WORKERS COMPENSATION (MEDICAL PRACTITIONER FEES) ORDER 2024

under the

Workers Compensation Act 1987

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

Dated this 9th day of January 2024

Adam Dent
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. 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 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 2024

1. Name of Order

This Order is the *Workers Compensation (Medical Practitioner Fees) Order 2024.*

2. Commencement

This Order commences on 1 February 2024.

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. The Authority reserves the right to conduct an audit of Assistance at Operation fee payments to ensure their proper distribution into the named trust fund.

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

- seek to clarify the worker's capacity/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 Authority as a Specialist in surgery in their chosen field. It includes a Surgeon who is a staff member at a public hospital providing services at that hospital.

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 2024, 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 $53.80. 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: $26.90 per 5 minutes
- Medical Specialist: $37.40 per 5 minutes
- Surgeon or Orthopaedic Surgeon: $49.30 per 5 minutes.

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

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

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

(6) Where medical records are maintained electronically by a Medical Practitioner/practice a flat fee of $65.30 is payable (for provision of all requested medical records held by the medical practice) inclusive of postage and handling. A Medical Practitioner/practice should not provide or bill for hard copy medical records if they are maintained electronically.

Where medical records are not maintained electronically the maximum fee for providing hard copies of medical records is $41.40 (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 – AA320)
- 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 – AM 240, 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.