Workers' Compensation Board – Alberta

PHYSICIAN'S REFERENCE GUIDE

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Workers' Compensation Board - Alberta

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*. As a practitioner, you are required to submit a report to 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 like John. 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 better understanding of our process for handling claims and processing reports and invoices (page 3).

As soon as an adjudicator accepts a claim, the injured worker and employer are advised of the decision and we work with them 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. We believe 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.

We value your contribution and expertise 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 website at www.wcb.ab.ca for more information.

WCB-Alberta and You

What happens if you are injured at work?

1 Tell your employer
The details of your injury

After receiving notice, your employer must report your injury to 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
If you were injured at work

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

3 Tell WCB.
Send your Report of Injury form to WCB right away.

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

We register your claim and assign the claim to an adjudicator

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

Claim not accepted

Decision made by WCB

Claim 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.

You may submit more information or ask for an internal review. You also have the option to request a review of the decision within one year.

The legislative and policy requirements were met. Benefits and services may include the following:

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

Reporting

Electronic reporting

Electronic reporting means providing reports and invoices to us using:

- Our internet-based reporting system known as Electronic Injury Reporting (EIR).
- A vendor to provide reporting to us in an appropriate format.
- Other approved systems.

Electronic reporting:

- Is the required means of reporting.
- Increases payment timeliness.
- Provides information to WCB decision-makers more quickly.

Electronic Injury Reporting (EIR)

All you need to get started is:

- Supported browsers are listed here https://www.wcb.ab.ca/utility-navigation/help/.
- Adobe Reader (6.0 or higher).
- High-speed Internet access.

Online reporting access

For detailed information about online access visit the *Resources>For health care and service providers>Online services* section of our website at www.wcb.ab.ca.

Vendor

If your software vendor is not on the approved list, please contact us.

Reporting requirements

Timely, legible and complete reporting is critical to the management of a worker's case**.** The *WCA* states:

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

(a) forward a report to the Board

(i) within two 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 (C050/C151)

When creating a new report using the EIR system, a search can determine if the patient is already in the system and if a claim has already been established for the injury being treated. If a 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 EIR system has a show/hide function. Depending on how you answer some questions, additional fields may be available or unavailable. For example, if it is indicated that a worker has missed time from work, additional information regarding the time loss is required and 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.

Report section	Field description
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 for claim purposes. **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.

Report section	Field description
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. 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 (end-of-life care) which means at high risk for dying in the near future in hospice care, hospitals, long-term care settings, or at home. • An injured worker is being treated for severe injuries with recognized, organically-based pain. We 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. • 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. **Note:** If opioids are prescribed and the date of examination is 90 days from the date of accident (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 (e.g., physiotherapist, chiropractor, podiatrist). • Non-opioid medication prescribed (e.g., dosage amount, frequency and duration). • Surgery(ies) booked, including date(s). • Any complicating factors affecting recovery (e.g., psychosocial issues, pre-existing or concurrent disorders). **Consultations/referrals/investigations** • Please indicate the *Category, Type,* and *Details* of the any *Consultations/Referrals* that you have completed. • Select *Expedite* to have services expedited. If the expedite box is not available the service cannot be expedited.

Report section	Field description
	WCB-assisted services required • Select the appropriate box if you would like to be contacted by a case manager or physician (WCB medical consultant). • If you would like a referral to a return-to-work (RTW) provider. A RTW assessment provides a detailed evaluation of a patient's current medical and rehabilitation levels, and the services they may require to enhance or sustain employability. A variety of services can be provided by health care and related professionals (physiotherapists, occupational therapists and exercise therapists, etc.). Services may include treatment (physical therapy, acupuncture, chiropractic and work simulation activities) and physical conditioning (gradual improvement of abilities).
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. • 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 medical 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 medical appointments) and has not returned to work in any capacity, select ***No.*** **Is the patient working:** **a. 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.*** If *Yes* indicate the number of hours the patient is capable of working per day within the **current capabilities** noted. **b. 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.***

Report section	Field description
	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. This date may be adjusted in Progress Reports as actual medical recovery takes place.
Other information	**Attachment type** You can add up to three file attachments to this report (DOC. DOCX, Tif/Tiff, Pdf, Rtf, or Txt). 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)*
Please note we mirror the AH Schedule of Medical Benefits. Where applicable, please submit the appropriate service code, skill code, modifier, and calls as detailed below.

