Workers' Compensation Board
Alberta

PHYSICIAN'S REFERENCE GUIDE

Table of Contents

Alberta Workers' Compensation Board

This information guide is provided to assist medical practitioners treating workers for injuries covered under the Workers' Compensation Act (WCA) of Alberta.

Preamble

A young man named John comes into your office complaining of severe back pain following a tumble off a roof that morning while working. Since John was hurt on the job in Alberta, he is required to file a claim with the Alberta Workers' Compensation Board (WCB) under Section 32 of the WCA. In addition, you as a practitioner are required to submit a report to the WCB as outlined in Section 34 of the WCA.

As a health care provider, your contribution and expertise play a vital role in the care of injured workers. Injured workers depend on you to contribute to a clear outcome focused return-to-work plan that will help them get their lives back on track as soon as possible.

The information provided in this guide should give you a sense of the process at WCB for handling claims and processing reports and invoices (page 3).

As soon as an Adjudicator accepts a claim on behalf of the WCB, the injured worker and employer are advised of the decision and work to develop a return to work plan. The goal is to provide appropriate support to allow the injured worker to safely return to work as soon as possible. Various options may be explored including modified work or placement in another suitable position with the same employer.

When the injury causes the worker to be away from work for an extended period of time, or a complex medical or vocational issue exists, the Adjudicator transfers the claim to a Case Manager. The Case Manager then contacts the injured worker, employer and health care practitioner to develop and coordinate a return to work plan specific to that particular worker. The WCB believes that working in partnership with the worker, employer, and health care provider is critical to successful outcomes.

The Adjudicator or Case Manager communicates the return to work plan to the injured worker and employer regularly, verbally and in writing. Your cooperation in developing, reviewing, and implementing the return to work plan is crucial. Injured workers who do not understand their return to work plan should be encouraged to contact their Adjudicator or Case Manager with any questions or concerns.

The WCB values the contribution and expertise provided by health care providers in the care of injured workers. Please contact us at (780) 498-3999, toll-free anywhere in Alberta at 1-866-922-9221, or visit our web site at www.wcb.ab.ca for more information.

The WCB-Alberta and You

What happens if you are injured at work?

1 Tell Your Employer

details of your injury

After receiving notice, your employer must report your injury to the WCB within 72 hours if:

- **you need medical treatment other than first aid, or**
- **you cannot do your job beyond the day of accident.**

2 Tell Your Health Care Provider

you were injured at work

Your doctor, chiropractor, or physiotherapist must report your injury to the WCB within 48 hours.

3 Tell the WCB

Send your Report of Injury form to the WCB right away!

You can get forms from your employer, any WCB office or report online at www.wcb.ab.ca

The WCB registers your claim and assigns it to an adjudicator

The adjudicator determines if your claim meets legislation and policy requirements. WCB will contact you, your doctor, or your employer if more information is required.

Decision made by the WCB

Claim not accepted

The legislative and policy requirements were not met by the information collected. You will be advised of the reason by phone and in writing.

The injured worker may submit more information or ask for an internal review. The injured worker has the option to request a review of the decision within one year.

Claim accepted

The legislative and policy requirements were met.

Benefits and services may include:

- **Wage loss replacement**
- **Medical costs**
- **Case management services**
- **Return to work assistance**

Reporting

Electronic Reporting

Electronic reporting means providing reports and invoices to the WCB utilizing:

- the WCB's internet based reporting system currently known as the "Electronic Injury Reporting" or EIR,
- a vendor to provide reporting to the WCB in a format required by the WCB, or
- such other system as may be approved by the WCB.

Electronic reporting:

- is the required means of reporting to WCB,
- increases payment timeliness, and
- provides information to the WCB decision makers more quickly.

WCB Internet Based Reporting System

All you need to get started is:

- Microsoft Internet Explorer (6.0 or 7.0),
- Adobe Reader (6.0 or higher) and
- High-speed internet access.

Vendor

To see if your vendor is accredited by WCB, visit our website at www.wcb.ab.ca and click on 'WCB for Health Care Providers'. Then look in the 'Online Services' box in the top left hand corner of the page, and click on Medical Software Vendors for a list of vendors. If your software vendor is not on the list, please contact us either by the telephone number or email listed on the website.

On-Line Reporting Access

For detailed information about online access, visit our website at www.wcb.ab.ca and click on 'WCB for Health Care Providers", then look in the 'Online Services' box in the top left hand corner of the page.

Reporting Requirements

Timely, legible and complete reporting is critical to the management of workers' cases**.** The Workers' Compensation Board Act states:

34(1) A physician who attends an injured worker shall

(a) forward a report to the Board

(i) within 2 days after the date of the physician's first attendance on the worker if the physician considers that the injury to the worker will or is likely to disable the worker or more than the day of the accident or that it may cause complications that may contribute to disablement in the future, and

(ii) at any time when requested by the Board to do so,

(b) advise the Board when, in the physician's opinion, the worker will be or was able to return to work, either in the physician's report referred to in clause (a)(i) or in a separate report forwarded to the Board not later than 3 days after the worker was, in the physician's opinion, so able, and

(c) without charge to the worker, give all reasonable and necessary information, advice and assistance to the worker and the worker's dependents in making a claim for compensation and in furnishing any certificates and proofs that are required in connection with the claim.

Non-specialist First Reports/Progress Reports (C050E/C151E)

When creating a new report using the Electronic Injury Reporting system a search can be initiated to determine if the patient is already in the system and if a claim has already been established for the injury being treated. If the WCB Client has recent records within the system, some fields within the report will pre-populate.

If your search matches an existing WCB client the client's information and claim number(s) will be listed. A drop down menu entitled *Create new report* will allow you to select the type of report you wish to create.

If there is more than one WCB client that matches the search information provided, or no matches are found, no search results will be returned. In that case, a drop down menu will be provided to create a new report for the patient.

Note: The Electronic Injury Reporting System is enabled with a show/hide function. Depending on how you answer some questions, additional fields may be available or unavailable for completion. For example if it is indicated that a worker has missed time from work additional information regarding the time loss is required and therefore additional fields will be visible for completion.

