wcb Workers' Compensation Board – Alberta
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HC-983
Alberta Medical Association (AMA)
AMA-WCB Billing Guide

General Instructions:

- These instructions apply to the **AMA contract effective January 1, 2025, through December 31, 2029**.
- The **AMA Billing Contract Reference Guide (CRG)** serves as the interpretive resource for submitting all contract-related billings. Health Care Strategy (HCS) will update the CRG as needed to include clarifications or rulings on new billing scenarios that have emerged since the last publication.
- If a WCB specific billing scenario is not addressed in the CRG, physicians/clinics should consult with the **Health Care Consultant (HCC)** on a case-by-case basis **prior to submitting the invoice**.

Role Modifier Requirement

This modifier identifies the role or capacity in which the service provider is functioning (e.g., surgeon, assistant). It is considered an explicit modifier and must be entered at the time of billing. If no role modifier is submitted, the system will default to assuming the provider acted as the surgeon. **To ensure accurate billing and role recognition, all applicable modifiers must be entered.** Common modifiers include:

- ANE: Anesthetist
- ANEST: Anesthetist TRC
- SA: Surgical assistant

Invoice Submission:

- **All billings should be submitted electronically using the Medical Invoice (C568) form.**
- To ensure timely and accurate payment, invoices must follow the billing rules outlined in the AMA WCB agreement and clarified in the Billing Contract Reference Guide (CRG). Invoices submitted using alternate billing rules may not be eligible for payment.

All fees, except those specific to WCB—defined as premium codes, expedited fees, and reporting fees—are paid in accordance with the Alberta Health (AH) Schedule of Medical Benefits (SOMB).

For current fee information, please refer to the SOMB at: http://www.health.alberta.ca/professionals/SOMB.html

Non-Contracted Services and Billing Exceptions

- Authorization for non-contracted services and exception payments must come directly from the HCC.
- Claim Owners (COs) do not have the authority to approve these payments, and any authorization provided by a CO is not considered binding.

Invoicing Errors:

- **If a physician or clinic needs to revise a previously submitted invoice**, the correction should be submitted electronically using the **Medical Invoice Correction (C570) form**.
- To help avoid billing discrepancies, it's important to use the C570 form for all corrections. Not using the designated form may result in processing errors.

Administrative Fee for Reversed Payments

When WCB reverses a payment to a physician under **Article 5 of the Agreement** for billing(s) originally paid **prior to the current calendar year**, and the physician must subsequently bill **Alberta Health (AH)** to recover the payment, the physician may submit the **administrative fee code RAF01** to WCB. The RAF01 fee is payable once per reversal episode.

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Trauma Definition

The following circumstances **do not qualify** for expedited or premium services fees:

- **Medically required consultation or surgery** performed within four (4) calendar days of the date of accident due to a medical emergency or trauma. These services are provided to prevent significant deterioration or additional complications and are considered part of standard urgent care.
- **Immediate interventions** aimed at preventing loss of limb, life, or permanent impairment are not considered expedited services.
- **Trauma cases** where the consultation or surgery was medically necessary within four (4) calendar days of the accident are excluded from expedited billing.

To be eligible for an expedited fee, the service must be delivered more quickly than it would have been in the normal course of treatment, and not solely due to medical necessity.

Example scenario:

	1-June (DOA)	2-June	3-June	4-June	5-June
Fees Entitlement	Day 1	Day 2	Day 3	Day 4	Day 5

Rural Remote Northern Program (RRNP)

Variable Fee Premium (VFP)

- For services provided in a community designated as a **variable rate community** under the RRNP community table (or any successor program), the physician will continue to receive the **applicable percentage-based payment**, which is **issued retroactively on a quarterly basis.**
- RRNP VFP are paid as per the Alberta Health community table rate: https://open.alberta.ca/dataset/1c8cdb96-11ef-4be9-96d7-42c579a9be5c/resource/54aa3d72-e61b-4384-a5af-884e74752f7b/download/health-rrnp-community-rate-table-2020-04.pdf
- Payments are processed automatically by WCB on a retroactive basis.
- RRNP VFP Incentive Formula:
  - *Original compensation transaction amount × (Location incentive percentage ÷ 100)*

RRNP Flat Fee (FF)

- For services provided in a community designated as a **flat rate community** under the RRNP community table (or any successor program), the physician is entitled to a **flat fee of $32.77**, billed **once per claim per physician**.
- **RRNPFF**: flat rate of $32.77 for rural physicians eligible for AH flat fee as per the community table rate.
- Billed once per claim, per eligible physician.