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. Please call Registry at 780-498-4316, 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. **General practice/family practice** 000001 **Contracted orthopaedic surgeons** 000004 **Specialists** 000006
Billing contact name	Enter the first and last name of the person 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 (e.g., back strain: 724). The ICD-9CM may be accessed from the Alberta Health website at https://open.alberta.ca/publications/alberta-health-diagnostic-codes.
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.

Field	Description
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 nine encounters can be indicated.

Supplementary reports

We may request supplementary (additional) information from a physician. Each supplementary report must be accompanied by a Medical Care Invoice including the name of the claim owner requesting the report and the date of the request in the "Name of Referring Physician" and "Date of Notification of Referral" respectively. Please see AMA fee guide for billing.

Initial Specialist or VSC Consultation Report

The sequence and content of reports will 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.
    iii) History of non-occupational activities (e.g., 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.
    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.
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.
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.
    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	LIGHT
Work activities involve handling loads up to five kg (11 lbs). Examples: • Examining and analyzing financial information. • Selling insurance to clients. • Conducting economic and technical feasibility studies. • Administering and marking written tests.	Work activities involve handling loads of 5-10 kg (11-22 lbs). 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	**HEAVY**
Work activities involve handling loads between 10-20 kg (22-44 lbs). Examples: • Setting up and operating finishing machines or finishing furniture by hand. • Measuring, cutting and applying wallpaper. • Adjusting, replacing or repairing mechanical or electrical components using hand tools and equipment. • Operating film cameras to record live events.	Work activities involve handling loads more than 20 kg (>44 lbs). Examples: • Operating and maintaining deck equipment and performing other deck duties aboard ships. • Shoveling 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 workday, make note of that restriction as well.

Frequency capabilities should be reported as follows:

Never - 0% of the day

Occasional - 6-33% of the day (includes the frequency of ***"rare"*** which is 1-5% of the day**)**

Frequent - 34-66% of the day

Constant - 67-100% of the day

Specialized diagnostic tests

We can normally expedite specialized diagnostic tests (e.g., MRI, CT, bone scans, PFTs and nerve conduction studies/EMG studies) recommended as a result of examinations. In order to facilitate an expedited specialized diagnostic test, the physician must notify us. We will then confirm claim entitlement and book the test.

A MRI, CT, bone scan, or PFT may be requested by completing and sending a requisition by fax.
Nerve conduction studies/EMG can be requested by sending a written request by fax.

Claims toll-free fax number 1-800-661-1993

We will confirm all bookings by faxing the physician's office directly with a confirmation of date once scheduled. Should other specialized diagnostic tests (not identified above) be required, we may be able to arrange these tests more expediently than the physician. Please contact our Health Care Strategy team at 780-498-3219 for more information.

Billing rules

EXPEDITED SERVICES

There are two time frames for expedited services:

- Within 15 business days (full expedited services fee apply).
- Between 16 – 25 business days (pro-rated expedited services fee apply). Services will only be considered expedited:
    - **For initial consultations** when the report is received by WCB within the above number of business days following receipt of the referral letter.
    - **When the surgery** is completed within the above number of business 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 who 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.

Unbundling

Physician fees will 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:

- The fee charged for a surgical procedure will not include pre-surgical or post-surgical visits, which may be billed separately;
- Anesthetists will 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;
- Where a procedure is carried out in conjunction with a visit, both items may be billed;

- As a general rule, procedural or intravenous sedation may be billed in addition to the procedure, when necessarily done by a different physician;
- Cast application may be billed in addition to the procedure; and
- 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 will include examination of each organ system of the body, except in psychiatry, dermatology and the surgical specialties. "Complete physical examination" will 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 a phone call takes place between a physician and a WCB claim owner or physician, payment may be requested on the C568 Medical Care Invoice for the date the phone call occurred as:

- **TCAMA**—First 30 minutes plus each additional 10 minute increment billed as an additional call (e.g., a 50 minute call would be billed as TCAMA with three calls).
- If the phone call from a case manager is to obtain information missing from the report, TCAMA is not applicable. Any other phone communication with a case worker should be billed using this code.
- Voicemail 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.

If the phone call took place between a physician and another community physician or medical professional, payment may be requested on the C568 Medical Care Invoice for the date the phone call occurred as:

Interdisciplinary conference

- **03.05JA**–Formal, scheduled, multiple health discipline team conference, per 15 minutes or major portion thereof.