It is important that all sections of the report are filled out. Incomplete reports cannot be submitted electronically and will not be processed. For electronic reporting, a**ll mandatory fields are denoted by (*) and an error message will appear if not completed.**

Invoice Information (a complete description of fields is available in online Help within each report)

Report Section	Field Description
Participant Details	**Billing number/Practitioner** • This field may be prepopulated. • If there is more than one billing number associated with your myWCB UserID a drop down menu will be provided. Select the appropriate billing number from the options provided. **Contract ID** • This field may be prepopulated. • If there is more than one contract number associated with your myWCB UserID a drop down menu will be provided. Select the appropriate billing number from the options provided. **Role** • This field may be prepopulated. • If you have more than one skill code, role or specialization a drop down menu will be provided. Select the correct role from the options provided.
Accident Details	**Did the injury/condition develop over time?** Indicate whether the injury occurred over a period of time or from a specific incident and/or distinct event. If the injury occurred over a period of time select ***Yes***. If the injury was from a distinct incident, or a specific event or accident select ***No***. **Note:** When an injury or condition develops over time, the date of accident is normally the first date on which medical treatment was provided to the patient.

Accident Details cont'	**Describe how and when the injury/condition occurred:** Provide a description of the circumstances around the accident and how the accident occurred. If the injury or condition developed over time, provide a description of the job duties and physical demands that increased or caused the symptoms. For First Reports, include relevant history; such as first aid, EMS, and physician and/or facility rendering first treatment.
Injury Details	**Symptoms** Enter the exhibited symptoms. Describe the nature and site(s) of the symptoms according to the patient. Include how the patient describes the symptoms (e.g., pain, numbness, tingling, etc…). Document if the symptoms are local, regional and/or referred. **Objective Findings** Describe the nature and site(s) of symptoms and include range of motion, palpation findings, flexibility, strength, swelling, neurological deficit and/or other relevant findings. Provide positive and pertinent negative objective test findings. Follow-up reporting should include objective medical findings and if there is improvement from prior reports. Comments such as: "unchanged", "as/see before" are not helpful.
Treatment Plan Details	**Were narcotics/opioids prescribed on this visit?** The information you provide in this section will allow for accurate decisions to be made regarding the coverage of opioid medications for your patient. The WCB may authorize payment for prescribed opioid analgesics (narcotics) when: • an injured worker is in the early, acute stage of treatment for a compensable injury (generally the first 12 weeks following injury). • an injured worker is being treated in the later stages of a terminal disease which generally means a life expectancy of 12 months or less. • an injured worker is being treated for severe injuries with recognized, organically based pain. The WCB may also authorize payment for prescribed opioid analgesics (narcotics) for the management of chronic, non-malignant pain when: • the prescribed opioid analgesics are part of an integrated, multi-disciplinary approach to pain management. • the prescribed opioid analgesics do not form the first line of treatment for longer-term or chronic injuries, and • there is evidence that treatment with prescribed opioid analgesics is resulting in demonstrable improvement in the injured worker's function, progress towards return to work and substantial reduction in pain.

Treatment Plan Details cont'	**Note:** If opiods are prescribed and the date of examination is 90 days from the date of accident (and no exceptions apply), additional information about the opioid treatment plan and any adverse opioid behaviours is required. **Treatment plan and non-opioid medications:** • Referrals to allied health practitioners (i.e., physical therapist, chiropractor, podiatrist). • Non-opioid medication prescribed: dosage amount, frequency and duration. • Surgery(ies) booked, including date(s). • Any complicating factors affecting recovery: psychosocial issues, pre-existing or concurrent disorders. **Consultations/Referrals/Investigations** • Please indicate the *Category, Type,* and *Details* of the any *Consultations/Referals* that you have completed. • Select *Expedite* if to have services expedited by WCB. If the expedite box is not available the service cannot be expedited by WCB. **WCB assisted services required** Select the appropriate box if you would like to be contacted by a WCB case manager or physician, or if you would like a referral to a return to work provider. A return-to-work (RTW) assessment center provides a detailed evaluation of a patient's current medical and rehabilitation levels, and the services they may require to reach employability. A variety of services can be provided by health care and related professionals (physical therapists, occupational therapists and exercise therapists, etc.). Services may include treatment (physical therapy, acupuncture, chiropractic and work simulation activities), physical conditioning (gradual improvement of abilities) and assistance with a gradual return to work plan (with date of accident employers).
Return to Work Details	**Will/has the patient missed work beyond the date of accident?** Answer ***no*** to this question if: • Your patient is able to perform regular or modified duties, or • Your patient is absent from work to attend medical appointments but continues to work except for these appointments. **Has the patient returned to work?** • If the patient missed time from work beyond the date of accident (except for medcial appointments) and, as of the date of the examination, returned to work of any kind, including modified work, indicate ***Yes.*** • If the patient missed time from work beyond the date of accident (except for medcial appointments) and has not returned to work in any capacity, select ***No.*** **Is the patient working:** **Modified hours?** • If the patient has returned to work but is working less hours due to the work related injury, select ***Yes*** • If the patient has returned to work and is working the same number of hours per week or shift, select ***No***

Return to Work Details cont'	If *Yes* indicate the number of hours the patient is capable of working per day within the **Current Capabilities** noted. **Modified Duties?** • If the patient has returned to work but is not completing all aspects of the job due to the work injury, select *Yes* • If the patient has returned to work and is completing all aspects of the job, select *Yes* **Note:** if the patient has not yet returned to work or has returned to modified work you will be required to provide information about the patient's current capabilities. **Current Capabilities** Select *Able, Unable,* or, *Limited to* for the capabilities indicated. If *Limited to* is selected, note *Hours* and *Max of* where applicable. **Other restrictions or additional comments/special considerations:** This section is provided for you to include any additional comments or restrictions you may wish to place on the patient's capabilities. **Estimated date you expect the patient will be able to perform pre-accident level work:** • Enter the date that you expect the patient will be able to return to their regular work. • If you anticipate the patient will have permanent restrictions that will prevent them from returning to their regular work please provide the date you feel the patient will reach maximum medical recovery. **Note:** The estimated date provided should be based on the available information at the time of the visit, but this date may be adjusted in Progress Reports as actual medical recovery takes place.
Other Information	**Attachment type** Up to 3 file attachments to this report (DOC. DOCX, Tif/Tiff, Pdf, Rtf, or Txt.) are allowed. Attachment options include: • MRI Report (max 1MB) • X-Ray Report (max 1MB) • CT Scan Report (max 1MB) • Ultrasound Report (max 1MB) • Imaging Requisition(max 1MB) • EMG Referral (max 1MB) • Specialist's Consultation Report(max 1MB) • Operative Report (max 1MB) • Chart Notes(max 2MB) • Other (max 2MB).

