Effective 1 February 2025

SIRA

Accredited Exercise Physiology Fees and Practice Requirements

State Insurance
Regulatory Authority

NSW GOVERNMENT

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Accredited exercise physiology services and maximum fees

The information in Table 1 sets out legally binding requirements extracted from the *Workers Compensation (Accredited Exercise Physiology Fees) Order 2025* (Fees Order), the *Workers Compensation Guidelines* (WC Guidelines) and the *Guidelines for the Provision of Relevant Services (Health and Related Services)* (Service Provider Guidelines). The Fees Order[1], WC Guidelines[2] and the Service Provider Guidelines[3] are the ultimate source of your legal obligations. The full text of the Fees Order, the WC Guidelines and the Service Provider Guidelines can be accessed using the links and references provided at the bottom of this page.

The maximum fees in this table apply to services provided on or after 1 February 2025. The related injury may have been received before, on or after this date. The maximum fees apply to treatment of exempt workers and to injured workers receiving treatment outside of NSW.

Table 1: Maximum fees for Accredited Exercise Physiology services

Accredited Exercise Physiology Item	Type of Treatment	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

[1] *Workers Compensation (Accredited Exercise Physiology Fees) Order 2025*, Government Gazette of the State of New South Wales, Number 27 – Other, of Friday 24 January 2025, p. 9-15; https://gazette.nsw.gov.au/gazette/2025/1/2025-1_27-gazette.pdf

[2] *Workers Compensation Guidelines*, SIRA, March 2021; https://www.sira.nsw.gov.au/workers-compensation-claims-guide/legislation-and-regulatory-instruments/guidelines/workers-compensation-guidelines#part-4

[3] The *Guidelines for the Provision of Relevant Services (Health and Related Services)*: https://www.sira.nsw.gov.au/fraud-and-regulation/new-regulation-for-health-and-related-services-in-workers-compensation-and-ctp-schemes/guidelines-for-the-provision-of-relevant-services-health-and-related-services

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 1 hour)
EPA004	Group/class intervention	$65.50 / participant
EPA005	Incidental expenses (e.g. strapping tape, theraband, exercise putty, etc). **Incidental expenses above $110 per claim requires Insurer pre-approval.** Note: This code does not apply to external facility fees or to consumables used during a consultation.	Cost price, including postage/freight
EPA006	Case conference Note: Over two hours of case conferencing per Practitioner requires Insurer pre-approval.	$18.70 / 5 minutes
EPA007	Report writing **(requires pre-approval and must be requested by the Insurer)**	$18.70 / 5 minutes (maximum 1 hour)
EPA008	Travel **(requires pre-approval by the Insurer)**	Use of private motor vehicle: • 88 cents per kilometre
WCO005	Fees for providing copies of clinical notes and records where clinical records are maintained electronically by a Practitioner/practice. This must be requested and approved by the Insurer. A Practitioner/practice should not provide or bill for hard copy clinical records if they are maintained electronically.	$68.20 (for provision of all requested clinical records held by the practice) inclusive of postage and handling.
	Fees for providing copies of clinical notes and records (hard copies) where clinical records are not maintained electronically by a Practitioner/practice. This must be requested and approved by the Insurer.	$43.30 (for 33 pages or less) and an additional $1.40 per page if more than 33 pages, inclusive of postage and handling.
OAS003	Submission of an initial Allied Health Treatment Request (AHTR) only. All other AHTR submissions do not attract a fee.	$44.10 (initial AHTR per claim only)

Understanding this document

This document is intended to provide easily accessible information on fees, billing and approval processes and other practice requirements and guidance in the NSW workers compensation scheme, drawn together from multiple sources into a single document. It is anticipated this will make administration of billing, approval processes and practice requirements easier for insurers and providers and reduce the potential for billing and coding errors.

This document refers to legally binding requirements imposed by the:

- *Workers Compensation Act 1987* (1987 Act)
- *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act)
- *Workers Compensation Regulation 2016* (the Regulation)
- *Workers Compensation Guidelines* (WC Guidelines)
- *Workers Compensation Guidelines for the approval of treating allied health practitioners 2021* (Allied Health Guideline)
- *Workers Compensation (Accredited Exercise Physiology Fees) Order 2025* (Fees Order)
- *State Insurance and Care Governance Act 2015* (SICG Act)
- *State Insurance and Care Governance Regulation 2021* (SICG Regulation)
- *Guidelines for the Provision of Relevant Services (Health and Related Services)* (Service Provider Guidelines).

The requirements are reproduced here for your convenience. This document also includes best practice guidance from SIRA.