Referring physician

- **03.01LG**—Physician to physician telephone consultation, referring physician, weekdays 0700 - 1700 hours.
- **03.01LH**—Physician to physician telephone consultation, referring physician, weekdays 1700 - 2200 hours, weekends 0700 - 2200 hours.
- **03.01LI**—Physician to physician telephone consultation, referring physician, any day 2200 - 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 - 1700 hours.
- **03.01LK**—Physician to physician telephone consultation, consultant, weekdays 1700 - 2200 hours, weekends 0700 - 2200 hours.
- **03.01LL**—Physician to physician telephone consultation, consultant, any day 2200 - 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, we may have made payments to physicians for medical aid, reporting or expedited services and may recover some or all of those payments. The physician may seek recovery of the costs of medical aid from Alberta Health or other non-WCB payors. Physicians will be notified, in writing, of this recovery.

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 denied claims.

We may set off any amount owing as against any other amounts then due or due in the future by WCB to the physician. 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.
- Payments made for any other reports, including associated costs.

Physicians may invoice the administrative fee (RAF01) once per reversal episode. The fee applies to payment reversals outside of the current calendar year.

In addition, where we seek recovery of the costs associated with medical aid, the physician may bill Alberta Heath, in accordance with the Physician Funding Framework or any other third party, for work performed. We will limit our recovery to the amount payable by Alberta Health. When requested, the physician must provide a copy of the Alberta Health billing record when reimbursing WCB.

In the unusual circumstance where Alberta Health or a third party denies payment, including but not limited to Alberta Health denying a payment to the physician as a result of a claim for the benefit being outside Alberta Health's defined time limit, we will reimburse the physician for the money recovered upon submission of the request for payment and the denial.

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. Billings are to be done the same fashion as billing to Alberta Health. 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. Billings are to be done the same as billing to Alberta Health. Use one of the procedures and bill for the entire time under that procedure.

Pre-anesthetic 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 claim
Modifier: **ANE**

- If an anesthetist is billing by procedure they would use the ANE modifier.
- If the ANE modifier is used, more than one health service code can be billed, and the ANE modifier will modify the payment for each code.

Modifier: **ANEST**

- If an anesthetist is billing by time, they would use the ANEST modifier signifying (T) time.
- In this case the anesthetist should only be billing one procedure code and indicating the amount of time by the number of calls. One call represents each five minute segment of the surgery.

Anesthetic rates for contracted orthopedic procedures

See WCB Fee Schedule.

Have questions?

	Contact information	**Contact telephone number**
All inquiries	Claims Contact Centre	780-498-3999 or 1-866-922-9221
Billing inquiries	Medical Aid team	medical.aid@wcb.ab.ca
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 Strategy	Contract inquiries	780-498-3219
Physician assistance	Physician Help Line	1-855-498-4919

Expedited Services & Visiting Specialist Clinic (VSC)

The intent of expedited services is to recognize the commitment of physicians to provide expedited services and reports where these services are performed on an expedited basis without being medically required on that basis. WCB will 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 has a severe medical condition or injury or has experienced a medical emergency or trauma requiring services and such services are provided as medically indicated given the nature and severity of the injury. In order for a service to be billed as an expedited service, the service must be delivered more expediently than it would have in the ordinary course of treatment. (e.g., services that are provided immediately to reduce the possibility of a loss of life or limb or permanent impairment).
c) Consultation or surgery medically required to be performed within four calendar days of date of accident to prevent significant deterioration or additional problems from developing.
d) Emergency surgery when the specialist is on call.

With the exception of expedited consultation and expedited surgeries performed in VSC's, all specialists will 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).
b) Between 16 - 25 working days (pro-rated expedited fee apply).

Services will only be considered expedited when:

a) For initial consultations, the report is received within the above number of business days following receipt of the referral letter.
b) For surgeries, where the surgery is completed within the above number of business 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, please advise our Health Care Strategy team. They may extend the period or periods referred to above.

If the specialist fails to complete expedited comprehensive consultation or expedited surgery and provide us with a report within the timeframes stated above, an expedited fee will **not** be payable. The periods of time to complete expedited services will not be extended as a result of office closures, specialist unavailability or vendor service issues.

Forms

General practitioners - Physician's Report and Invoice (C050/151) - Appendix "A" (includes ER specialists/FTER)

First Report (C050)

- A First Report (C050) is required for all WCB injuries and is completed for all first visits.

Progress Report (C151)

- A Progress Report (C151 – Create a Follow-up 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
- 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 health service codes provided (e.g., surgery/anesthetic/DI claims) No report fee unless report submitted and invoiced.
- Do not forget to add tray fee as this is not automatic.