Invoice Information (Some invoice fields will be pre-populated from the corresponding report)

Field	Description
Billing number	This field will be pre-populated from the corresponding report for which the invoice is being completed.
Contract ID	This field will be pre-populated from the report for which the invoice is being completed. **Note:** There is the option to provide an alternate contact for billing if the invoice is completed by someone other than the practitioner. The contract ID is assigned by the WCB. Please call registry at 780-498-4316 or 780-498-4262 or toll free at 1-866-922-9221 if you have questions on your contract attachment. If you use the wrong Contract ID, your payment may be delayed. Specialists — Contract ID 000006 Contracted Orthopaedic Surgeons — 000004 General Practice / Family Practice — 000001
Billing contact name	Enter the first and last name of the individual who completed the invoice.
Fax number	Enter the billing contact's area code and fax number.
Diagnostic Codes:	The diagnostic codes will be pre-populated with the ICD-9 codes from the corresponding report. Use ICD-9 codes (i.e., back strain: 724). The ICD-9CM may be accessed from the Alberta Health website at http://www.health.gov.ab.ca.
Date of Examination	This field should be pre-populated with the diagnostic codes from corresponding report.
Skill Code	• This field may be prepopulated. • Otherwise please choose the correct discipline, specialty, or accreditation that the service was performed under.
Clinic reference umber	This field is provided for you to enter the reference number your clinic may use to identify the medical report or invoice.
Facility type	Select the appropriate type of facility where the medical service was provided from the drop down menu provided.
Health service code	Enter the health service code for the service that was provided.
Modifier	• Alberta Health modifiers should be used when applicable. • For each health service code entered there are three fields where fee modifier codes can be entered. • Enter the fee modifier codes that relate to the conditions of the service provided.
Calls	• Indicate the number of units of service provided by time, size, or number. For example the number of consecutive hospital visit days, the number of services performed, or the number of units. • Enter the information in numeric format (e.g., 2).
Encounters	• Indicate the number of separate and distinct times the patient was provided care on the date of service. Multiple services provided to a patient may not be initiated by the physician, or may not be a continuation of service which began earlier in the day. • A maximum of 9 encounters can be indicated.

Supplementary Reports

The WCB may request supplementary (additional) information from a physician. Each supplementary report must be accompanied by a Medical Care Invoice including the name of the WCB Case Manager requesting the report and the date of the request in the "Name of Referring Physician" and "Date of Notification of Referral" respectively.

Initial Specialist or VSC Consultation Report

The sequence and content of reports shall be as follows:

a) Typewritten,
b) Name of the referring physician,
c) Date of Exam,
d) Date of Referral,
e) History of illness or injury,
    i) mechanism of injury and relationship of condition to workplace injury,
    ii) previous history of injury or problems to same part of body, and
    iii) history of non-occupational activities (i.e., social, domestic, and recreational) related to a compensable injury.
f) Present complaints,
g) Objective findings, including observed discrepancies and significant negative findings,
h) Diagnosis or differential diagnosis, and
i) Opinion and Recommendations:
    i) statement of any investigations or treatment required,
    ii) list any complicating factors affecting recovery,
    iii) a summary of the discussion with the Worker on the reasonable period of recovery and expected return to work date, and
    iv) report of the fitness to work- date of accident work, duration of modified work with restrictions and projected date for return to employment.

Surgical Report

The report should contain at a minimum the information below:

a) Typewritten,
b) Date of Surgery,
c) Thorough description of surgical procedure,
d) Worker tolerance to procedure,
e) Any abnormal findings and/or complications observed during the procedure,
f) Anticipated recovery date, and
g) Approximate date of follow-up.

Specialist Consult/Surgical Follow-up

The report should contain at a minimum the information below:

a) Typewritten,
b) Date of Exam,
c) Results from any diagnostic test performed and the specific implications for diagnosis, treatment, rehabilitation and return to work,
d) Present Complaints,
e) Progress to date, and
f) Opinion and Recommendations:
    i) statement of any investigations or treatment required,
    ii) list any complicating factors affecting recovery,
    iii) a summary of the discussion with the Worker on the reasonable period of recovery and expected return to work date, and
    iv) report of the fitness to work- date of accident work, duration of modified work with restrictions and projected date for return to employment. The chart below provides the Physician with the necessary work capability classification.

Classification of Work Capabilities

Reference: National Occupational Classification Career Handbook (NOC-CH)

Limited Work activities involve handling loads up to 5 kg. Examples: • examining and analyzing financial information • selling insurance to clients • conducting economic and technical feasibility studies • administering and marking written tests **Light** Work activities involve handling loads of 5 kg but less than 10 kg. Examples: • repairing soles, heels and other parts of footwear • filing materials in drawers, cabinets and storage boxes • preparing and cooking meals • repairing paintings and artifacts	**Medium** Work activities involve handling loads between 10 kg and 20 kg. Examples: • setting up and operating finishing machines or finishing furniture by hand • measuring, cutting and applying wallpaper to walls • adjusting, replacing or repairing mechanical or electrical components using hand tools and equipment • operating film cameras to record live events **Heavy** Work activities involve handling loads more than 20 kg. Examples: • operating and maintaining deck equipment and performing other deck duties aboard ships • shovelling cement into cement mixers and assisting in the maintenance and repair of roads • measuring, cutting and fitting drywall sheets for installation on walls and ceilings • operating power saws to thin and space trees in reforestation areas

When reporting capabilities, also consider and document the frequency at which a task can be performed. For example, if a worker is capable of lifting at a light level overhead, but should limit the frequency over the course of a work day, make note of that restriction as well.

Frequency capabilities should be reportined as follows:

Never - 0% of the day
Rarely - 1-5% or not daily
Occasional - 6-33% of the day
Frequent - 34-66% of the day
Constant - 67-100% of the day

Specialized Diagnostic Tests

The WCB can normally arrange specialized diagnostic tests (e.g. MRI or nerve conduction studies/EMG studies) recommended as a result of examinations more expediently than the Physician. In order to facilitate an expedited specialized diagnostic test, the Physician must notify the WCB who shall confirm claim entitlement and book the test.

An MRI may be booked by completing and sending a MRI requisition by facsimile to a Booking Expeditor. Nerve conduction studies/EMG studies can be booked by sending a request by facsimile to a Booking Expeditor.

Booking Expeditor:
Facsimile: 780-498-7807
Voice: 780-498-4041

The WCB will confirm all bookings by contacting the Physician's office directly.

Should other specialized diagnostic tests (not identified above) be required, the WCB may be able to arrange these tests more expediently than the Physician. The Physician must contact WCB Health Care Services at 780-498-3219 for further information.

Fees & Billing Rules

WCB Fee Schedule

Provided that the Physician has complied with the terms, conditions and provisions of the WCB/AMA Agreement, the Physician shall bill as outlined in the WCB Fee Schedule below. Service fees shall be based on the Alberta Health Schedule of Medical Benefits as amended.