Billing Number & RRNP

Each WCB billing number is unique to a specific practice location. Physicians who work in multiple communities can request separate billing numbers for each location. This allows WCB to apply the correct incentive structure based on the geographic eligibility of each site.

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Example Scenarios:

- Dr. A practices in Abee, Alberta, a community eligible for the Variable Fee Premium (VFP).
    - Dr. A requests a billing number linked to Abee service location.
    - WCB assigns a RRNP Location ID based on Abee's eligibility.
    - Dr. A automatically receives the VFP when billing under this number.

- Dr. B provides services in multiple communities:
    - In Abee (VFP-eligible), Dr. B uses a billing number associated with Abee and receives the VFP automatically.
    - In Banff (flat-fee eligible), Dr. B uses a billing number associated with Banff and may bill a flat fee of $32.77 once per new WCB claim.

Multiple Locations and RRNP Eligibility – Application Guidance
Physicians who work in multiple communities may be eligible for RRNP incentives in some or all those locations. To ensure accurate RRNP payments, the following steps must be followed when completing the billing number application:

Instructions for Application:

- You must request a separate billing number for each distinct service location where RRNP-eligible services are provided.
- Each billing number must be tied to the physical address where care is delivered—not your home or administrative office.
- The application form will include a designated field for entering the clinic address. This address will be used to assign the correct RRNP Location ID (RRNP_LOC_ID), which determines the applicable incentive percentage.

Using an incorrect address—such as a non-eligible home or central office—will result in inaccurate RRNP payments or no incentive at all.

Mandatory Use of EFT for RRNP Payments
To support accurate and timely RRNP compensation, Electronic Funds Transfer (EFT) is now required for all physicians participating in RRNP.

EFT Requirements:

- EFT details must be submitted and verified for each billing number.
- Payments will be deposited directly to the account associated with the billing number.
- All payment records and reconciliations are available through the myWCB platform.
- Paper statements are no longer mailed.

Failure to provide correct EFT information may result in delays or errors in RRNP payments.

Telephone Conference Fee

TCAMA: telephone consultation for physician to WCB physician, or physician to WCB claim owner. Please refer to the AMA-WCB fee scheduled for current rates.

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AMA Codes for Specialist Consults (not affiliated with the Visiting Specialist Clinic (VSC))

03.08A: Initial consult in a community office. The fee paid is as per AH SOMB.

- Example of an appropriate 03.08A billing: a WCB injured worker is seen by a specialist for an initial consult in a community office.
- Example of an inappropriate 03.08A billing: A worker was seen for an initial consult within a VSC facility.

COM01N: Initial consult when the worker no/shows or cancels within three (3) business days or less from the date of consult or the worker does not show up for the consult.

- Example of an appropriate COM01N billing: A worker is booked for an initial consult on February 5, 2024, but does not show up for the appointment.
- Example of an inappropriate COM01N billing: A worker is booked for an initial consult on February 11, 2024, and calls on February 5, 2024, to cancel the appointment.
- If COM01N is billed (initial consult, no-show/cancellation), the timeframe rests to the date of the missed appointment as day zero (0). Billable once per physician, per claim.
    - Example: If a worker no shows or cancels within three (3) days of their January 1 appointment, this date becomes day zero (0) and the clock resets, so January 2 becomes day one (1) for the purposes of counting days for consultation premium payments, and the physician has 25 days to expedite the patient again.

03.03A: Follow-up consults in a community office. The fee paid is as per AH SOMB.

- Example of an appropriate 03.03A billing: A WCB worker is seen by a specialist for a follow-up appointment two (2) months after the initial consult. The appointment is held in the specialist's community office.
- Example of an inappropriate 03.03A billing: A worker attends a follow-up appointment in a VSC facility.