The legislation, Fees Order and guidelines set out above are the ultimate source of your legal obligations. The words 'must', 'required' (and variations of that word) or 'mandatory' indicate a legal requirement that must be complied with. The words 'should' or 'is expected' indicate recommended best practice.

Insurer pre-approval

Insurer pre-approval means that certain treatments and services cannot be provided or charged for until the insurer has provided approval. Approval is sought by the Practitioner by submitting an ***Allied Health Treatment Request*** form.

Insurer pre-approval is required for face-to-face and telehealth services, except in the following circumstances:

- if the injury was not previously treated by an Accredited Exercise Physiologist, physiotherapist, chiropractor or osteopath and the treatment begins within three months of the injury, up to eight consultations may be provided without insurer pre-approval; **or**
- if the same Practitioner is continuing treatment within three months of the injury, and sought pre-approval by sending an AHTR to the insurer, and the insurer did not respond within five working days of receiving the AHTR, up to eight consultations (per the AHTR) can be provided without insurer pre-approval; **or**
- if the injury was not previously treated by an Accredited Exercise Physiologist, physiotherapist, chiropractor or osteopath and the treatment begins more than three months after the injury, up to three consultations can be provided without insurer pre-approval; **or**
- if the Practitioner previously treated the injury more than three months ago, one consultation with the same Practitioner can be provided without pre-approval by the insurer. This is considered a ***new episode of care***; **or**
- if the injury was previously treated by an Accredited Exercise Physiologist, physiotherapist, chiropractor or osteopath, one consultation with a different Practitioner from this group can be provided without pre-approval from the insurer.

Types of consultations that may be provided

Initial consultation

The initial consultation is the first consultation provided by the Accredited Exercise Physiologist in respect of an injury, or the first consultation in a new episode of care for the same injury. The initial consultation is to be delivered on a one-to-one basis with the worker and may include:

- history taking
- physical assessment
- tailored goal setting and treatment planning
- setting expectations of recovery and return to work
- treatment
- clinical recording
- communication with referrer, insurer and other relevant parties and
- preparation of an Allied Health Treatment Request when indicated.

There are two types of initial consultation:

- *Initial consultation*: this is to be used for every initial consultation except where the injury is related to complex pathology and a Consultation C initial consultation is indicated.
- *Consultation C*: this is to be used when the injury is related to complex pathology as set out in 2.2.3 below.

Subsequent consultations

A subsequent consultation is any consultation provided after the initial consultation provided by the Accredited Exercise Physiologist irrespective of the modality of treatment provided. The subsequent consultation is to be delivered on a one-to-one basis with the worker and may include:

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

There are two types of subsequent consultation:

- *Subsequent consultation*: this is to be used for every subsequent consultation that is not a Consultation C subsequent consultation.
- *Consultation C*: this is to be used when the injury is related to complex pathology as set out in 2.2.3 below.

Consultation C

Consultation C refers to 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.

Requirements for a case conference

A case conference is 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 the Practitioner and any or all of the following:

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

A case conference can be between the worker (including a support person, if requested by the worker) and the 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 the 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.

Payment of travel costs

Travel costs can be claimed when the most appropriate clinical management of the worker requires the Practitioner to travel away from their normal practice. Travel costs need to be pre-approved by the insurer. The rate per kilometre applies only to the number of kilometres of travel reasonably involved and directly related to the treatment.

Travel costs cannot be claimed where:

- the Practitioner provides services on a regular or contracted basis to facilities such as a private hospital, hydrotherapy pool or gymnasium.
- the Practitioner does not have (or is employed by a business that does not have) a normal practice for the delivery of treatment services (e.g. mobile practice).

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

Practice requirements for accredited exercise physiologists

To give or provide a treatment or service to a worker in NSW, an exercise physiologist must be an exercise physiologist who is accredited with Exercise & Sports Science Australia.

In addition, the Allied Health Guideline requires accredited exercise physiologists to be approved by SIRA to provide services in the NSW workers compensation scheme.

All allied health practitioners in the NSW workers compensation scheme should adopt the principles of the *Clinical Framework for the Delivery of Health Services.* The five principles are:

1. Measure and demonstrate the effectiveness of treatment
2. Adopt a biopsychosocial approach
3. Empower the injured person to manage their injury
4. Implement goals focused on optimising function, participation and return to work
5. Base treatment on the best available research.

Allied Health Treatment Request

When requesting approval of treatment services, including equipment needs and case conferencing, Practitioners should provide clinical justification to support the services requested.