WCB FEE SCHEDULE – ALBERTA PHYSICIANS

Effective April 1, 2017

Fee for Service			
Service fees based on Alberta Health's Schedule of Medical Benefits			
Reporting Fees			
General Practitioner Report Fees	**WCB Fee**		**WCB Health Services Code**
First report (C050)	Same-day	$73.22	Select "create a new report" or "create a follow-up report" within Electronic Injury Reporting
	On-time	$66.73	
	Late	$50.04	
Progress report (C151)	Same-day	$44.48	
	On-time	$40.54	
	Late	$30.41	
Specialist Report Fees **NOTE:** All Specialists' invoices must be submitted using Form C568 within Electronic Injury Reporting.	**WCB Fee**		**WCB Health Services Code**
Consultation report	Same-day	$89.48	RF01E
	On-time	$81.56	
	Late	$61.17	
Follow-up report	Same-day	$44.48	RF03E
	On-time	$40.54	
	Late	$30.41	
Supplementary Report Fees	**WCB Fee**		**WCB Health Services Code**
NOTE: Use CALL fields to enter the number of pages (e.g. a 10-page chart would be billed as **RF04, CALLS 10**).	$38.59 Photocopies: 48¢/page		RF04
Summary of medical information without opinion			
General practitioner (first 30 minutes)	$138.90		RF05
General practitioner (additional 15-minute increments)	$54.04		
Specialist (first 30 minutes)	$169.79		RF05
Specialist (additional 15-minute increments)	$54.04		
Summary of medical information with opinion			
General practitioner (first 30 minutes)	$162.06		RF06
General practitioner (additional 15-minute increments)	$54.04		
Specialist (first 30 minutes)	$208.35		RF06
Specialist (additional 15-minute increments)	$54.04		
Copies of specified documents or reports from a chart are requested by the WCB and are part of a summary of medical information (RF05/RF06).	48¢/page		RF08

Definitions:

"Business Day" means Monday through Friday from 12:00:00 a.m. to 11:59:59 p.m. Mountain Time (MT) each day, excluding the Employment Standards Code of Alberta designated holidays (New Year's Day, Alberta Family Day, Good Friday, Victoria Monday, Canada Day, Labour Day, Thanksgiving Day, Remembrance Day, and Christmas Day) as well as the August 1st Civic Holiday and Boxing Day;

"Examination date" = day 0;

"Received by WCB" = the date the information is received (automatically time stamped) by WCB. Please note this is not the date that the physician completes the report or submits to a vendor;

"Same Day Report Submission" means that the report is received by WCB on the same date as the completed examination, which includes up to 10:00 a.m. Mountain Time (MT) the following Business day;

"On Time Report Submission" refers to the time when WCB receives a report, and does not refer to the time when submitted by a General Practitioner or Specialist, and means:

- for a GP **First Report**, that the report is received within three (3) Business Days from the date of the completed examination, including up to 10:00 a.m. Mountain Time (MT) on the fourth (4th) Business Day following the completed examination;

- for a GP **Progress Report**, that the report is received within four (4) Business Days from the date of the completed examination, including up to 10:00 a.m. Mountain Time (MT) on the fifth (5th) Business Day following the completed examination;

- for a **Specialist Consultation Report and a Specialist Follow up Report**, that the report is received within four (4) Business Days from the date of the completed examination, including up to 10:00 a.m. Mountain Time (MT) on the fifth (5th) Business Day following the completed examination;

"Late Report Submission" refers to a report received by the WCB at any time after the times prescribed for On-Time Report Submissions.

Expedited Consultation	WCB Fee	WCB Health Services Code
Report received within 15 working days from referral	$347.28	RF02
Report received within 16 – 25 working days from referral	$115.78	RF09
Expedited Surgery	**WCB Fee**	**WCB Health Services Code**
Surgery completed within 15 working days from date of consult		
• Surgeon	$443.55	ES01
• Anaesthetist	$295.71	ES02
• Surgical assistant	$147.85	ES03
Surgery completed within 16 – 25 working days from date of consult		
• Surgeon	$147.85	ES04
• Anaesthetist	$98.55	ES05
• Surgical assistant	$49.30	ES06

EXPEDITED SERVICES

There are two time frames for expedited services:

a) Within 15 working days (full expedited services fee apply).

b) Between 16 – 25 working days (pro-rated expedited services fee apply).

Services will only be considered expedited when:

a) For initial consultations, the report is received by the WCB within the above number of working days following receipt of the referral letter.

b) For surgeries, the surgery is completed within the above number of working days following the day the decision is made to proceed with the surgery.

If a delay is imminent or anticipated due to outstanding investigations regarding the same worker, the specialist will advise the WCB contract manager and the WCB contract manager may, at their discretion, extend the period or periods referred to above. If the specialist fails to complete expedited consultation or expedited surgery and provide WCB with a report within the time frames stated above, an expedited services fees will not be payable. The periods of time to complete expedited services will not be extended due to office closures or specialist unavailability.

SEE CODES & FEES ON THE FOLLOWING PAGE

Anaesthetist Fee for Orthopaedic Procedures (When surgery performed by a contracted orthopaedic surgeon)			
WCB Code	**Equivalent AH Code**	**Description**	WCB Fee
OP01	93.83C	Posterior shoulder instability repair **NOTE:** May not be claimed in association with 93.83D or 95.65B	$544.32
	93.83D	Bankart repair or capsular shift for anterior instability	
OP02	95.91C	Subacromial decompression including bursectomy **NOTE:** May not be billed in association with 95.65B	$215.33
OP08A	93.09D	Instrumentation of dorsolumbar and cervical spine with or without fusion — posterior, 2 vertebrae	$861.29
OP08B	93.09F	Instrumentation of dorsolumbar and cervical spine with or without fusion — posterior, 3 vertebrae	$979.78
OP08C	93.05D	Instrumentation of spine following decompression	$725.77
OP08D	93.05E	Instrumentation of spine following excision of spinal or paraspinal tumor	$1363.72
OP08E	93.09G	Instrumentation of dorsolumbar and cervical spine with or without fusion — posterior, 4 vertebrae	$1124.94
OP09	92.32B	Arthroscopy knee including menisectomy	$326.59
OP10	16.09P	Anterolateral or posterolateral decompression of spine — not simple discectomy or laminectomy	$1090.25
OP11	93.45A	Anterior cruciate ligament reconstruction with bone — patellar tendon graft	$689.48
OP17	93.41A	Total knee arthroplasty including hemiarthroplasty	$870.34
	93.59A	Total hip arthroplasty	
OP18	93.83H	Rotator cuff repair including tendon transfer	$362.88
OP 22	93.11A	Ankle fusion	$417.61
OP23	93.12A	Single hindfoot joint fusion or syndesmosis fusion	$400.24
OP24	93.12B	Double hindfoot joint fusion	$487.24
OP26	93.49A	Reconstruction ligament(s) ankle — early repair, less than 14 days	$313.22
OP27	93.49B	Reconstruction ligament(s) ankle — late repair, more than 14 days	$435.44
OP28	89.22B	Wedge osteotomy ulna	$290.31
OP29	93.25	Arthrodesis — carporadial fusion	$399.17
OP30	93.28	Interpalangeal fusion — arthrodesis or tenodesis	$217.73

