time of service) that best reflects the service provided.

(7) Same day admissions for full and half day Rehabilitation and Psychiatric programs (excluding

ECT) should be charged using the applicable Day Facility Fee. This fee includes the cost of all allied health services provided during the admission (including any allied health services which may not be covered by a Workers Compensation Fees Order).

(a) A Full-Day Rehabilitation Program is for patients who have an established rehabilitation need, do not require overnight care, and whose rehabilitation program and goals require the involvement of a multidisciplinary team. Full-Day rehabilitation programs should be used for treatments with at least 3 hours' duration.

(b) A Half-Day Rehabilitation Program is for patients who have an established rehabilitation need, do not require overnight care, and whose rehabilitation program and goals require the involvement of a multidisciplinary team. Half-Day rehabilitation programs should be used for treatments with at least 1.5 hours' duration.

(c) A Full-Day Psychiatric Program (excluding ECT) is for patients who have an established need for mental health services, do not require overnight care, and whose psychiatric program and goals require the involvement of a multidisciplinary team. Full-Day psychiatric programs should be used for treatments with at least 4.5 hours' duration.

(d) A Half-Day Psychiatric Program (excluding ECT) is for patients who have an established need for mental health services, do not require overnight care, and whose psychiatric program and goals require the involvement of a multidisciplinary team. Half-Day psychiatric programs should be used for treatments with at least 2.5 hours' duration.

6. Invoices for private hospital patients

Invoices for private hospital patients are to be submitted to insurers and must include the following information:

- worker's first name and last name and claim number
- payee details
- ABN
- name of service provider who provided the service
- date of service
- Authority payment classification code
- Medicare Benefits Schedule (MBS) item and theatre band (where applicable)
- service cost for each Authority classification code
- theatre duration (if applicable).

7. Additional Information

The Insurer or the Authority may request additional information as evidence of the service provided and billed.

8. Fees for Surgically Implanted Prostheses and Handling

(1) Surgical prostheses are to be selected from the Department of Health Prostheses List (in accordance with the *Private Health Insurance (Prostheses) Rules (Cth)* rate current at the time of service) at the minimum benefit rate.

(2) A 5% handling fee may be applied to each item up to a maximum of $197.50 per item.

9. Fees payable for Allied Health Services for Non-Admitted patients for single mode of therapy for an individual or group program up to 2 hours

(1) Where a worker is provided with allied health services as a non-admitted patient for either a single mode of therapy or group program in a private hospital, the maximum amount for which an employer is liable under the Act for the provision of those services is in accordance with the relevant Workers Compensation Fees Order for that professional discipline.

(2) Where there is no relevant Workers Compensation Fees Order for an allied health service provided, the service must be billed in accordance with the relevant community rate for that professional discipline.

(3) A group program, defined as two or more patients receiving the same service at the same time with allied health or medical professionals, must be outcome based with a return-to-work emphasis.

10.Single rooms

There is no additional fee payable for a single room.

11.Fees for Electro Convulsive Therapy (ECT)

As there is no theatre banding fee for ECT, this service is to be billed using the facility fee Band 3 (PTH006) and theatre Band 1 (PTH008) stated in the Fee Schedule to this Order.

Code	Private Hospitals Fee Schedule – commencing 1 February 2025 **Under section 62 (1A) of the *Workers Compensation Act 1987***	**Maximum Fees for services**
	OVERNIGHT FACILITY FEES (Daily)	
PTH001	**Advanced surgical** 1 to 14 days	$979.40
	>14 days	$663.60
PTH002	**Surgical** 1 to 14 days	$921.90
	>14 days	$663.60
PTH003	**Psychiatric** 1 to 21 days	$876.10
	22 to 65 days	$677.40
	Over 65 days	$621.90
PTH004	**Rehabilitation** 1 to 49 days	$951.70
	>49 days	$699.30
PTH005	**Other (Medical)** 1 to 14 days	$818.50
	>14 days	$663.60
PTH007	**Intensive Care** < 5 days, level 2	$3,808.60
	< 5 days, level 1	$2,636.50
PTH006	**DAY FACILITY FEES (including Accident and Emergency attendance) (Daily)**	
	Psychiatric Full-Day Program – treatments with at least 4.5 hours' duration Half-Day Program – treatments with at least 2.5 hours' duration.	 $421.10 $329.00