COM02N: Follow-up consult when the worker no/shows or cancels within three (3) business days or less from the date of consult or the worker does not show up for the consult.

- Example of an appropriate COM02N billing: A worker is booked for a follow-up consult on February 7, 2025, (in the surgeon's community office) but calls to cancel on February 6, 2025.
- Example of an inappropriate COM01N billing: A worker is booked for a follow-up consult on February 11, 2025, (in the surgeon's community office). The worker calls on February 4, 2025, to cancel due to illness.
- If COM02N is billed (initial consult, no-show/cancellation), the timeframe rests to the date of the missed appointment as day zero (0). Billable once per physician, per claim.
    - Example: If a worker no shows or cancels within three (3) days of their January 1 appointment, this date becomes day zero (0) and the clock resets, so January 2 becomes day one (1) for the purposes of counting days for consultation premium payments, and the physician has 25 days to expedite the patient again.

Reporting Codes and Definitions

Consultation Report Fee Codes:

The following fees are billable by a physician for consultation reports for consults completed outside of a VSC facility. Fee differences within each code are based on submission timelines and outlined within the AMA-WCB fee schedule.

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RF01E: Initial consultation report.
RF03E: Follow-up consultation report.

Supplementary Report Billing Codes:

RF04: Photocopy of medical chart
RF05: Summary of medical information, without opinion.
RF06: Summary of medical information, with opinion.
RF08: Copies of specified documents or reports from a chart are requested by WCB and are part of a summary of medical information (RF05/RF06).

Please refer to the AMA-WCB fee schedule for current fees.

Reporting Submission Guidelines

Definitions

- **Business Day**: Monday through Friday from 12:00 a.m. to 11:59 p.m. Mountain Time (MT) each day (excluding New Year's Day, Alberta Family Day, Good Friday, Victoria, Monday, Canada Day, Labor Day, Thanksgiving Day, Christmas Day, August 1st Civic Holiday and Boxing Day).
- **Examination date**: day 0.
- **Received by WCB**: the information is received (and automatically timestamped) by WCB. Please note, this is not the date the physician completes the report or submits to a vendor. If myWCB experiences an outage (scheduled or unscheduled), the outage notification will be posted on the initial login page (under announcements). Physicians or clinics using third-party vendor software can submit their reports into the queue, and the system will process them once the batch is ready. The submission will remain in "submitted" status until it is processed.
- **Same-day report submission**: the report is received by WCB on the same date as the completed examination, which includes up to 10:00 am MT the following Business Day.
- **On-time report submission**: the time when WCB receives a report. This does not refer to the time when submitted by a GP or specialist.
    - GP first report: the report is received within three (3) Business Days from the date of the completed examination up to until 10:00 a.m. MT on the fourth (4^{th}) Business Day following the completed examination.
    - GP progress report: the report is received within four (4) Business Days from the date of the completed examination up to 10:00 a.m. MT on the fifth (5^{th}) Business Day following the completed examination.
- **Specialist consultation report and specialist follow-up report**: the report is received within four (4) Business Days from the date of the completed examination up until 10:00 a.m. MT on the fifth (5^{th}) Business Day following the completed examination.
- **Late report submission**: the report is received by WCB any time after the designated on-time report submissions.

Expedited Consultation Report Billing Codes

The following two (2) codes are billable for consultations performed by a physician on an expedited basis. Fees are determined by the timeframe from the referral letter to the date of the consultation. However, if COM01N or COM01N are billed, then the fees are determined by the timeframe of the date of the missed appointment to the date of the consultation (once per physician, per claim).

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RF02: Consultation report is received within 15 business days from the referral.
RF09: Consultation report is received within 16-25 business days from the referral.

AMA Codes for Consults in a VSC Facility

Note, VS codes are not billable with AH SOMB visit/consult codes.

VS01: non-back, billable for a first consult and inclusive of reporting fee.

- Example of an appropriate VS01 billing: The specialist completes an initial consult for a shoulder injury.
- Example of an inappropriate VS01 billing: The specialist completes a follow-up shoulder consult. Do not bill VS01 - refer to VS02.

VS01N: non-back, first consult worker no show or cancellation is billable if less than three (3) business days' notice was given for a cancellation or if the worker did not show for the consult.