Unbundling

Fees billed to the WCB by physicians shall be on an unbundled basis. This means the physician is entitled to a separate fee, payable at 100%, for each component of a procedure when those components are separate and distinct. For example, Alberta Health Rules prohibit billing SOMB Code 92.8D (debridement of knee) with SOMB Code 92.32B (knee arthroscopy).

Unbundling does not apply when a component of a procedure, in accordance with best medical practices, facilitates or is required for the completion of another. In those cases the components are considered to be intrinsically linked and the usual Alberta Health Rules apply. For example, SOMB Code 13.59H (Local infiltration of tissue/local anesthetic) cannot be unbundled when done to facilitate SOMB Code 89.22A (Suture of skin and subcutaneous tissue) because Code 13.59H facilitates the completion of Code 89.22A.

Without restricting the generality of the foregoing, the following rules will apply to determining what components are unbundled:

a) the fee charged for a surgical procedure shall not include pre-surgical or post-surgical visits, which may be billed separately;

b) Anesthetists shall be entitled to bill a fee equivalent to a Comprehensive Visit (03.04A) for pre-surgical Patient examinations in addition to the Anesthetic fee otherwise payable;

c) where a procedure is carried out in conjunction with a visit, both items may be billed;

d) as a general rule, procedural or intravenous sedation may be billed in addition to the procedure, when necessarily done by a different physician;

e) cast application may be billed in addition to the procedure; and

f) nerve blocks for management of post-operative pain performed at the end of a procedure may be billed in addition to both the procedure and the anesthetic.

Comprehensive Visits (03.04A)

A comprehensive visit (03.04A) should NOT be billed automatically for every first WCB visit. SOMB rules apply which are as follows:

> "In the context of rule 4, complete physical examination shall include examination of each organ system of the body, except in psychiatry, dermatology and the surgical specialties. "Complete physical examination "shall encompass all those organ systems which customarily and usually are the standard complete examination prevailing within the practice of the respective specialty. What is customary and usual may be judged by peer review."

Telephone Calls

When receiving or making calls to a case manager or physician at WCB, claims should be submitted using Form C568 (Medical Invoice) for General Practitioners and for Specialists.

<u>Case Manager</u>

- <u>03.05JA</u> - Formal, scheduled, multiple health discipline team conference, per 15 minutes or major portion thereof.

- If the phone call from a case manager is to obtain information missing from the report, 03.05JA is not applicable. Any other phone communication with a WCB case worker should be billed using this code.
- Voice mail messages are eligible for payment if a message is left by the physician providing the requested information.
- Document time and the specifics of the discussion on the patients file.

WCB Physician
Document time and the specifics of the discussion on the patients file. The following HSC's can be billed for any telephone communication with a WCB physician.

Referring Physician
- 03.01LG - Physician to physician telephone consultation, referring physician, weekdays 0700 to 1700 hours.
- 03.01LH - Physician to physician telephone consultation, referring physician, weekdays 1700 to 2200 hours, weekends 0700 to 2200 hours.
- 03.01LI - Physician to physician telephone consultation, referring physician, any day 2200 to 0700 hours.
- Documentation must be recorded by both the referring physician and the consultant in their respective records.

Consultant Physician
- 03.01LJ - Physician to physician telephone consultation, consultant, weekdays 0700 to 1700 hours.
- 03.01LK - Physician to physician telephone consultation, consultant, weekdays 1700 to 2200 hours, weekends 0700 to 2200 hours.
- 03.01LL - Physician to physician telephone consultation, consultant, any day 2200 to 0700 hours.
- Documentation must be recorded by both the referring physician and the consultant in their respective records.

Denied Claims

Services may be provided by physicians to individuals who are initially identified as Workers, but, based on subsequent investigations, may have that status modified or revoked. In such instances the WCB may have made payments to Physicians for Medical Aid, Reporting or Expedited Services, and may recover some or all of those payments and allow the Physicians to seek recovery of the costs of Medical Aid from Alberta Health or other non-WCB payor.

You may submit your invoice with text, **within 90 days of this letter,** to Alberta Health for payment. The 180 day limit will be waived for claims denied by WCB.

WCB may set-off any amount owing as against any other amounts then due or due in the future by the WCB to the Physician. The WCB will not seek recovery of:

- payments made for Medical Aid and reporting in respect of a First Visit;
- payments made for Expedited Services and associated reporting; and
- payments made for any other reports, including associated costs.

In addition, where the WCB seeks recovery of the costs associated with Medical Aid, the physician may bill AH, in accordance with the Master Agreement and the AH Schedule of Medical Benefits. The WCB will limit its recovery to the amount payable by AH. When requested, the Physician must provide a copy of the AH billing record when reimbursing the WCB.

Surgical Assist Claims

When submitting claims for a surgical assist where multiple procedures are done at the same encounter, please ensure that you only bill for one of the codes for the total time. Double payments have occurred when all services provided have been listed. Billings are to be done in the same fashion as billing to AH. Use one of the procedures and bill for the entire time under that procedure.

Anesthetic Services

ANEST (time-based) claims for an anesthetic where multiple procedures are done at the same encounter are to be submitted under one code only using the total time. Problems have arisen with double payments when all services provided have been listed. Billings are to be done in the same fashion as billing to AH. Use one of the procedures and bill for the entire time under that procedure.

Pre-Anesthetic Evaluation

An 03.04A may be billed by the same physician on the same or different day as an anesthetic service for any patient for pre surgical patient examinations.

Anesthetic Claim

As with Alberta Health fee for service anesthetic claims may be submitted on a time basis (ANEST) claims or as a listed rate for the anesthetic (ANE). Multiple anesthetic services may be submitted using ANE at 100% of the listed benefit for each service provided or ANEST for total time.

Anesthetic Rates for Contracted Orthopedic Procedures

See WCB Fee Schedule in this document.

Have Questions?