	Rehabilitation Full-Day Program – treatments with at least 3 hours' duration Half-Day Program - treatments with at least 1.5 hours' duration	 $421.10 $329.00
	Band 1 – absence of anaesthetic or theatre times	$421.10
	Band 2 – local anaesthetic, no sedation	$494.70
	Band 3 – general or regional anaesthetic or intravenous sedation, less than 1 hour theatre time	$558.30
	Band 4 – general or regional anaesthetic or intravenous sedation,1 hour or more theatre time	$623.80
PTH008	**THEATRE FEES – as per National Procedure Banding List** Multiple procedure rule: 100% of fee for first procedure, 50% for second procedure undertaken at the same time as the first, 20% for the third and subsequent procedures undertaken at the same time as the first.	
	Band 1A	$236.60
	Band 1	$421.10
	Band 2	$721.30
	Band 3	$882.20
	Band 4	$1,194.00
	Band 5	$1,754.20
	Band 6	$2.012.60
	Band 7	$2,690.00
	Band 8	$3,745.00
	Band 9A	$3,872.30
	Band 9	$4,948.10
	Band 10	$5,853.00
	Band 11	$6,929.90
	Band 12	$7,488.20
	Band 13	$9,081.50
PTH009	**SURGICAL PROSTHESES FEES**	
	Prostheses	As per Dept of Health listed minimum rate
	Handling fee	5% of prosthesis fee capped at $197.50
WCO005	**PROVISION OF HEALTH RECORDS**	
	Fee for the electronic provision of health records	Flat fee of $68.20

	Fee for providing hard copies of health records (only where not maintained electronically). Fees are inclusive of postage and handling.	$43.30 (for first 33 pages or less) and an additional $1.40 per page (up to a maximum of $162 for additional pages) if more than 33 pages.

WORKERS COMPENSATION (PSYCHOLOGY AND COUNSELLING FEES) ORDER 2025

under the

Workers Compensation Act 1987

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

Dated this 21st day of January 2025.

Megan Osborne
A/Chief Executive
State Insurance Regulatory Authority

Explanatory Note

Treatment by a Psychologist or Counsellor is medical or related treatment 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 an injured worker. For clarity, this Order applies to an exempt worker or a worker receiving treatment outside of NSW under the Act.

A Practitioner cannot bill for services set out in Schedule A or Schedule B 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 injury being a "catastrophic injury" as defined under section 87EAA(2) of the Act. Rates for this treatment are to be agreed between the Practitioner and Insurer.

The Authority has not set a maximum amount for trauma focused psychological treatment provided to a worker who has been diagnosed with a work injury being post-traumatic stress disorder. Rates for this treatment are to be agreed between the Psychologist and Insurer.

Workers Compensation (Psychology and Counselling Fees) Order 2025

1. Name of Order

This Order is the *Workers Compensation (Psychology and Counselling Fees) Order 2025.*

2. Commencement

This Order commences on 1 February 2025.

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 Treatment 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 and must:

- seek to clarify the worker's capacity/fitness 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 Practitioner and any or all of the following:

- the employer
- the workplace rehabilitation provider
- an Injury Management Consultant or Independent 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 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 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 a Practitioner 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.

Catastrophic injury means an injury that meets the criteria for one or more of the kinds of injury specified on clauses 9.1.1 to 9.1.5 of the Workers Compensation Guidelines dated 1 March 2021 as provided for under section 87EAA of the Act.

Certificate of Capacity means the certificate given by the nominated treating doctor or treating Psychologist in accordance with any requirement under the *Workers Compensation Regulation 2016* (the Regulation) and under the following circumstances:

(a) ***Initial Certificate of Capacity*** means the first certificate given by the nominated treating doctor in the form approved by the Authority in accordance with any requirement under the Regulation.

(b) ***First subsequent Certificate of Capacity*** means the first Certificate of Capacity issued by the worker's treating Psychologist subsequent to the Initial Certificate of Capacity issued by the nominated treating doctor. The Psychologist must be approved by the Authority in accordance with any requirement under the Regulation.

(c) ***Subsequent Certificate of Capacity*** means any Certificate of Capacity issued by the worker's treating Psychologist after the First subsequent Certificate of Capacity. The Psychologist must be approved by the Authority in accordance with any requirement under the Regulation.

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.

Exempt worker refers to specific classes of workers set out in Part 19H of Schedule 6 of 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*.

Group/class intervention occurs where a Practitioner 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 (Cth)*.

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 Treatment Request means the first Allied Health Treatment Request completed and submitted to the Insurer for the claim.

Initial consultation means the first consultation provided by the Practitioner 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 Treatment Request when indicated.

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

Insurer means the employer's workers compensation insurer.

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

Normal practice means a commercial place of business in or from which a Practitioner regularly operates a Psychology or Counselling practice and provides treatment services. 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 Practitioner compile a written report, other than an Allied Health Treatment Request, providing details of the worker's treatment, progress and work capacity. The Insurer must provide pre-approval for such a service.

Subsequent consultation means a treatment consultation provided subsequent to the Initial Consultation and may include:

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

This definition applies to a service provided on a one-to-one basis with the worker for the entire consultation, irrespective of the modality of treatment delivered during the consultation.

Telehealth consultation means delivery of Psychology or Counselling services that use videoconferencing or telephone as an alternative to an in-person consultation in compliance with Part 2 of the *Guidelines for the Provision of Relevant Services (Health and Related Services)*.