The Allied Health Treatment Request allows you to:

- describe the impact of the injury on the worker, including current signs and symptoms and capacity to engage in work and usual activities
- document risk screening, identify barriers to recovery and strategies to address
- set SMART goals and empower the worker to be actively involved in their recovery
- outline a treatment plan including both self-management and your proposed intervention
- demonstrate the effectiveness of treatment using standardised outcome measures
- indicate the anticipated timeframe the recovery will take.

Treating exempt workers

Exempt workers include police officers, paramedics and firefighters, coal miners and volunteers prescribed by the *Workers Compensation (Bush Fire, Emergency and Rescue Services) Act 1987*.

Exempt workers are not required to use SIRA-approved Accredited Exercise Physiologists.

There is no requirement for providers of treatment and services to exempt workers to seek pre-approval from their employer's insurer for treatment. However, payment for treatment and services to exempt workers will be assessed by insurers based on whether the treatment or service is required as a result of the injury, is considered reasonably necessary and on the provision of properly verified costs.

Service provision via telehealth

Part 2 of the Service Provider Guidelines requires that accredited exercise physiologists must provide telehealth services:

- in combination with in-person services unless the services are pre-approved by the insurer managing the injured person's claim for delivery exclusively by telehealth.
- by videoconference unless it is unavailable. Email, SMS, or an app may only be used in conjunction with the delivery of telehealth via videoconference.

The Service Provider Guidelines also require that you must only provide telehealth services to an injured worker if:

- the injured worker requests or consents to participate in a telehealth service, and
- the Practitioner determines that telehealth is appropriate for the injured worker concerned following consideration of the following factors:
  - ✓ whether a physical assessment or treatment is required
  - ✓ whether it will compromise worker outcomes
  - ✓ availability of support at the injured worker's location
  - ✓ availability and access to a suitable device e.g. videoconferencing units/systems or a personal device capable of videoconferencing
  - ✓ ability of the injured worker to participate, considering any physical, mental, social, and cognitive barriers
  - ✓ ability to schedule telehealth session within the timeframes for a service
  - ✓ the injured person's access to fast secure internet connection and sufficient internet or mobile data quota/allowance
  - ✓ the injured person's capability/capacity to access care this way.

Requirements for payment of fees

The fees in Table 1 are maximum fees

You must not charge more than the maximum fees stated in this document and gazetted in the Fees Order. You may charge a lower fee.

The maximum fees apply even if the treatment is provided outside of NSW for workers entitled to compensation under the 1987 Act.

The employer/insurer is not liable to pay the cost of treatment in excess of the maximum fees set by SIRA and may seek to recover any fees in excess of the maximum fee that have been paid to a Practitioner.

Insurers may set their own fee limits for services to workers. These must not exceed the maximum fees in the Fees Order.

Workers are not liable for the cost of treatment covered by the Fees Order. The employer (and/or their insurer) is liable to pay these fees.

Circumstances in which fees will not be paid

A Practitioner must not:

- request pre-payment of fees for reports and services from the insurer
- charge a fee for cancellation or non-attendance by an injured worker for treatment services
- directly bill relevant services to an injured worker who has a claim
- charge the injured person any additional or gap fee.

The employer/insurer is not liable to pay for treatment or services that are provided by a Practitioner who is suspended or disqualified from practice, or if the Practitioner's registration is limited or subject to any condition imposed as a result of a disciplinary process.

Payment of external facility fees for workers

In some exceptional circumstances, the insurer may give approval for treatment to be provided at an external facility such as a gymnasium or pool. In these cases:

- external facility fees apply only to the cost for the worker's entry
- the facility (and not the service provider) should invoice the insurer directly under the code OTT007
- fees payable for the entry of the Practitioner must not be charged to the insurer
- an entry fee will not be paid where the facility is owned or operated by the Practitioner, or the Practitioner contracts their services to the facility.

Where the facility cannot invoice the insurer directly, the service provider must clearly state the name, location and charge cost price of the facility fee on their invoice. They must also attach a copy of the facility's invoice to their account.

Payment for treatment of catastrophic injuries

The Fees Order does not set a maximum fee for treatment provided to a worker with a catastrophic injury because of the complexity and additional care requirements for these cases.

Instead, the Practitioner is to agree fees for catastrophic injury treatment with the insurer prior to the delivery of services.

When invoicing, Practitioners are to use the most appropriate code/s from Part 1 but will not be bound by the maximum fee set for that code.

Use of the Allied Health Treatment Request form is optional for the request of treatment for workers with catastrophic injury.