	CONTACT INFORMATION	CONTACT TELEPHONE NUMBER
All Inquiries	Customer Contact Centre	780-498-3999, or 1-866-922-9221
Billing Inquiries	Medical Aid Team	780-498-4229
Claims Inquiries	Claims Information	780-498-3999, or 1-866-922-9221
Electronic Reporting	eBusiness Support	780-498-7688, or 1-866-922-9221
MRI Bookings	Booking Expeditor	780-498-4041
Health Care Services	Contract Inquiries	780-498-3219

Expedited Services & Visiting Specialist Clinic (VSC)

The intention of expedited services is to financially recognize the added inconvenience to physicians in providing expedited services and reports where these services are performed on an expedited basis without being medically required on that basis. The WCB shall determine if an expedited service fee is payable. The following circumstances will not result in the payment of an expedited service fee:

a) Where the worker requires urgent care,
b) Where the worker requires emergent care,
c) Consultation or Surgery medically required to be performed within 4 calendar days of date of Accident, or
d) Emergency surgery when the Specialist is on call.

With the exception of Expedited Consultation and Expedited Surgeries performed in VSC's all Specialists shall have the opportunity to provide Expedited Services on the terms specified in this Agreement.

Expedited Service Timing

There are two time frames for expedited services:

a) Within 15 working days (Full expedited fee apply), or
b) Between 16 to 25 working days (Pro-rated expedited fee apply).

Services will only be considered expedited when:

a) For initial consultations, the report is received by the WCB within the above number of working days following receipt of the referral letter, and
b) For surgeries, where the surgery is completed within the above number of working days following the day the decision is made to proceed with the surgery.

If a delay is imminent or anticipated due to outstanding investigations regarding the same Worker, advise the WCB Contract Manager forthwith and the WCB Contract Manager may, in its discretion, extend the period or periods referred to above. If the Specialist fails to complete Expedited Comprehensive Consultation or Expedited Surgery and provide WCB with a report within the time frames stated above, an expedited fee shall **not** be payable. The periods of time to complete expedited services shall not be extended as a result of office closures or Specialist unavailability.

Forms

General Practitioners - Physician's Report and Invoice (C050E/151E) - Appendix "A"

(includes ER Specialists/FTER)

First Report (C050E)

- A First Report (C050E) is required for all WCB injuries and is completed for all first visits.

Progress Report (C151E)

- A Progress Report (C151E – Create a Followup Report) is used for follow-up visits where relevant changes occurred since first report.

Medical Invoice (C568)

- A Medical Invoice (C568) is used when a follow-up visit has no relevant change in status to report, or for services where a report is not required.

Please ensure that all mandatory fields are complete. These fields include:

- the injured worker's PHN or WCB Claim Number or patient tombstone information,
- physician's Name,
- WCB Billing number,
- contract ID,
- date of examination,
- date of injury,
- Health Service Codes, and
- worker name and Date of Birth (not mandatory but highly recommended).

Specialists - Medical Consultation Report (C568A) - Appendix "B"

- Used by all specialists for all services provided.
- Used by all physicians when billing for a supplementary report.
- Used to identify HSC provided (i.e. surgery/ anesthetic/ DI claims) (no report fee unless report submitted and invoiced).
- Do not forget to add tray fee as this is not automatic.

Medical Supplies Invoice (C569) (Appendix "C")

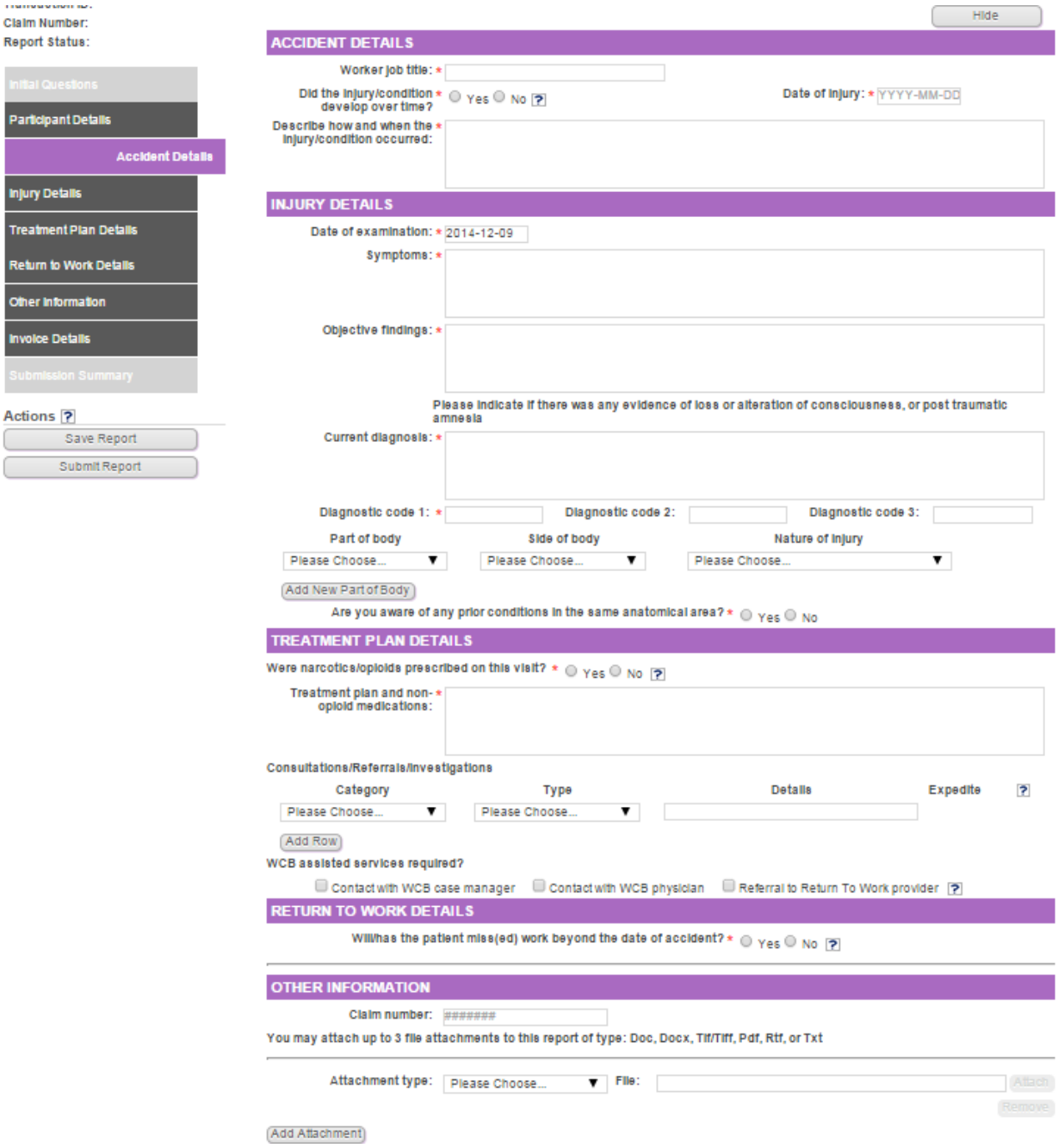
- Used by physicians to bill for Medical Supplies provided to injured workers.
- At cost – No report fee.