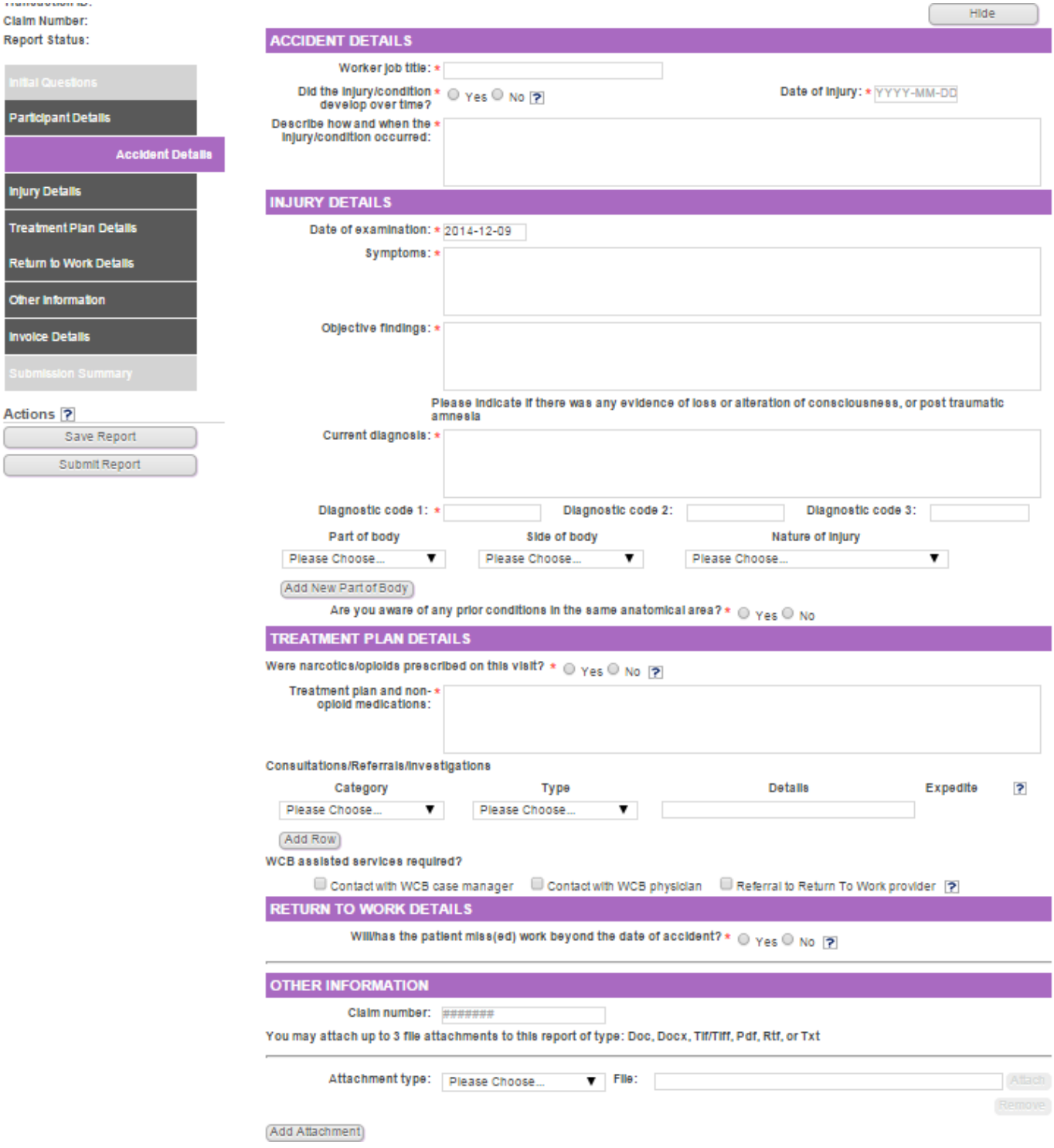
Medical Supplies Invoice (C569) (Appendix "C")

- 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 us of the overpayment portion that Alberta Health did not cover.
- Attach Alberta Health proof of remittance, if requested.

Appendix "A"– Physician's Invoice and Report–C050/C151



Appendix "B"–Medical Invoice–C-568

Medical Invoice [?]

Report Overview

Transaction ID: 5952428
Claim Number:
Report Status: Draft

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

Actions [?]