Catastrophic injury refers to one or more of the following diagnoses:

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

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

Penalties for non-compliance

SIRA and insurers will monitor compliance with billing and payments rules:

- The incorrect use of any item referred to in the Fees Order may result in the service provider being required to repay payments that have been incorrectly received.
- Failure to comply with a provision of the workers compensation legislation, including the WC Guidelines and the Fees Order, or the Service Provider Guidelines, may result in the provider being given a direction by SIRA. Non-compliance with the direction given is an offence and may result in SIRA pursuing a prosecution or penalty notice.
- The workers compensation legislation provides for criminal penalties for a person who:
  - commits fraud on the workers compensation legislation (s 235A of the 1998 Act) or
  - knowingly makes a false or misleading statement relating to a claim (s 235C of the 1998 Act).
- SIRA reserves the right to refer misconduct to Exercise and Sports Sciences Australia, the Health Care Complaints Commission, and/or other relevant professional bodies.

How to invoice

What information must I include on invoices?

To enable consistent data collection from service providers and insurers and to ensure accurate payments, certain information must be included on invoices. An example invoice is included below to assist providers and insurers. Invoices for relevant services rendered must include:

- ✓ the injured worker's first and last name, and claim number
- ✓ payee name, address, telephone number and email address
- ✓ payee Australian Business Number (ABN)
- ✓ name of the relevant service provider who delivered the relevant service
- ✓ the accredited exercise physiologist's:
  - SIRA approval number
  - AHPRA number/professional association accreditation/membership number
  - in the case of allied health services provided interstate by a service provider who doesn't have a SIRA approval number, the service provider number INT0000 must be included on the invoice instead

- in the case of allied health services provided to exempt workers, by a service provider who doesn't have a SIRA approval number, the service provider number **EXT0000** must be included on the invoice instead.

✓ relevant SIRA payment classification code

✓ service cost for each SIRA payment classification code

✓ date of service

✓ date of invoice (must be on the day of or after last date of service listed on the invoice).

Invoices must be submitted within 30 calendar days of the service being provided.

Example invoice format:

Company Name: XXXXXX
ABN: XXXXXX
SIRA approval number: [where appropriate] XXXXX
AHPRA Number: XXXXX
[Insert payee details: Name, Street address City, STATE/TERR, Postcode, email address]

INVOICE NUMBER: XXXX
INVOICE DATE: XXXX

[To:
Insert insurer name
Street address
City, STATE/TERR, Postcode]

[For:
Worker: Insert first and last name
Claim number: Insert worker's claim number]

SIRA PAYMENT CLASSIFCATION CODE	SERVICE	NAME OF PRACTITIONER	DATE OF SERVICE	AMOUNT	GST	TOTAL
EPA002	Subsequent consultation	John Smith	10/02/25	$96.50	$9.65	$106.15
					TOTAL	$106.15

How is GST applied?

Maximum fees for treatments listed in Part 1 do not include GST. Please note:

- all services provided by an Accredited Exercise Physiologist to a worker are subject to GST.

When do I submit an invoice?

Invoices must be submitted within 30 calendar days of the service being provided.

Definitions

In this guide:

Accredited Exercise Physiologist means an exercise physiologist accredited by Exercise and Sports Science Australia to provide accredited exercise physiology services.

Allied Health Treatment Request (AHTR) refers to the SIRA form (available on the SIRA website) that must be used to request prior approval for treatment and services from the insurer where

required. The AHTR is also used to communicate with the insurer about a worker's treatment, timeframes and anticipated outcomes.

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

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* of the Commonwealth.

Insurer means the employer's workers compensation insurer.

New episode of care is when a worker has ceased treatment for an injury and returns for additional treatment for the same injury after at least three months. The additional treatment may be 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 document means an Accredited Exercise Physiologist who delivers services in accordance with the Fees Order to a NSW worker.

Relevant service has the same meaning given in s26A of the *State Insurance and Care Governance Act 2015* and means a service prescribed by the regulations provided in connection with a claim under the workers compensation and motor accidents legislation.

Report writing occurs only when the insurer requests an Accredited Exercise Physiologist 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.

Treatment provided interstate: A treatment provider does not require SIRA approval under the *Allied Health Guideline* to deliver treatment to a worker in the NSW compensation scheme where:

- the treatment provider practises exclusively outside of NSW and provides services in practices only outside of NSW and
- the NSW worker is living outside of NSW.

Use of private motor vehicle: Reimbursed in accordance with the Australian Taxation Office cents per kilometre method for business and organisations for 2024 - 2025.

Disclaimer

This publication may contain information that relates to the regulation of workers compensation insurance, motor accident compulsory third party (CTP) insurance and home building compensation in NSW. This publication does not represent a comprehensive statement of the law as it applies to particular problems or to individuals, or as a substitute for legal advice.

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