- Example of an VS01N billing: A worker is booked for an initial consult for a shoulder injury on February 7, 2025, but cancelled on February 6, 2025.
- Example of an inappropriate VS01N billing: A worker is booked for an initial consult for a shoulder injury on February 14, 2025 but cancelled on February 7, 2025.

VS02: non-back, follow-up consult is billable for a follow-up consult and inclusive of reporting fees.

- Example of appropriate VS02 billing: The specialist initially saw a worker for a knee injury six (6) weeks ago and referred them for conservative treatment. The worker has now returned for a follow-up appointment which is completed by the specialist.
- Example of inappropriate VS02 billing: the specialist completes an initial consult. Do not bill VS02 – refer to VS01.

VS02N: non-back, follow-up consult worker no show or cancellation is billable if less than three (3) business days' notice was provided for a cancellation or if the worker did not show up for the follow-up consult.

- Example of an VS02N billing: A worker is booked for an initial consult for a shoulder injury on February 7, 2025, but cancelled on February 6, 2025.
- Example of an inappropriate VS02N billing: A worker is booked for an initial consult for a shoulder injury on February 14, 2025 but cancelled on February 7, 2025.

VS03: back, billable for a first consult and inclusive of reporting fee.

- Example of an appropriate VS03 billing: The specialist completes an initial consult for a compensable back injury.
- Example of an inappropriate VS01 billing: The specialist completes a follow-up back consult. Do not bill VS03 - refer to VS04.

VS03N: back, first consult worker no show or cancellation is billable if less than three (3) business days' notice was given for a cancellation or if the worker did not show for the consult.

- Example of an VS03N billing: A worker is booked for an initial consult on February 7, 2025, but cancelled on February 6, 2025.
- Example of an inappropriate VS03N billing: A worker is booked for an initial consult on February 14, 2025 but cancelled on February 7, 2025.

VS04: back, follow-up consult is billable for a follow-up consult and inclusive of reporting fees.

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- Example of appropriate VS04 billing: The specialist initially saw a worker for a compensable back injury six (6) weeks ago and referred them for conservative treatment. The worker has now returned for a follow-up appointment which is completed by the specialist.
- Example of inappropriate VS02 billing: the specialist completes an initial consult. Do not bill VS04 – refer to VS03.

VS04N: back, follow up consult worker no show or cancellation is billable if less than three (3) business days' notice was given for a cancellation or if the worker did not show for the consult.

- Example of VS04N billing: A worker is booked for follow-up back consult on February 12, 2025, but leaves a voicemail message cancelling the evening of February 11, 2025.
- Example of inappropriate VS04N billing: a worker is booked for a follow-up back consult on February 14, 2025, but calls the morning of February 13, 2025, to advise that they will not be attending the appointment.

Expedited Surgery Billing Codes:

Surgeries completed within the timeframes noted below are billable for an expedited fee. Note, trauma surgeries (defined as within four (4) days of the date of accident) are not applicable for these fees.

ES01: billable for a surgery completed within fifteen (15) business days from the date of consult (surgeon).

- Example of an appropriate ES01 billing: the surgeon completed an initial consult on January 31, 2025 and recommended surgery. Surgery was performed on February 7, 2025.
- Example of an inappropriate ES01 billing: the surgeon completed an initial consult on January 6, 2025 and recommended surgery. Surgery was performed on January 29, 2025, ES04 code is applicable (surgery takes place 16 – 25 business days after consult).

ES01N: only applicable for VSC cases, surgery cancellation or worker no show fee for surgeries that were booked within fifteen (15) business days from the date of consult (surgeon).

- ES01N cannot be billed with ES01 or any procedure code (including premium codes) on the same date of service as the procedure did not take place.
- Example of an appropriate ES01N billing: the surgeon completed an initial consult on January 31, 2025 and recommended surgery, surgery was scheduled to be performed on February 7, 2025. However, the worker cancelled on February 6, 2025.
- Example of an inappropriate ES01N billing: the surgeon completed an initial consult on January 31, 2025 and recommended surgery, surgery was scheduled to be performed on February 17, 2025. However, the worker cancelled on February 6, 2025.

ES02: billable for a surgery completed within fifteen (15) business days from the date of consult (anesthesiologist)

- Example of an appropriate ES02 billing: the initial consult was completed on January 31, 2025 and recommended surgery. Surgery was performed on February 7, 2025 with the anesthesiologist.
- Example of an inappropriate ES02 billing: the initial consult was completed on January 6, 2025 and recommended surgery. Surgery was performed on January 27, 2025 with the anesthesiologist, ES05 code is applicable (surgery takes place 16 – 25 business days after consult).

ES02N: only applicable for VSC cases, surgery cancellation or worker no show fee for surgeries that were booked within fifteen (15) business days from the date of consult (anesthesiologist).

- ES02N cannot be billed with ES02 or any procedure code (including premium codes) on the same date of service as the procedure did not take place.

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- Example of an appropriate ES02N billing: the initial consult was completed on January 31, 2025 and recommended surgery, surgery was scheduled to be performed on February 7, 2025 with the anesthesiologist. However, the worker cancelled on February 6, 2025.
- Example of an inappropriate ES02N billing: the initial consult was completed on January 31, 2025 and recommended surgery, surgery was scheduled to be performed on February 17, 2025 with the anesthesiologist. However, the worker cancelled on February 6, 2025.

ES03: billable for a surgery completed within fifteen (15) business days from the date of consult (surgical assistant)

- Example of an appropriate ES03 billing: the initial consult was completed on January 31, 2025 and recommended surgery. Surgery was performed on February 7, 2025 with the surgical assistant.
- Example of an inappropriate ES03 billing: the initial consult was completed on January 6, 2025 and recommended surgery. Surgery was performed on January 30, 2025 with the surgical assistant. ES06 code is applicable (surgery takes place 16 – 25 business days after consult).

ES03N: only applicable for VSC cases, surgery cancellation or worker no show fee for surgeries that were booked within fifteen (15) days from the date of consult (surgical assistant).

- ES03N cannot be billed with ES03 or any procedure code on the same date of service as the procedure did not take place.
- Example of an appropriate ES03N billing: the initial consult was completed on January 31, 2025 and recommended surgery, surgery was scheduled to be performed on February 7, 2025 with the surgical assistant. However, the worker cancelled on February 6, 2025.
- Example of an inappropriate ES02N billing: the initial consult was completed on January 31, 2025 and recommended surgery, surgery was scheduled to be performed on February 17, 2025 with the surgical assistant. However, the worker cancelled on February 1, 2025.

ES04: Billable for a surgery completed between 16 to 25 business days from the date of consult (surgeon)

- Example of an appropriate ES04 billing: the surgeon completed an initial consult on January 8, 2025 and recommended surgery. Surgery was completed on January 27, 2025.
- Example of an inappropriate ES04 billing: the surgeon completed an initial consult on January 8, 2025 and recommended surgery. Surgery was completed on March 7, 2025.

ES04N: **only applicable for VSC cases**, surgery cancellation or worker no show fee for surgeries that were booked within 16 to 25 business days (surgeon).

- ES04N cannot be billed with ES01/ES04 or any procedure codes (including premium codes) on the same date of service, as the procedure did not take place.
- Example of appropriate ES04N billing: the surgeon completed an initial consult on January 8, 2025, surgery was booked for January 30, 2025. However, the worker did not show up for the procedure.
- Example of an inappropriate billing: The surgeon completed an initial consult on January 8, 2025, surgery was booked for January 30, 2025. However, the worker cancelled on January 9, 2025.

ES05: Billable for a surgery completed between 16 to 25 business days from the date of consult (anesthesiologist)

- Example of an appropriate ES05 billing: the initial consult was completed on January 31, 2025 and recommended surgery. Surgery was performed on February 7, 2025 with the anesthesiologist.
- Example of an inappropriate ES05 billing: the initial consult was completed on January 6, 2025 and recommended surgery. Surgery was performed on January 12, 2025 with the anesthesiologist, ES02 code is applicable (surgery takes within 15 business days after consult).

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ES05N: only applicable for VSC cases, surgery cancellation or worker no show fee for surgeries that were booked within 16 to 25 business days (anesthesiologist)

- ES05N cannot be billed with ES05 or any procedure code (including premium codes) on the same date of service as the procedure did not take place.
- Example of an appropriate ES05N billing: the consult was completed on January 8, 2025 and recommended surgery, surgery was scheduled to be performed on January 30, 2025 with the anesthesiologist. However, the worker did not show up for the procedure.
- Example of an inappropriate ES05N billing: the initial consult was completed on January 8, 2025 and recommended surgery, surgery was scheduled to be performed on March 31, 2025 with the anesthesiologist. However, the worker cancelled on January 9, 2025.

ES06: Billable for a surgery completed between 16 to 25 business days from the date of consult (surgical assistant)

- Example of an appropriate ES06 billing: the consult was completed on January 8, 2025 and recommended surgery, surgery was performed on January 30, 2025 with the surgical assistant.
- Example of an inappropriate ES06 billing: the initial consult was completed on January 8, 2025 and recommended surgery, surgery was performed on March 31, 2025 with the surgical assistant.

ES06N: only applicable for VSC cases, surgery cancellation or worker no show fee for surgeries that were booked within 16 to 25 business days (surgical assistant)

- ES06N cannot be billed with ES06 or any procedure code on the same date of service as the procedure did not take place.
- Example of an appropriate ES06N billing: the initial consult was completed on January 8, 2025 and recommended surgery, surgery was scheduled to be performed on January 30, 2025 with the surgical assistant. However, the worker did not show up for the procedure.
- Example of an inappropriate ES06N billing: the initial consult was completed on January 8, 2025 and recommended surgery, surgery was scheduled to be performed on January 30, 2025 with the surgical assistant. However, the worker cancelled on January 9, 2025.

Premium Codes

All specialties, whether practicing in public or private facilities, may bill the 351 premium codes at two (2) times the SOMB base rate. These premium codes apply to 351 designated SOMB procedures listed in the fee guide and are limited to the single highest-paid procedure (base rate) during a patient intervention.

Physicians and anesthesiologists may each bill one (1) major premium code per surgical intervention. Anesthesiologists may claim two (2) times the anesthetic (ANE) base rate for the same procedure. However, procedures performed within four (4) calendar days of the date of accident—trauma cases—are excluded from premium billing.

All remaining codes must be unbundled in accordance with the current AMA-WCB agreement, including the use of applicable modifiers. Modifiers such as BMIPRO, REDO, and others are billed based on the equivalent SOMB code and do not apply to the premium code.

Procedures that are medically required within four (4) calendar days of the accident to prevent significant deterioration or additional complications are considered urgent care and are not eligible for premium billing.

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Example scenario:

	1-June (Date of accident)	2-June	3-June	4-June	5-June
Day number	Day 1	Day 2	Day 3	Day 4	Day 5
Premium Code entitlement	No	No	No	No	Yes

Examples of appropriate surgeon premium code billing:

The physician performing the procedure can bill the highest paid code performed at two (2) times the SOMB base rate. Only one (1) premium code can be billed per physician per operative encounter.

89.09A	Sequestrectomy unspecified (large)	$439.44
92.32C	Excision of semilunar, cartilage of knee (meniscal plasty, meniscal repair)	$571.36
92.32CP	**PREM meniscal repair**	**$571.36**
92.32B	Arthroscopy of knee, including meniscectomy	$351.61
Total:		**$1,933,77**

Note: the billing includes only one (1) premium code for the major (highest SOMB base rate) SOMB code.

Example of an appropriate anesthesiologist premium code billing for the same procedure:

The anesthesiologist can bill the anesthetic premium code corresponding to the premium code claimed by the surgeon at two (2) times the ANE base rate. Only one (1) premium code can be billed per physician per operative encounter.

89.09A	Sequestrectomy unspecified (large)	$207.27
92.32C	Excision of semilunar, cartilage of knee (meniscal plasty, meniscal repair)	$169.57
92.32CA	**PREM meniscal repair – anesthetist**	**$169.57**
92.32B	Arthroscopy of knee, including meniscectomy	$169.57
Total:		**$715.98**

Note: the billing includes only one (1) premium code corresponding to the premium code claimed by the surgeon.