Trauma focused psychological treatment means cognitive behavioural therapy or eye movement desensitisation reprocessing provided by a Psychologist in accordance with the *Expert guidelines: Diagnosis and treatment of post-traumatic stress disorder in emergency service workers* endorsed by the Black Dog Institute.

4. Application of Order

This Order applies to treatment provided on or after 1 February 2025, whether it relates to an injury received before, on or after that date.

5. Maximum fees for Psychology or Counselling services

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

(2) If it is reasonably necessary for a Practitioner to provide treatment of a type specified in any of items PSY001, PSY002, PSY004 and PSY006 (for Psychologists) in Schedule A or COU002, COU003, COU005 and COU007 (for Counsellors) in Schedule B at a place other than the normal practice, the maximum fee amount for which an employer would otherwise be liable under the Act for that type of treatment is increased by an amount calculated for travel under items PSY005 and COU006 at the rate per kilometre in Column 2 of those Schedules. Travel costs cannot be charged:

- where the Practitioner provides services on a regular or contracted basis to facilities such as a private hospital
- where a Practitioner does not have, or is employed by a business that does not have, a normal practice for the delivery of Psychology or Counselling 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 claims.

(3) The maximum amount payable for an Initial Allied Health Treatment Request is $44.10 (+ GST). This fee is payable only once (1) per claim for completion of the Initial Allied Health Treatment Request.

(4) The maximum amount payable for the First subsequent Certificate of Capacity is $44.10 (+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

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 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 Psychology services

Psychology Item	**Column 1 Type of Treatment**	**Column 2 Maximum Amount ($) (excl GST)**
PSY001	Initial consultation and treatment	$135.80/30 mins (maximum 60 minutes) (Pro-rata rates in units of 30 minutes apply)
PSY301	Initial consultation and treatment via telehealth	$135.80/30 minutes (maximum 60 minutes) (Pro-rata rates in units of 30 minutes apply)
PSY002	Subsequent consultation and treatment	$113.40/30 minutes (maximum 60 minutes) (Pro-rata rates in units of 30 minutes apply)
PSY302	Subsequent consultation and treatment via telehealth	$113.40/30 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)**	$18.90(+GST)/5 minutes (maximum one hour)
PSY004	Case conference	$18.90(+GST)/5 minutes
PSY005	Travel **(requires pre-approval by the Insurer)** As provided in Clause 5(2), the rate per kilometre applies only to the number of kilometres of travel reasonably involved and directly related to the treatment, where this service has been pre-approved by the Insurer.	Reimbursed in accordance with the Australian Taxation Office cents per kilometre method for businesses and organisations for 2024 - 2025: - 88 cents per kilometre
PSY006	Group/class intervention	$67.80/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 agreed between the Psychologist and Insurer.
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. A Practitioner/practice should not provide or bill for hard copy clinical records if they are maintained electronically. Fees are inclusive of postage and handling.	Where clinical records are maintained electronically by a Practitioner/practice, a flat fee of $68.20is payable (for provision of all requested clinical records held by the practice). Where clinical records are not maintained electronically, the maximum fee for providing hard copies of clinical records is $43.30 (for 33 pages or less) and an additional $1.40 per page if more than 33 pages.
OAS003	Submission of an *Initial Allied Health Treatment Request* (AHTR) only. All other AHTR submitted are not subject to a fee.	$44.10 (Initial AHTR per claim only)
OAS004	Submission of a *First subsequent Certificate of Capacity* only. Note: Must be a SIRA approved Psychologist to issue a Certificate of Capacity. All other subsequent Certificate of Capacity submitted are not subject to a fee.	$44.10 (First subsequent Certificate of Capacity only)

Schedule B

Maximum fees for Counselling services

Counselling Item	Column 1 Type of Treatment	Column 2 Maximum Amount ($) (excl GST)
COU002	Initial consultation and treatment	$101.10/30 minutes (maximum 60 minutes) (Pro-rata rates in units of 30 minutes apply)
COU302	Initial consultation and treatment via telehealth	$101.10/30 minutes (maximum 60 minutes) (Pro-rata rates in units of 30 minutes apply)
COU003	Subsequent consultation and treatment	$90.40/30 minutes (maximum 60 minutes) (Pro-rata rates in units of 30 minutes apply)
COU303	Subsequent consultation and treatment via telehealth	$90.40/30 minutes (maximum 60 minutes) (Pro-rata rates in units of 30 minutes apply)
COU004	Report writing **(requires pre-approval, and must be requested by the Insurer)**	$14.90 (+GST)/5 minutes (maximum one hour)
COU005	Case conference	$14.90 (+GST)/5 minutes
COU006	Travel **(requires pre-approval from the Insurer)** As provided in Clause 5(2), the rate per kilometre applies only to the number of kilometres of travel reasonably involved and directly related to the treatment, where this service has been pre-approved by the Insurer.	Reimbursed in accordance with the Australian Taxation Office cents per kilometre method for businesses and organisations for 2024 - 2025: - 88 cents per kilometre
COU007	Group/class intervention	$57.40/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. A Practitioner/practice should not provide or bill for hard copy clinical records if they are maintained electronically. Fees are inclusive of postage and handling.	Where clinical records are maintained electronically by a Practitioner/practice, a flat fee of $68.20 is payable (for provision of all requested clinical records held by the practice). Where clinical records are not maintained electronically, the maximum fee for providing hard copies of clinical records is $43.30 (for 33 pages or less) and an additional $1.40 per page if more than 33 pages.

OAS003	Submission of an *Initial Allied Health Treatment Request* (AHTR) only. All other AHTR submitted are not subject to a fee.	$44.10 (Initial AHTR per claim only)

WORKERS COMPENSATION (SURGEON AND ORTHOPAEDIC SURGEON FEES) ORDER 2025

under the

Workers Compensation Act 1987

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

Dated this 21st day of January 2025

Megan Osborne
A/Chief Executive
State Insurance Regulatory Authority

Explanatory Note

Treatment by a Medical Practitioner who is a Surgeon or Orthopaedic Surgeon 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 treatment by a Surgeon or Orthopaedic Surgeon provided to an injured worker. For clarity, this Order applies to an exempt worker or a worker receiving treatment outside of NSW under the Act.

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 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 Act, 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 Act or the Authority's *Workers Compensation Guidelines* in effect at the time.

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 Fees List item, 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 Fees List item that specifically describes the combination of procedures, then only that item should be billed. Where a comprehensive item 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.

A Surgeon or Orthopaedic Surgeon 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 (Medical*

Practitioner Fees) Order.

Workers Compensation (Surgeon and Orthopaedic Surgeon Fees) Order 2025

1. Name of Order

This Order is the *Workers Compensation (Surgeon and Orthopaedic Surgeon Fees) Order 2025.*

2. Commencement

This Order commences on 1 February 2025.

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 Fees 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 or Orthopaedic Surgeon), using the AMA Fees List item code MZ900.

Assistance at Operation is only payable once per eligible item 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.

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 means the first consultation by the Surgeon or Orthopaedic Surgeon and includes the report to the referring Medical Practitioner and a 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 Certificate 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.

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, except for items specifically listed as a multiple procedure item in the AMA Fees 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.

Radiation User Licence means a radiation user licence granted by the Environment Protection Authority (EPA) under Part 2 of the *Protection from Harmful Radiation Act 1990* (NSW) 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 Fees 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 means each attendance subsequent to the first in a single course of treatment. A subsequent consultation fee is not to be billed if conducted on the same day as surgery or in the normal aftercare that applies following surgery. The cost of these consultations is included in the fee for the surgical procedure**.**

The subsequent consultation fee includes a subsequent consultation with a Medical specialist/Surgeon/Orthopaedic Surgeon, a report from the subsequent consultation to the referring Medical Practitioner and a 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 Agency 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.

Telehealth consultation means delivery of a consultation via videoconferencing or telephone by a Surgeon or Orthopaedic Surgeon as an alternative to an in-person consultation in compliance with Part 2 of the *Guidelines for the Provision of Relevant Services (Health and Related Services)*.

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 AMA 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 1 February 2025, whether it relates to an injury received before, on, or after that date.

5. Maximum fees for Surgeon or Orthopaedic Surgeon services (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 worker'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. 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.

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)	$387.70
2.	Subsequent consultation and report (AC510T/AC610T to be utilised when consultation delivered via telehealth)	AC510/AC510T (MBS 105) AC610/AC610T (MBS 6009)	$267.10
Procedures			
3.	Surgical procedure(s)	EA015 (MBS 30001) to MZ871 (MBS 51171)	AMA Fees List fee for the primary item number. (For any additional item numbers refer to item 5 of this Schedule).
4.	Assistance at Operation 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 Fees 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 Fees List applies, except for items specifically listed as a multiple procedure item in the AMA Fees 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 Fees List
8.	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.	OF812 (MBS 60500) OF816 (MBS 60503) OF820 (MBS 60506) OF824 (MBS 60509) OF952 (MBS 61109)	As per AMA Fees List
Insurer/lawyer requests			
8.	Opinion on file request	WCO009	$267.10
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	$51.50 per 5 minutes
10.	Lost reports and reprints		$181.60 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 Injury Management and Workers Compensation (Medical Examinations and Reports Fees) Order* Schedule 2
12.	Fees for providing copies of clinical notes and records. A Medical Practitioner/practice should not provide or bill for hard copy medical records if they are maintained	WCO005	Where medical records are maintained electronically by a Medical Practitioner/practice a flat fee of $68.20 is payable (for provision of all requested held by the medical practice).

	electronically. Fees are inclusive of postage and handling.		Where medical records are not maintained electronically the maximum fee for providing hard copies of medical records (including Surgeon or Orthopaedic Surgeon's notes and reports) is $43.30 (for 33 pages or less) and an additional $1.40 per page if more than 33 pages.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 9, 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/(No MBS equivalent)	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 Fees 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): (a) removal of 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.