Save Report
Submit Report
Last saved: 2/13/2015 9:47:01 AM

INVOICE DETAILS

Billing number/practitioner: 0BFF00 - AARON MACINTOSH   Contract ID: 000006 - Specialist

Optional billing contact if different from practitioner.
Billing contact name: Fax number: Canad ▼ ###-###-####

Clinic reference number: [?]

Fee for Service

	Date of service	Health service code	Diagnostic code	Modifier	Facility type	Skill code	Fees submitted
From:	YYYY-MM-DD				Please Choo: ▼	Please Choo: ▼	$
To:	YYYY-MM-DD				Calls: #.##	Encounters: [?]	
							Remove
From:	YYYY-MM-DD				Please Choo: ▼	Please Choo: ▼	$
To:	YYYY-MM-DD				Calls: #.##	Encounters: [?]	
							Remove
From:	YYYY-MM-DD				Please Choo: ▼	Please Choo: ▼	$
To:	YYYY-MM-DD				Calls: #.##	Encounters: [?]	
							Remove
From:	YYYY-MM-DD				Please Choo: ▼	Please Choo: ▼	$
To:	YYYY-MM-DD				Calls: #.##	Encounters: [?]	
							Remove
From:	YYYY-MM-DD				Please Choo: ▼	Please Choo: ▼	$
To:	YYYY-MM-DD				Calls: #.##	Encounters: [?]	
							Remove

Add Row   Invoice amount billed: $0.00

Medical Supplies

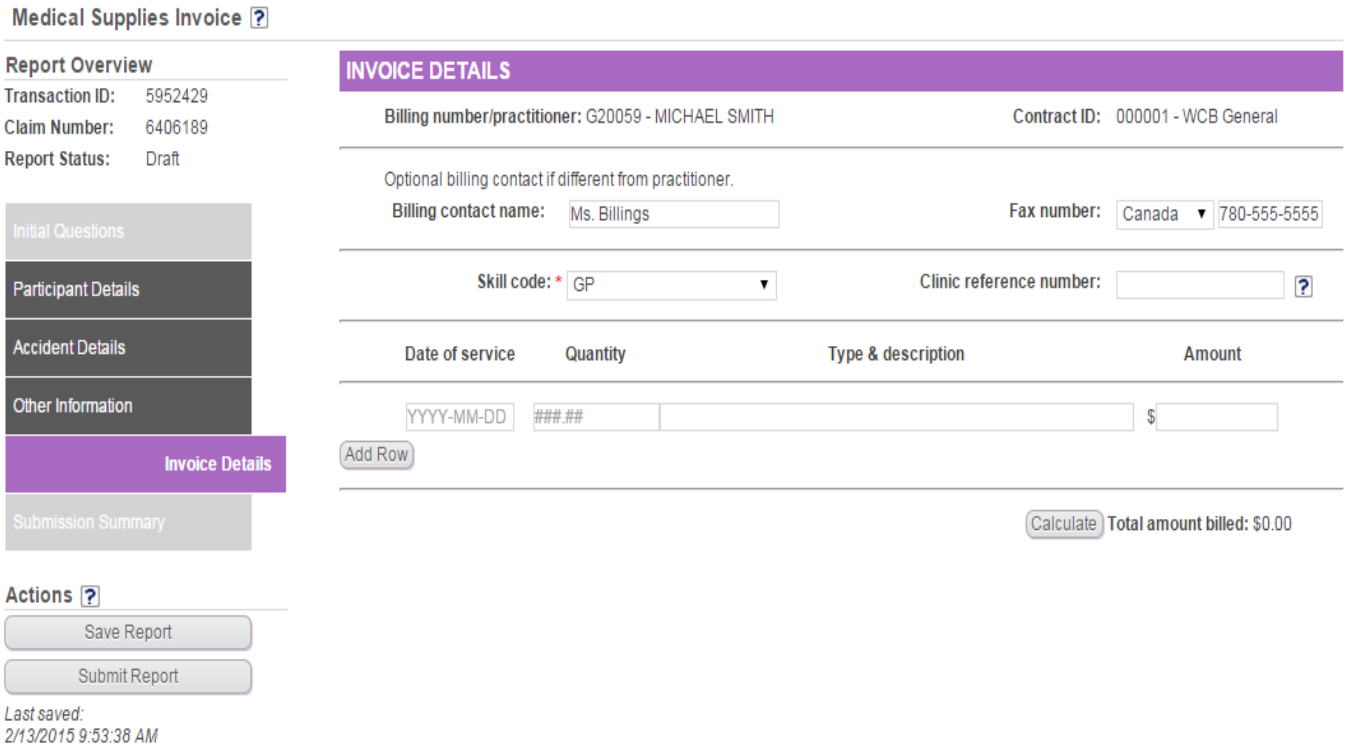
Date of service	Health service code	Diagnostic code	Modifier	Facility type	Skill code	Fees submitted
YYYY-MM-DD				Please Choo: ▼	Please Choo: ▼	$
				Calls: #.##	Encounters: [?]	