When used for medication please provide DIN and quantity.

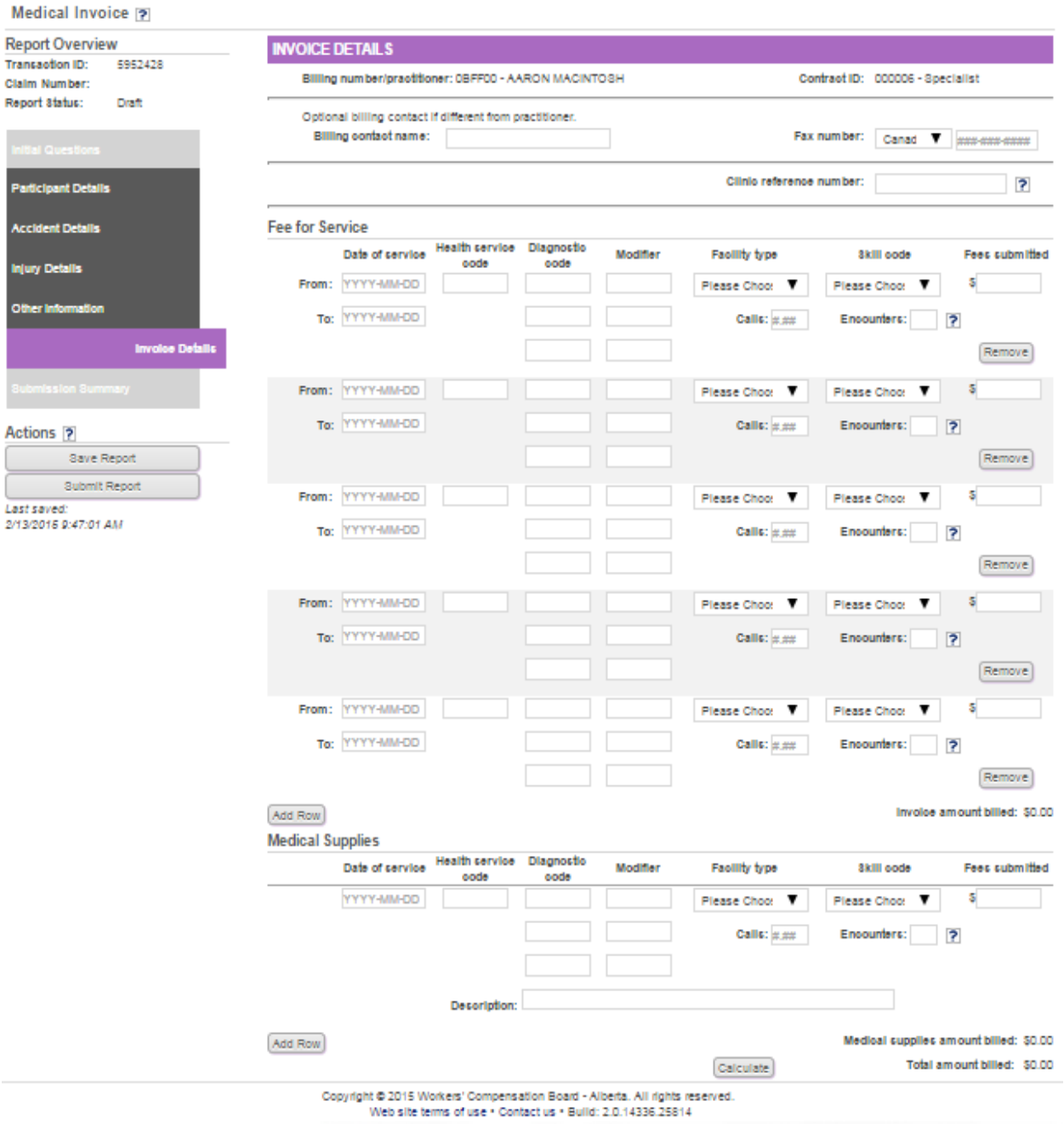
Medical Invoice Correction (C570) (Appendix "D")

- Used by physicians to correct errors on invoices or reports previously sent.
- Do not use to submit enquiries on unpaid or previously paid services.
- Use to advise WCB of the overpayment portion that AH did not cover.
- Attach AH proof of remittance, if requested.

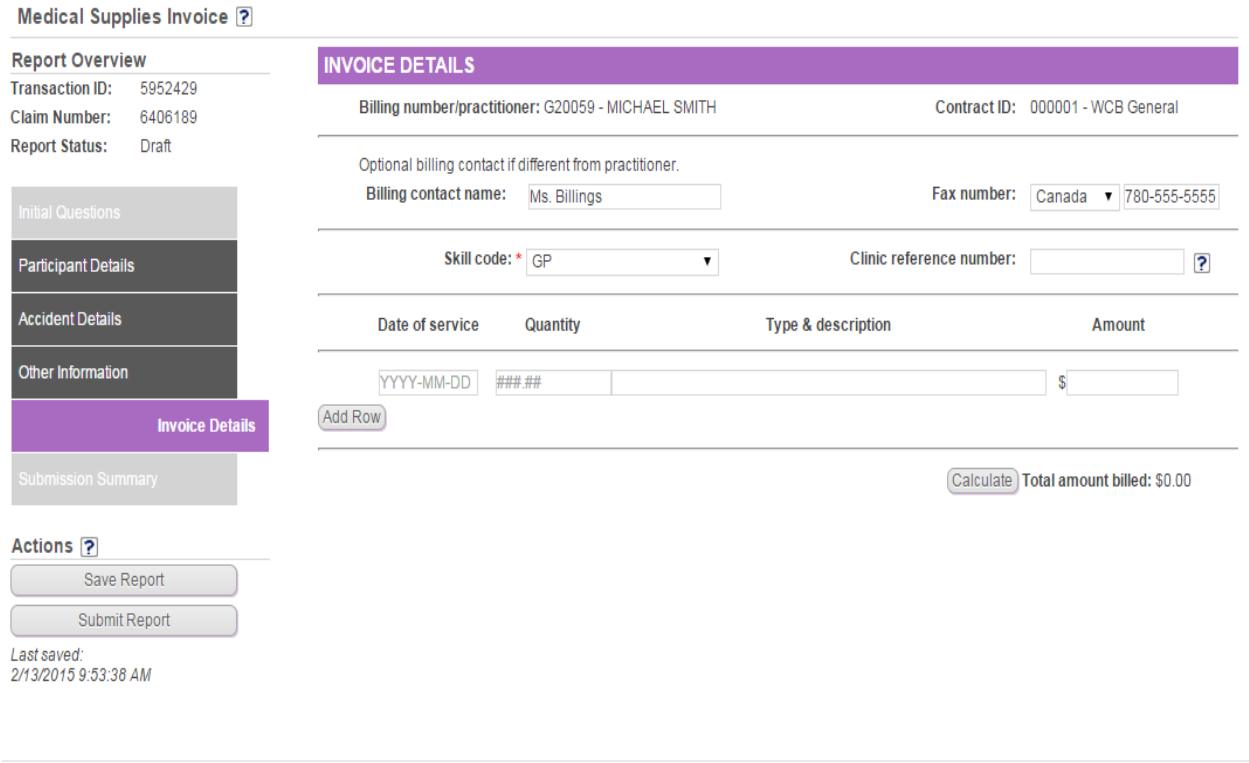
Appendix “A” – Physician’s Invoice and Report – C050E/C151E