AMA/MBS item number	Descriptor	Reason for decline
	(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.

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.
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.

AMA/MBS item number	Descriptor	Clinical indication
		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,	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,

AMA/MBS item number	Descriptor	Clinical indication
	LN832, LN835, MU402, MX474 or MX475 applies	LN829, LN832, LN835, MU402, MX474 or MX475. This item is not to be billed in conjunction with item MU400 or MU410. However, items LN810 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.

AMA/MBS item number	Descriptor	Clinical indication
MJ075/45515	SCAR, other than on face or neck, NOT MORE THAN 7 CMS IN LENGTH, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital or approved day hospital facility, or where performed by a Specialist in the practice of his or her specialty	This item cannot be billed in conjunction with other items e.g. nerve repair, tendon repair, flap repair (i.e. intended to be an independent procedure).
MJ245/45563	NEUROVASCULAR ISLAND FLAP, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness	This item is for a true island flap, elevated on a neurovascular pedicle for an existing traumatic defect. This item is not to be billed for VY advancement flaps where item MH125/45206 is applicable.
ML105/46325	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 pre-operative 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 pre-operative 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	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
	(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	
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 or ML155/46339.
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.

AMA/MBS item number	Descriptor	Clinical indication
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.
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	Not being a service associated with a service to which item EA355/30107 or ML145/46336 applies.

AMA/MBS item number	Descriptor	Clinical indication
	(c) synovectomy, other than a service associated with a service to which item EA355 or ML145 applies—one joint	
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.
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

AMA/MBS item number	Descriptor	Clinical indication
		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).
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.

AMA/MBS item number	Descriptor	Clinical indication
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): (a) ligament rebalancing (b) removal of prosthesis (c) tendon rebalancing	Flag if this procedure is requested.
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 Fees 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	Not being a service associated with any other arthroscopic procedure of the wrist.

AMA/MBS item number	Descriptor	Clinical indication
	(b) total synovectomy, other than a service associated with a service to which another item in the Fees List applies if the service described in the other item is for the purpose of 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 Fees 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 (February 2022)* 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	**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	**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.
SHOULDER		
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 SIRA 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 not arthroscopic. 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 MT600/48900 applies	Open operation not arthroscopic. Also known as open cuff repair without acromioplasty. Not to be billed in combination with item MT600/48900. 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 MT610/48903 applies	Open operation not arthroscopic. Also 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 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 SIRA claims. May be 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 Fees 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 SIRA claims. **Flag if this item is billed.**
MT670/48921	SHOULDER, total replacement arthroplasty, revision of	Use of this item rarely seen in SIRA claims. **Flag if this item is billed.**
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 SIRA claims. **Flag if this item is billed.**
MT690/48927	Shoulder prosthesis, removal of	Use of this item rarely seen in SIRA claims. **Flag if this item is billed.**

AMA/MBS item number	Descriptor	Clinical indication
MT730/48939	SHOULDER, arthrodesis of, with synovectomy if performed	Use of this item rarely seen in SIRA. **Flag if this item is billed once or more.**
MT740/48942	Arthrodesis of shoulder, with bone grafting or internal fixation, including 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 MR645/48245, MR650/48248, MR655/48251, MR660/48254 or MR665/48257 applies	Not to be billed with a service to which item MR645/48245, MR650/48248, MR655/48251, MR660/48254 or MR665/48257 applies. Use of this item rarely seen in SIRA 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 item 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 Fees 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 used for open procedures. 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.**

AMA/MBS item number	Descriptor	Clinical indication
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 the Fees 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.	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.
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 **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 LN810/39330 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 SIRA 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 SIRA claims. **Flag if this item is billed.**
MU075/49112	Radial head replacement of elbow, other than a service associated with a service to which item MU085/49115 applies	Seen with fractures, dislocations and acute trauma. Not to be billed in combination with item MU065/49109 or MU085/49115**.** **Flag if this item is billed.**
MU085/49115	Total or hemi humeral arthroplasty of elbow, excluding isolated radial head	Use of this item rarely seen in SIRA claims.