Description:

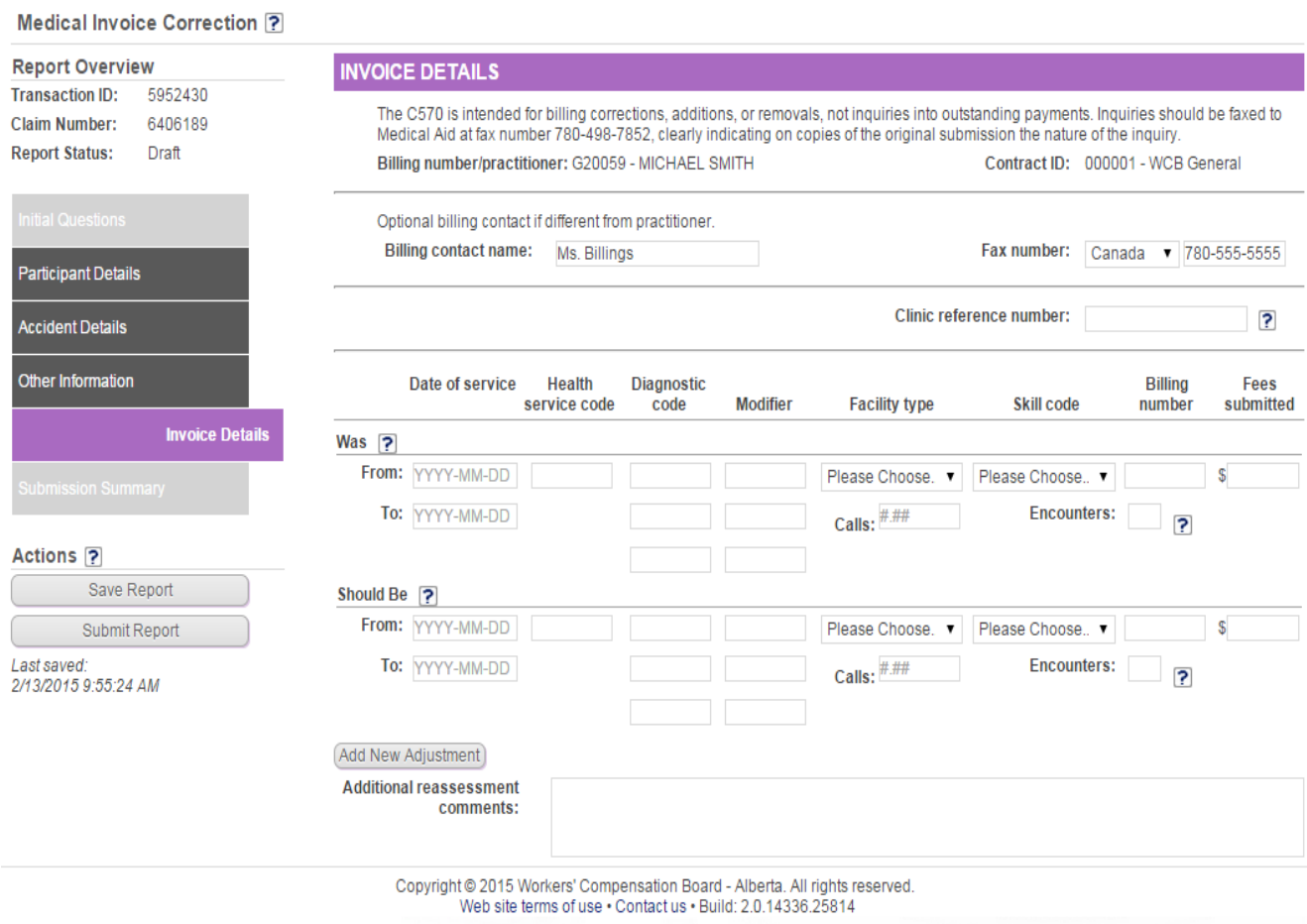
Add Row   Medical supplies amount billed: $0.00

Calculate   Total amount billed: $0.00

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: