

WCB BILLING RULES and FEES
(Rates Effective April 1, 2010)

1. LEGISLATIVE AUTHORITY

Any work related injury must be reported to WCB as per section 34 of the WCB Act

Section 34 – Report by Physician

“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 for more than the day of the accident or that it may cause complications that may contribute to disablement in the future, and 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 dependants in making a claim for compensation and in furnishing any certificates and proofs that are required in connection with the claim.”

Section 86 - No charge for medical aid

“No part of the cost of any medical aid provided to or in respect of a worker under this Part is payable by the worker.”

2. FEES FOR MEDICAL SERVICES:

Billing for WCB services is done in accordance with the rules associated with the Alberta Health and Wellness Schedule of Medical Benefits (SOMB) with the exception of **UNBUNDLING** which is defined as:

- The ability to bill for services provided at the same encounter. If a visit service is provided at the time of a procedure both may be billed. However, you may not bill for more than one visit service at the same encounter. Thus, if you see a WCB patient in the office for an injured back, injured elbow and suture a laceration on the leg - you may bill either a 03.03A or 03.04A (depending on the extent of the examination) in addition to the 98.22A or B.
- All services are paid at 100% unless otherwise stated in the SOMB. An example of this would be where there are multiple calls allowed and the second and subsequent calls have distinct rates listed in the SOMB.

FEES FOR MEDICAL SERVICES cont'd:

- **Inclusive care periods** (pre- and post-operative inclusive care) do not apply:
 - General Rule 6.8.1 outlines the pre-operative and post-operative inclusive care period. However, one of the components of unbundling is separating out the preoperative and postoperative care and allowing those to be billed in addition to the surgical procedure. This applies to both office and hospital visit services.
 - Daily hospital care (03.03D) may not be claimed for the day of surgery.
- **Intravenous sedation** may be billed in addition to the procedure when done by a different physician.
- **Cast application** may be billed in addition to the procedure. Subsequent cast changes can be billed in addition to the visit service if both are provided. (The 14 day restriction listed in GR 6.11.11 does not apply to WCB cases.)
- **Nerve blocks** (17.71A) for post-operative pain done at the end of a procedure for management of postoperative pain may be billed in addition to either the procedure or the anesthetic.
- **First visits** defined as the first occasion that a physician provides medical aid and reporting in relation to a work-related accident.

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 AHW. 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 AHW. Use one of the procedures and bill for the entire time under that procedure.

Preanesthetic evaluation:

A 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 services cont'd:

Anesthetic claims:

As with Alberta Health and Wellness 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 orthopedic procedures

OP1	Posterior shoulder instability repair (93.83C) or Bankart repair or capsular shift for anterior instability (93.83D)	\$386.12
OP2	Subacromial decompression, including bursectomy(95.91C)	\$289.60
OP8	Instrumentation of spine following decompression (93.05D) Instrumentation of spine following excision of spinal or paraspinal tumor (93.05E) Instrumentation with or without fusion posterior, 2 vertebrae (93.09D) Instrumentation with or without fusion posterior, 3 vertebrae (93.09F) Instrumentation with or without fusion posterior, 4 vertebrae (93.09G)	\$838.60
OP9	Arthroscopy knee, including menisectomy (92.32B)	\$168.92
OP10	Posterior, lateral or anterior decompression of spinal canal (16.09P) ...	\$561.08
OP11	Anterior cruciate ligament reconstruction (93.45A)	\$386.12
OP13	Arthroplasty, lower radio-ulnar joint (93.87A)	\$229.25
OP17	Total knee arthroplasty, including hemiarthroplasty (93.41A) Total hip arthroplasty (93.59A)	\$654.99
OP18	Rotator cuff repair including tendon transfer (93.83H)	\$512.29
OP21	Instrumentation of dorsolumbar and cervical spine with or without fusion, posterior, 5 vertebrae (93.09H)	\$1502.70
OP22	Ankle fusion (93.11A)	\$939.20
OP23	Single hindfoot joint fusion (93.12A)	\$563.51
OP24	Double hindfoot joint fusion (93.12B)	\$751.35
OP25	Triple hindfoot joint fusion (93.12.C)	\$939.20
OP26	Ankle ligament reconstruction <14 days (93.49A)	\$341.52
OP27	Ankle ligament reconstruction >14 days (93.49A)	\$512.29

Trauma Services

Where an Orthopaedic surgeon, who has a separate contract with the WCB to provide services to Workers (the "Contract"), provides Trauma Services under that Contract, the WCB shall pay the assisting anesthetists 28% above the Alberta Health and Wellness (AH&W) Schedule of Medical Benefits (SOMB) consult and surgical codes for Services provided in those Trauma cases. This fee shall be payable for Services provided on and after July 1, 2008. OP codes and expedited fees shall not be payable to the anesthetist in such Trauma cases. For the purpose of this clause, Trauma shall have the meaning in the Contract.

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."

3. TELEPHONE CALLS

NOTE: When receiving or making calls to a case manager or physician at WCB, claims should be submitted using form C252 (Invoice only) for General Practitioners and C568 (Medical Care Invoice) for specialists.

Case Manager:

- NOTE:**
- 1. 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.**
 - 2. Voice mail messages are eligible for payment if a message is left by the physician providing the requested information.**
 - 3. Document time and the specifics of the discussion on the patients file.**

03.05JA Formal, scheduled, multiple health discipline team conference, per 15 minutes or major portion thereof \$ 42.60

WCB Physician

- NOTE:**
- 1. Document time and the specifics of the discussion on the patients file.**
 - 2. The following HSC's can be billed for any telephone communication with a WCB physician, SOMB restrictions do no apply.**

Referring physician

03.01LG	Physician to physician telephone consultation, referring physician, weekdays 0700 to 1700 hours.....	\$ 35.50
03.01LH	Physician to physician telephone consultation, referring physician, weekdays 1700 to 2200 hours, weekends 0700 to 2200 hours.....	\$ 52.54
03.01LI	Physician to physician telephone consultation, referring physician, any day 2200 to 0700 hours.....	\$ 62.01

Consultant physician:

03.01LJ	Physician to physician telephone consultation, consultant, weekdays 0700 to 1700 hours	\$74.18
03.01LK	Physician to physician telephone consultation, consultant, weekdays 1700 to 2200 hours, weekends 0700 to 2200 hours.....	\$109.80
03.01LL	Physician to physician telephone consultation, consultant, any day 2200 to 0700 hours	\$129.58

4. REPORT FEES

- NOTE:**
- 1. Timely, legible and complete reporting is critical and a requirement of the AMA/WCB agreement**
 - 2. "Electronic Reporting" means providing reports and invoices to the WCB utilizing:**
 - a) the WCB's internet based reporting system currently known as the "Electronic Injury Reporting" system", as modified from time to time;**
 - b) a vendor to provide reporting to the WCB in a format required by the WCB; or**
 - c) such other system as may be approved by the WCB from time to time.**

General Practice:

C050	First report	\$ 56.65
C151	Subsequent attendance report/Progress report.....	\$ 34.42

Specialists (Use Form C568 only)

RF01E	Consultation report	\$69.24
RF03E	Follow-up report.....	\$34.42

Supplementary Report Fees:

The WCB may request supplementary (additional) information from a physician. Each supplementary report must be accompanied by a Medical Care Invoice (C568) (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.

RF04` Photocopy of chart \$ 34.42
Additional per page \$ 0.42

NOTE: Use Calls field to enter the number of pages e.g a 10 page chart would be billed as RFO4, calls 10 for a total payment of \$38.62

Summary of medical information without opinion,

RF05 General Practitioner, first 30 minutes \$123.91
Additional 15 minute increments..... \$ 48.20

Supplementary report Fees cont'd

RF05 Specialist, first 30 minutes \$151.45
Additional 15 minute increments..... \$ 48.20

Summary of medical information with opinion,

RF06 General Practitioner, first 30 minutes \$144.57
Additional 15 minute increments..... \$ 48.20

RF06 Specialist, first 30 minutes \$185.86
Additional 15 minute increments..... \$ 48.20

Supplementary Report Fees cont'd

RF08 Photocopy of specified documents or reports from a chart requested by the WCB, and are part of a summary of medical information (additional to RF05 or RF06) per page..... \$ 0.42

5. **Expedited services:**

NOTE: 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 following circumstances will not result in the payment of an expedited service fee:

- Where the worker requires urgent care
- Where the worker requires emergent care
- Consultation or Surgery medically required to be performed within 4 calendar days of the date of accident
- Emergency surgery when the specialist is on call

Consultations

RF02	Report received within 15 days from referral	\$309.76
RF09	Report received within 16 - 25 working days from the referral	\$103.28
RF10	Opioid Management Report (C-914)	Visit + Complex modifier
RF11	Substance Abuse Assessment Checklist report Fee (C942)	\$34.42

Surgery within 15 working days from date of consult

ES01	Surgeon	\$413.04
ES01N	Surgeon no show late cancellation	\$413.04
ES02	Anesthetist	\$275.37
ES02N	Anesthetist no show late cancellation	\$275.37
ES03	Surgical assist	\$137.68
ES03N	Surgical assist no show late cancellation	\$137.68

Surgery within 16 - 25 working days from date of consult

ES04	Surgeon	\$137.68
ES04N	Surgeon no show late cancellation	\$137.68
ES05	Anesthetist	\$ 91.78
ES05N	Anesthetist no show late cancellation	\$ 91.78
ES06	Surgical assist	\$ 45.90
ES06N	Surgical assist no show late cancellation	\$ 45.90

6. Other Invoice/forms:

C568 Medical Care Invoice

NOTE:

- To be used by all Specialists for all services provided.
- To be used by all specialties and non-specialties when billing for a supplementary report
- To identify HSC provided i.e. surgery/anesthetic/DI claims
- No report fee payable unless report is submitted with the form.
- Make sure to add tray service if applicable as this is not automatically paid by WCB

Other Invoice/forms cont'd:

C569 Medical Supplies Invoice At cost

NOTE: Used to claim for medical supplies

C570 Medical Service Reassessment

**NOTE: Used to correct errors on invoices or reports previously sent –
No report fee payable**

- Should not be used to submit enquiries
- Must be used when there is a correction/change to a report or invoice previously submitted, even if the report or invoice has not been paid
- Use to advise WCB of the overpayment portion that AHW did not cover

7. 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 & Wellness or other non-WCB payor.

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

Physician shall reimburse the WCB any fees it has paid within 60 days of receiving a request from the WCB failing which the WCB may set-off any such amount 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 shall bill AH&W, in accordance with the Master Agreement and the AH&W Schedule of Medical Benefits, for all such Medical Aid and pay the WCB the amount paid by AH&W. The WCB will limit its recovery to that amount. When requested, the Physician shall provide a copy of the AH&W billing record when reimbursing the WCB.

8. Business Cost Program (BCP)

The BCP program is available across the province to all physicians who provide visit services in an **office-based setting** are eligible to receive payments through a new fee modifier added on to select office visits and consultations.

BCP01 is used for service provide in locations other than Calgary or Airdrie

BCP02 is used for Calgary and Airdrie.

The location /facility field must be completed - indicating office. One BCP payment is applicable for each visit service provided. For example if you billed 03.03A CMGP02, you would claim 3 units of BCP.

BCP01	\$ 2.75
BCP02	\$ 3.25

- No application is required for the program as the health service code and facility number on the claim determine eligibility. The fee modifier will be added on automatically when the program is implemented.

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