AMA/MBS item number	Descriptor	Clinical indication
	replacement and ligament stabilisation procedures, other than a service associated with a service to which item MU075/49112 applies	**Flag if this item is billed.** Not to be billed in combination with item MU075/49112**.**
MU086/49116	ELBOW, total replacement arthroplasty of, revision procedure, including removal of prosthesis	Use of this item rarely seen in SIRA claims. **Flag if this item is billed.**
MU087/49117	Revision of total replacement arthroplasty of elbow, including bone grafting and removal of prosthesis	Use of this item rarely seen in SIRA claims. **Flag if this item is 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 Fees 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		
LN810/39330	Neurolysis by open operation without transposition, other than a service associated with a service to which Item EA075/30023, LN770/39321, LN804/39328, LN806/39329, LN826/39336, LN829/39339, LN832/39342, LN835/39345, MU402/39332, MX474/497745 or MX475/49775 applies	Not being a service associated with a service to which item EA075/30023, LN770/39321, LN804/39328, LN806/39329, LN826/39336, LN829/39339, LN832/39342, LN835/39345, MU402/39332, MX474/497745 or MX475/49775 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.**

AMA/MBS item number	Descriptor	Clinical indication
OTHER JOINTS		
MY055/50112	CICATRICIAL FLEXION or EXTENSION CONTRACTION of JOINT, correction of, involving tissues deeper than skin and subcutaneous tissue, other than 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.** 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 (MUA). 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.**

AMA/MBS item number	Descriptor	Clinical indication
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 LN810/39330 applies; or (b) a service to which another item in the Fees 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 LN810/39330 or a service to which another item in the Fees 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 (February 2022) 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 CONSULTANT FEES) ORDER 2025

under the

Workplace Injury Management and Workers Compensation Act 1998

I, Megan Osborne, A/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 21st day of January 2025

Megan Osborne
A/Chief Executive
State Insurance Regulatory Authority

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1. Name of Order

This Order is the *Workplace Injury Management and Workers Compensation (Independent Consultant Fees) Order* 2025.

2. Commencement

This Order commences on 1 February 2025.

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 means a review, conducted by an Independent Consultant, of the treatment/management provided by the allied health practitioner for the purpose of determining whether treatment/service provision is reasonably necessary or to provide specialised or expert assistance to progress treatment/management by the allied health practitioner. The review may be requested by either the treating allied health practitioner or the Insurer and is conducted as either:

i. Stage 1 review - where consultation with the treating allied health practitioner is not required, for example, where a file review takes place.

ii. Stage 2 review - where consultation with the treating allied health practitioner is required.

iii. Stage 3 review - where an examination of the worker and consultation with the treating allied health practitioner is required.

Telehealth consultation means delivery of Independent Consultant services that use videoconferencing or telephone as an alternative to an in-person consultation in compliance with Part 2 of the *Guidelines for the Provision of Relevant Services (Health and Related Services).*

Unreasonably late attendance means that the worker or interpreter arrives for the scheduled appointment, or joins their scheduled telehealth consultation, 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 Independent Consultant services provided on or after 1 February 2025, whether it relates to an injury received before, on, or after that date. For clarity, this Order applies to an exempt worker or a worker receiving treatment outside of NSW under the Act.

5. Maximum Fees for Independent Consultant services

(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 telehealth consultation, or the worker (or interpreter) attends their scheduled appointment or telehealth consultation **unreasonably** late, preventing a full examination being conducted.

(3) The incorrect use of any item referred to in this Order can result in penalties, including 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.

8. No pre-payment of fees

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

SCHEDULE A

Rates for Independent Consultant services

Item	Service description	Maximum Amount ($) (excl GST)
IIN110	Independent Consultation where referral is 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.	$268.50 per hour
IIN111	Independent Consultation where referral is initiated by the treating practitioner. May include file review, discussions, interview, examination and report.	$268.50 per hour
IIN310	Independent Consultation where referral is 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.	$268.50 per hour
IIN311	Independent Consultation where referral is initiated by the treating practitioner. May include file review, discussions, interview, examination and report. Delivered by telehealth.	$268.50 per hour
IIN112	Cancellation with 2 working days' or less notice, non-attendance at scheduled appointmentor **unreasonably** late attendance by worker or interpreter that prevents full examination being conducted.	$268.50
IIN113	Travel for assessment / consultation outside of consulting rooms.	Reimbursed in accordance with the Australian Taxation Office cents per kilometre method for businesses and organisations for 2024 – 2025: - *88 cents per kilometre*

WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION (INJURY MANAGEMENT CONSULTANT FEES) ORDER 2025

under the

Workplace Injury Management and Workers Compensation Act 1998

I, Megan Osborne, A/Chief Executive, State Insurance Regulatory Authority, make the following Order pursuant to section 339 of the *Workplace Injury Management and WorkersCompensation Act 1998.*

Dated this 21st day of January 2025

Megan Osborne
A/Chief Executive
State Insurance Regulatory Authority

Workplace Injury Management and Workers Compensation (Injury Management Consultant Fees) Order 2025

1. Name of Order

This Order is the *Workplace Injury Management and Workers Compensation (Injury Management Consultant Fees) Order 2025.*

2. Commencement

This Order commences on 1 February 2025.

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.

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.

Telehealth consultation means delivery of Injury Management Consultant services that use videoconferencing or telephone as an alternative to an in-person consultation in compliance with Part 2 of the *Guidelines for the Provision of Relevant Services (Health and Related Services)*.

Unreasonably late attendance means that the worker or interpreter arrives for the scheduled appointment, or joins their scheduled telehealth consultation, 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 1 February 2025, whether it relates to an injury received before, on, or after that date. For clarity, this Order applies to an exempt worker or a worker receiving treatment outside of NSW under the Act.

5. Maximum Fees for Injury Management Consultant services

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. 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/telehealth consultation, or the worker (or interpreter) attends their scheduled appointment/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 A

Rates for Injury Management Consultant services

Payment Classification Code	Service description	Fee (excl. GST)
IIN105	Assessments, examinations, file reviews, discussions and reports	$472.70 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	$472.70 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 consultation, or the worker or interpreter attends the appointment/joins the telehealth consultation **unreasonably late** preventing a full examination being conducted.	$472.70
IIN108	Examination conducted with the assistance of an interpreter	$591.00 per hour (examination only). Discussions with other parties and report to be charged under IIN105 at $472.70 per hour.
IIN308	Examination conducted via telehealth consultation with the assistance of an interpreter	$591.00 per hour (examination only). Discussions with other parties and report to be charged under IIN105 at $472.70 per hour.
IIN109	Travel for assessment/consultation at the worker's place of work	$472.70 per hour.

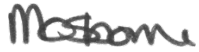
WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION (MEDICAL EXAMINATIONS AND REPORTS FEES) ORDER 2025

under the

Workplace Injury Management and Workers Compensation Act 1998

I, Megan Osborne, A/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 21st day of January 2025



Megan Osborne
A/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* or *Workers Compensation (Surgeon and Orthopaedic Surgeon Fees) Order* for medical services fees related to treatment.

Workplace Injury Management and Workers Compensation (Medical Examinations and Reports Fees) Order 2025

1. Name of Order

This Order is the *Workplace Injury Management and Workers Compensation (Medical Examinations and Reports Fees) Order 2025.*

2. Commencement

This Order commences on 1 February 2025.

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.*

File Review means a review of a 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 A 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 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.

The Medical Examination and Report:

i) 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

ii) 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 Practitioner Fees) Order)*

iii) 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

iv) 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 B 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, or joins their scheduled telehealth consultation, 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 (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.

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 1 February 2025, whether it relates to an injury received before, on or after that date. For clarity, this Order applies to an exempt worker or a worker receiving treatment outside of NSW under the Act.

5. Maximum fees for medical examinations and reports

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 A.

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

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 Medical Practitioner 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 Schedule A & B Services

(1) The party requesting a Medical Examination and/or Report described in Schedules A and B 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. The parties to a contractual arrangement referred to in paragraph 7(1)(b) above are not permitted under the Act to contract out of or otherwise pay above the maximum fees prescribed by Schedules A and B of this Order.

(4) Schedules A and B 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 A and B 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 Practitioner Fees) Order*.

(5) Schedules A and B 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 A

Maximum fees for the provision of Medical Examination and Report by a General Practitioner

Payment Classification Code	Service description	Fee (excl. GST)
IMG001 or WIG001	Examination and report -Standard Report (see definition of Medical Examination and Report)	$699.70
IMG301 or WIG301	Video examination and report - Standard Report (see definition of Medical Examination and Report)	$699.70
IMG002 or WIG002	Examination conducted withthe assistance of an interpreter and report – Standard Report (see definition of Medical Examination and Report)	$781.00
IMG302 or WIG302	Video examination conductedwith the assistance of an interpreter and report – Standard Report (see definition of Medical Examination and Report)	$781.00
IMG003 or WIG003	Examination and report -Complex Report (see definition of Medical Examination and Report)	$1,044.50
IMG303 or WIG303	Video examination and report - Complex Report (see definition of Medical Examination and Report)	$1,044.50
IMG004 or WIG004	Examination conducted withthe assistance of an interpreter and report – Complex Report (see definition of Medical Examination and Report)	$1,216.90
IMG304 or WIG304	Video examination conductedwith the assistance of an interpreter and report – Complex Report (see definition of Medical Examination and Report)	$1,216.90
IMG005 or WIG005	Cancellation with 2 working days' notice or less, worker or interpreter fails to attend the scheduled appointment/join the video examination, or the worker or interpreter attends the appointment/joins the video examination **unreasonably late** preventinga full examination being conducted.	$170.50
IMG006 or WIG006	File review and report (seedefinition of File Review)	$517.70
IMG007 or WIG007	Supplementary report (Seedefinition of Supplementaryreport)	$345.30

IMG008 or WIG008	Update examination and report of worker previously reviewed, where there is no intervening incident.	$436.20
IMG308 or WIG308	Update video examination andreport of worker previously reviewed, where there is no intervening incident.	$436.20
IMG009 or WIG009	Travel	Reimbursed in accordance with the Australian Taxation Office cents per kilometre method for businesses and organisations for 2024 – 2025: - 88 cents per kilometre
WCO005	Fees for providing copies of clinical notes and records. A Medical Practitioner/practice should not provide or bill for hard copy clinical records if they are maintained electronically. Fees are 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.	Where medical records are maintained electronically by a Medical Practitioner/ practice, a flat fee of $68.20 is payable (for provision of all requested medical records held by the medical practice). Where medical records are not maintained electronically the maximum fee for providing hard copies of medical records is $43.30 (for 33 pages or less) and an additional $1.40 per page if more than 33 pages.

SCHEDULE B

Maximum fees for the provision of Medical Examination and Report by a Medical Specialist

Payment Classification Code	Service description	Fee (excl. GST)
IMS001 or WIS001	Examination and report - Standard Report (see definition of Medical Examination and Report)	$945.20
IMS301 or WIS301	Video examination and report - Standard Report (see definition of Medical Examination and Report)	$945.20
IMS002 or WIS002	Examination conducted with the assistance of an interpreter and report – Standard Report (see definition of Medical Examinationand Report)	$1,180.20
IMS302 or WIS302	Video examination conducted with the assistance of an interpreter and report – Standard Report (see definition of Medical Examination and Report)	$1,180.20
IMS003 or WIS003	ENT examination (includes audiological testing) and report - Standard Report (see definition of Medical Examination and Report)	$945.20
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)	$1,180.20
IMS004 or WIS004	Examination and report – Moderately Complex Report (see definition of Medical Examinationand Report)	$1,416.90
IMS304 or WIS304	Video examination and report – Moderately Complex Report (see definition of Medical Examination and Report)	$1,416.90
IMS005 or WIS005	Examination conducted with the assistance of an interpreter and report – Moderately Complex Report (see definition of MedicalExamination and Report)	$1,653.70

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)	$1,653.70
IMS006 or WIS006	Examination and report – Complex Report including complex psychiatric (see definition of Medical Examination and Report)	$1,879.70
IMS306 or WIS306	Video examination and report – Complex Report including complex psychiatric (see definition of Medical Examination and Report)	$1,879.70
IMS007 or WIS007	Examination conducted with the assistance of an interpreter and report – Complex Report (see definition of Medical Examinationand Report)	$2,353.00
IMS307 or WIS307	Video examination conducted with the assistance of an interpreter and report – Complex Report (see definition of Medical Examination and Report)	$2,353.00
IMS008 or WIS008	Examination and report – psychiatric	$1,653.70
IMS308 or WIS308	Video examination and report – psychiatric	$1,653.70
IMS081 or WIS081	Examination conducted with the assistance of an interpreter and report – psychiatric	$2,069.90
IMS381 or WIS381	Video examination conducted with the assistance of an interpreter and report – psychiatric	$2,069.90
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.	$474.10
IMS010 or WIS010	File review and report (see definition of File Review)	$708.20
IMS011 or WIS011	Supplementary report (see definition of Supplementary report).	$471.90

Payment Classification Code	Service description	Fee (excl. GST)
IMS012 or WIS012	Update examination and report of worker previously reviewed, where there is no intervening incident.	$699.80
IMS312 or WIS312	Update video examination and report of worker previously reviewed, where there is no intervening incident.	$699.80
IMS013 or WIS013	Travel	Reimbursed in accordance with the Australian Taxation Office cents per kilometre method for businesses and organisations for 2024 – 2025: - 88 cents per kilometre Flying allowance reimbursed in accordance with Item 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 2023:* - *$23.70 per hour This is in addition to actual expenses incurred for air travel e.g. airfare, taxi fares.*
IMS014 or WIS014	Consolidation of assessments from different Medical Specialists by Lead Assessor to determine the final degree of permanent impairment resulting from the individual assessments.	$237.00
WCO005	Fees for providing copies of clinical notes and records. A Medical Practitioner/practice should not provide or bill for hard copy clinical records if they are maintained electronically.	Where medical records are maintained electronically by a Medical Practitioner/practice, a flat fee of $68.20 is payable (for

Payment Classification Code	Service description	Fee (excl. GST)
	Fees are 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.	provision of all requested medical records held by the medical practice). Where medical records are not maintained electronically the maximum fee for providing hard copies of medical records is $43.30 (for 33 pages or less) and an additional $1.40 per page if more than 33 pages.

Anti-Discrimination
New South Wales

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 8 and 51 of the *Anti-Discrimination Act 1977* (NSW) to History Council of New South Wales Inc to advertise, designate and recruit the position of a First Nations Histories Project Officer for Aboriginal and Torres Strait Islander people only.

This exemption will remain in force for 5 years.

Date: 22 January 2025

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

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