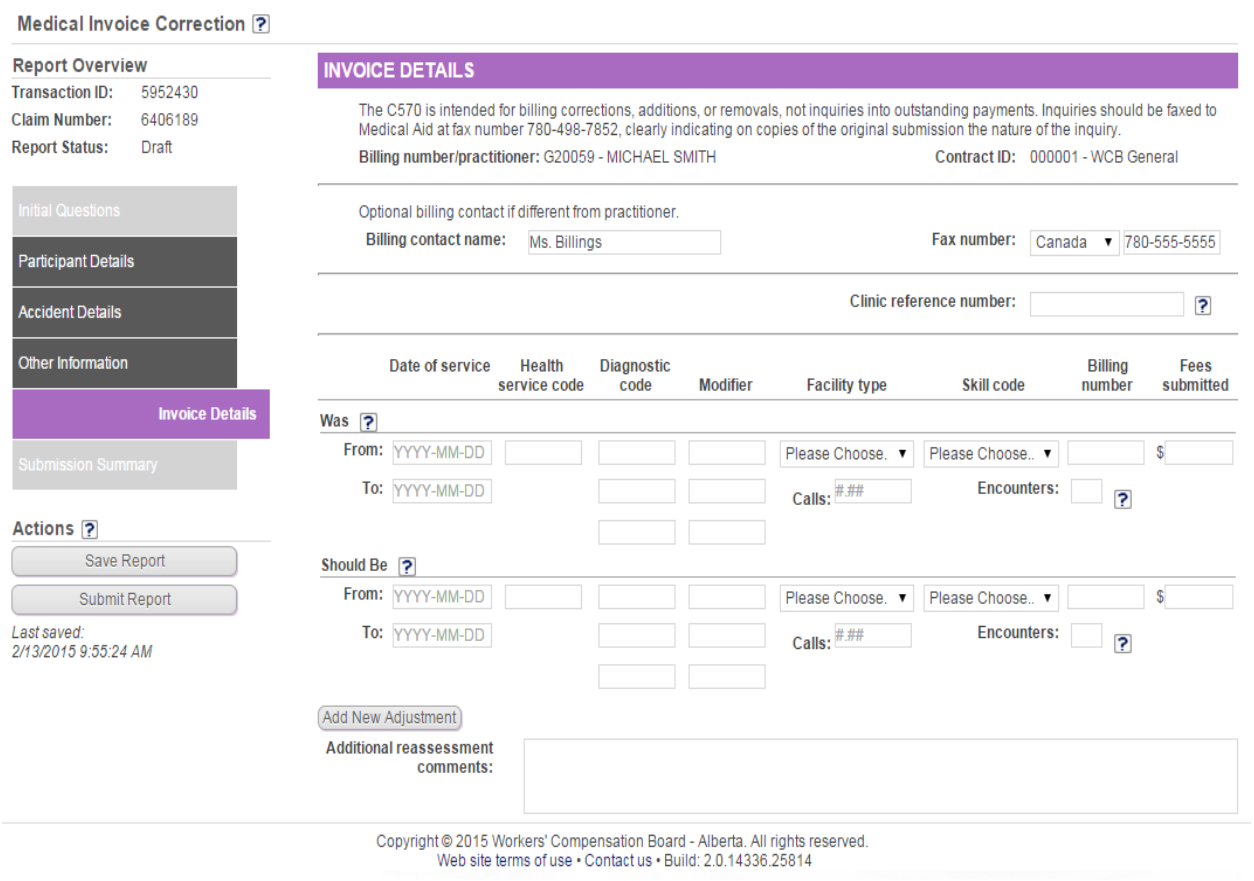
Appendix “B” – Medical Invoice – C-568



Appendix “C” – Medical Supplies Invoice – C569



Appendix “D” – Medical Service Re-Assessment – C570



Medical Invoice Correction

Report Overview
Transaction ID: 5952430
Claim Number: 6406189
Report Status: Draft

Initial Questions
Participant Details
Accident Details
Other Information
Invoice Details
Submission Summary

Actions
Save Report
Submit Report
Last saved:
2/13/2015 9:55:24 AM

INVOICE DETAILS

The C570 is intended for billing corrections, additions, or removals, not inquiries into outstanding payments. Inquiries should be faxed to Medical Aid at fax number 780-498-7852, clearly indicating on copies of the original submission the nature of the inquiry.

Billing number/practitioner: G20059 - MICHAEL SMITH
Contract ID: 000001 - WCB General

Optional billing contact if different from practitioner.
Billing contact name: Ms. Billings
Fax number: Canada 780-555-5555

Clinic reference number:

	Date of service	Health service code	Diagnostic code	Modifier	Facility type	Skill code	Billing number	Fees submitted
Was								
From:	YYYY-MM-DD				Please Choose.	Please Choose..		$
To:	YYYY-MM-DD				Calls: #.##	Encounters:		
Should Be								
From:	YYYY-MM-DD				Please Choose.	Please Choose..		$
To:	YYYY-MM-DD				Calls: #.##	Encounters:		

Add New Adjustment

Additional reassessment comments: