WORK SAFE BC

WORKING TO MAKE A DIFFERENCE

PHYSICIAN REFERENCE GUIDE

A Companion Document to the Agreement Between the Workers' Compensation Board (WorkSafeBC) and the British Columbia Medical Association (BCMA)

April 01, 2006 – March 31, 2012

Revised March 2007

Revisions indicated in "Red"

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INTRODUCTION

The Workers' Compensation Board of British Columbia is providing this Reference Guide to assist you with changes to the Agreement Between the Workers' Compensation Board (WorkSafeBC) and the British Columbia Medical Association (BCMA) and for completing and submitting forms and invoices to WorkSafeBC.

By law, the Workers' Compensation Board can only pay for medical services related to an acceptable WorkSafeBC claim. That means that the patient's injury or illness must be a direct result of a work-related activity or occupational disease to qualify for WorkSafeBC benefits.

Working with Physicians and Employers in this province, WorkSafeBC's goal is to facilitate a safe, timely, and durable return to work for Injured Workers. To this end a number of WorkSafeBC unique fees relate to return to work activities and expedited clinical services with reimbursement reflecting timely services and electronic submission of reports and invoices.

Payment for WorkSafeBC approved services for fee for service and unique WorkSafeBC fees is provided by electronic funds transfer, unless arrangements are made by the Physician's office with Teleplan for manual cheques. Transaction details are provided on Teleplan remittance statements.

A Note on the Word "Claim"

When a person suffers a work-related injury or contracts a work-related disease, he or she can make a claim for compensation to WorkSafeBC.

- To WorkSafeBC, that ***claim*** represents a relationship between the Injured Worker & WorkSafeBC that lasts for weeks, months or even years.
- However, in an MSP billing context, a ***claim*** is a submission of a new invoice.

Please note that throughout this document, the word ***claim*** refers to the ongoing relationship between an Injured Worker and WorkSafeBC, not to new invoices.

BCMA/WORKSAFEBC CONTRACT CHANGES

Background

Six year agreement covering April 01, 2006 to March 31, 2012

Information provided in this section:

- Discusses the changes in the BCMA/WorkSafeBC Agreement, outlines the business processes and indicates the dates that new rates are to be applied.
- Provides fee changes and effective dates for Form & Unique Fees and Expedited Service Fees (see Appendices K & L for Schedules B and D which are excerpts from the *Agreement*).
- A summary fee schedule with colour coding of rate changes and effective dates is also provided in Appendix M. Check dates carefully as there are increases effective April 01, 2006, December 01, 2006, February 01, 2007, April 01, 2007, April 01, 2008 & April 01, 2009. The rate changes are “selective” as not all items change each year.

General Practice Services

General Practitioner Services

1. New Fee Codes

1.1 Telephone Consultation (Fee Code 19508)

- A Telephone Consultation with a community physician initiated by a Medical Advisor,
- May also be billed by a Specialist
- Commences for telephone consults with service dates effective December 01, 2006,
- Must be completed within 24 hours of initial contact,
- Fee code added with an enhanced rate to encourage physicians to provide a faster response to a call from the Medical Advisor,
- Bill electronically through Teleplan effective February 01, 2007.
- **Other existing fee codes for communication** with WorkSafeBC include:
    - **Office Consultation** - Fee Code-19919 “WorkSafeBC Office Consultation with WorkSafeBC Officer"
      Office Consultation with a WorkSafeBC Officer or designate (up to fifteen (15) minutes).
    - **Telephone Consultation** - Fee Code "19930 WorkSafeBC Pre-Arranged Telephone Consult
      Telephone consultation with WorkSafeBC Claims Adjudicator/Case Manager or designate up to fifteen (15) minutes (not to be billed for routine inquiries).
- Existing fee items facilitating return to work:
    - **Fee Item 19950 – RTW Consultation (fee is all-inclusive)**
        - Can be initiated by Board officer or delegate, Board physician, employer or treating physician,
        - Can occur as early as the first office visit,
        - Must include consultation by physician with employer & Board officer AND follow up with worker,
        - Consultation and RTW plans must be documented and submitted on Form 11.

- **Fee Item 19976 – RTW Planning Request**

    - WorkSafeBC pays the physician for his/her time for reviewing a RTW plan,
    - The request may be initiated by a Board officer or a designated rehabilitation provider.

1.2. Community Physician Services for Complex Spinal Cord Injury

Three new fee codes have been added to specifically address the unique circumstances that are inherent in caring for an injured worker with a Spinal Cord Injury with Permanent Sequelae.

These fees recognize the additional time required to provide services to this population and to acknowledge the complexity of this type of injury.

1.2.1 Complex Spinal Cord Injury Initial Visit or Yearly Assessment (Fee Code 19509)

- Initial or Annual Assessment (yearly thereafter) to include a complete physical exam,
- Develop and update a yearly **care plan** documented on a Form 8/11
    - A template for documenting the care plan is proposed & will be developed through the Liaison Committee,
- Fee Code 19509 may be billed once per year,
- Form 8/11 will be paid in addition to Fee Code 19509.

1.2.2 Complex Spinal Cord Injury office visit (Fee Code 19510)

- Can be billed for all other office visits occurring during the year,
- Report on a Form 8/11; Form 8/11 will be reimbursed,
- Can not bill in addition to a first visit or yearly assessment Fee Code 19509.

1.2.3 Complex Spinal Cord Injury Home Visit (Fee Code 19511)

- Perform a home visit; complete and bill for a Form 8/11,
- If the home visit is the first visit or the yearly assessment then bill both Fee Codes 19511 and 19509 but cannot be billed with Office Visit (Fee Code 19510).

2. Changes to Current Services

WorkSafeBC Request for a copy of a consultation, operative, chart notes or other existing report (Fee Code 19904)

- Number of copies has increased from first five (5) to first twenty (20) pages,
- Fee Code 19906 - Continuation of 19904 is to be used for copies of over twenty (20) pages.

3. Form 8/11 Changes

- Proposed fields to be deleted from Form 8/11– CSA BP/AP (code) & CSA NOI (code),
- Proposed fields to be added to Form 8/11- Side of Body Codes, Prior History, & Trauma (check box),
- Changes expected to be made in late 2007.

4. Deleted Fee Codes

- The following fee codes were deleted effective December 01, 2006 and can no longer be billed:
    - 19920 – Completion of a Medical Review Panel, Enabling Certificate (Medical Review Panel no longer exists),
    - 19921 – Emergency Visit to Hospital (fee code can only be billed by Hospitals),
    - 19951 – Unreported claims fee (requested Physicians first report when requested by Board Officer).
    - When a first report of injury form is requested, invoice 19927 or 19939- Requested 1st Report of Injury
    - On Form 8 indicate “Unreported Claim” & original date of service

5. Pre-Operative Histories and Exams - Fee Code 19909 (Clarification)

- When **General Practitioner** is requested to perform a pre-operative history and exam bill Standardized Assessment Form Fee Code 19909.

6. Pharmacy-Generic Substitution Program (Confirmation)

- Generic substitution is mandatory; write “No Sub” for patients requiring brand name.

Specialist Services

1.0 Expedited Consultations

1.1 Expedited Comprehensive Consultations

- Fee increase for Fee Codes: 19911, 19913, 19915, 19917, & 19934 effective December 01, 2006,

- Increases in fees applies to Consultations only if invoice is submitted electronically through MSP Teleplan,

- If invoices are not submitted electronically then **Expedited Comprehensive Consultations** will be paid at the rate in effect April 1, 2006,
- If the expedited time frame of fifteen (15) days for submission for the report is exceeded then bill Fee code 19908 for a report fee plus the appropriate MSP specialty consultation fee code.

2.0 Expedited Surgery

2.1 Expedited Surgical Services Timeline Change

Rules for Expedited Surgical procedure timelines have changed as follows:

2.1.1 Expedited surgery - all elective procedures (except for shoulder and spine) must be performed within forty (40) business days from the **date of the initial expedited consultation.**

- This commences for Consultations with a service date as of February 01, 2007. Any diagnostic testing and or Authorizations for Surgery must occur within this time frame.

2.1.2 Expedited shoulder and non-extensive spine surgery must be performed **within sixty (60) business days from the date of the last patient visit** (may be either an expedited consultation or a follow-up with a service date commencing February 01, 2007) to qualify as an expedited surgery.

2.1.3 For procedures performed outside the limitation periods bill at the MSP surgical fee code rate.

2.2 Billing Changes

All expedited surgical procedures including trauma and emergency cases with a service date as of February 01, 2007 (with the exception of extensive spinal surgery) must be billed through MSP Teleplan using:

- the **appropriate MSP Fee Code,** and
  - Apply MSP Out of Office Premiums – Call Out Charges, Continuing Care Surcharges – Operative as required,
- the **appropriate time based unique WorkSafeBC Fee Code**
  - Fee Codes 19500-19506 (Levels 1-7),
  - Apply MSP Out of Office Premiums– Call Out Charges, Continuing Care Surcharges – Operative rates as required using the following fee codes
    - 19512: Expedited Surgical Procedure Surcharge, Operative Evening

    - 19513: Expedited Surgical Procedure Surcharge, Operative Night
    - 19514 Expedited Surgical Procedure Surcharge, Operative Sat/Sun/Holidays

- Fax Operating Room (OR) Reports to (604) 276- 3195,
- For extensive spinal surgery continue to bill on paper. Complete the Expedited Surgery Summary Invoice – Surgery and fax to (604) 244-6292 or toll free 1-888-669-9970 along with the Operating Room (OR) Report,
- For expedited surgeries with a service date prior to February 01, 2007 continue to bill by paper as previously.

See Section 5.0 for an example of application of the new expedited billing process.

2.3 Multiple Surgeries- Same Anatomical Area/Joint

- For multiple surgeries with separate service dates performed on the same anatomical area/ joint, only the first three (3) elective procedures per patient will be considered for expedited payment per surgeon.
- Any subsequent requests for additional surgery must obtain a second opinion from a Specialist at the Richmond Visiting Specialist Clinic.
- Further expedited surgery will require authorization from WorkSafeBC.

2.4 Multiple Surgeries non-Emergent Reconstructive Procedures

- Expedited payment may be extended beyond the first three elective procedures for multiple non-emergent reconstructive procedures for both surgical and anesthesia services upon submission of:
    - A Surgical Authorization form must be forwarded to the Claims Officer for entitlement approval; and
    - An explanatory letter providing early identification of the complexity, outlining the patient details, volume and proposed procedures with a timeline to completion. Must be submitted to the Visiting Specialist Clinic Medical Advisor for payment approval.
- First surgery must meet expedited timelines.

3.0 Surgical Assists

- For all surgical procedures Surgical Assists will continue to be reimbursed at sessional rates and billings will continue to be made on paper. To bill, complete the Expedited Surgery Summary Invoice – Assist and fax to (604) 244-6292 or toll free at 1-888-669-9970.

- Procedures requiring Assists have been identified and the list will be posted on the Health Care Practitioners and Providers section of WorkSafeBC website (Medical and Surgical Specialists – General Information): http://www.worksafebc.com/health_care_providers/health_care_practitioners/medical_and_surgical_specialists/default.asp.

  The current list is included in Appendix N.

  - If a procedure is not listed, the Physician must contact the Visiting Specialist Clinic for approval prior to the surgical procedure.
  - This list will be reviewed from time to time by the WorkSafeBC/BCMA Liaison Committee.

4.0 Expedited Anaesthesia Services

4.1 Billing Changes - Expedited Anaesthesia Surgical Services

- Anaesthesia services for all expedited surgical procedures (with the exception of Blocks and extensive spinal surgery), with a service date effective February 01, 2007, must be billed through MSP Teleplan using:
    - the **appropriate MSP Fee Code** (Intensity & Complexity Index),
        - For trauma Apply MSP Out of Office Premiums – Call Out Charges, Continuing Care Surcharges – Operative as required,
        -
    - **WorkSafeBC Unique Fee Code 19507** – Expedited Anesthesia Services (time based fee code per 15 minute time block),

- A copy of the Record of Anesthesia must be faxed for expedited surgical procedures for those procedures billed through Teleplan to (604) 276-3195. Be sure to include the **Claim Number on the Record of Anesthesia**.

- For extensive spinal surgery continue to bill sessional rates (as per Fee Schedule D of the Agreement) on paper. Complete the Expedited Surgery Summary Invoice – Anesthesia and fax along with the **Record of Anaesthesia** to (604) 244-6292 or toll free at 1-888-669-9970. Be sure to include the **Claim Number on the Record of Anesthesia**.

See Section 5.0 for an example of application of the new expedited billing process.

4.2 Expedited Block Procedures

For Block Procedures with a service date as of February 01, 2007 for the first block, bill sessional rates ($1,436) on paper. Fax invoice along with the Record of Anaesthesia and/or Blocks to (604) 244-6292 or toll free at 1-888-669-9970.

For Expedited Block Procedures the first block must be performed within forty (40) business days from the date of the referral from WorkSafeBC (Medical Advisor). If the first block is performed within the expedited time frames, up to an additional two (2) blocks will be paid at expedited rates.

- A maximum of three (3) blocks can be billed at the expedited rate unless **prior approval** (to first nerve block) for additional blocks at the expedited rate has been authorized by Visiting Specialist Clinic,
- Should further Blocks be performed they will be paid at MSP fee service rates,

- Historically, practice has demonstrated that a minimum of three (3) blocks can be performed in a three and half (3 ½) hour session,

- All previously established personal agreements are being cancelled effective January 31, 2007,
- New Personal Service Agreements will be issued as required.

5.0 Billing Procedure Example

Surgery: Fractured Tibia- Open Reduction & Internal Fixation (ORIF)
Time: Tuesday 0125-0425 hours
Surgery duration: three (3) hours

Expedited Surgical Billing Process

Surgeon Billing	**Fee Code**	**Process**
MSP Fee code- ORIF	56755	Bill through Teleplan
WCB Unique Fee- Expedited Surgical Procedure- Level 4	19503	Bill through Teleplan
MSP Out of Office Surcharge(s)	Apply as required	Bill through Teleplan

Anaesthesiologist Billing	**Fee Code**	**Process**
MSP Level 3 x time of 3.5 hours	01173	Bill through Teleplan
WCB Unique Fee- Anaesthesia Time Based Block	19507	Bill through Teleplan
MSP Out of Office Surcharge(s)	Apply as required	Bill through Teleplan

Surgical Assist Billing	**Fee Code**	**Process**
Expedited Sessional Surgical Assist	Use sessional rate	Bill on paper & fax
MSP Out of Office Surcharge(s)	Apply as required	Bill on paper & fax

CONTACT INFORMATION WORKSAFEBC & EXTERNAL CONTACTS

Key WorkSafeBC Contact Information:

1. **WorkSafeBC Online Information** (www.WorkSafeBC.com). See Appendices I & J for information regarding How to Confirm a Patient's WorkSafeBC Claim Status, Physician/MOA Resources.

   Visit www.WorkSafeBC.com for additional information regarding:

   - Resources such as brochures and post surgical rehabilitation guidelines
   - Injury coding tables
   - Instructions for billing & reporting
   - Contact information
   - Links to related sites

2. **Payment Services**

   Billing Inquiries or Billing Assistance (including Paper Invoice Processing System - PIPS)
   Phone: (604) 276-3085 or
   Phone Toll free: 1-888-422-2228

   Operations Manager
   Payment Services, Physician Inquiries
   Direct line (604) 232-5808

   Doctors' Submission Fax Line for Paper Reports and Invoices
   Fax: (604) 276-3195
   Fax Toll free: 1-888-922-3299

   Mailing Address
   WorkSafeBC Payment Services
   P.O. Box 94460
   Richmond, BC
   V6Y 2B4

3. **Medical Services Inquiries (Medical Administration)**

   Medical Administration General Inquiries (604) 244-6224
   Manager of Medical Services (604) 232-5825

4. **Visiting Specialist Clinic – Specialist Consultations/Diagnostic Imaging Bookings/Inquiries**

   Phone: (604) 214-6700
   Toll free phone: 1-888-967-5377
   Fax: (604) 214-6799

   Clinical/Management Matters call:

   Program Manager
   Direct Line: (604) 276-3168

   Films Distribution
   Phone: (604) 276-3066
   Fax: (604) 231-8890
   Email: Films@worksafebc.com

5. **Medical Imaging Expedited Referral Request**

   Expedited diagnostic imaging appointments will be set up by WorkSafeBC Visiting Specialist Clinic
   Complete Diagnostic Imaging Requisition & Fax to:
   Richmond VSC: (604) 231-8890
   For Kelowna only (Kelowna WorkSafeBC office): Fax to (250) 717-4388

6. **Call Centre (Claim/Claimant Inquiries)**
   (604) 231-8888 or 1-888-967-5377

7. **Ordering WorkSafeBC Forms:**
   www.WorkSafeBCstore.com
   Toll free phone: 1-866-319-9704
   Fax: (604) 232-9703
   Toll free fax: 1-888-232-9714
   Email: customer.service@WorkSafeBCstore.com
   Store hours: Mon – Fri 8:30am – 4:30pm

   You may **download** copies of forms and brochures from WorkSafeBC's website at the following address: www.WorkSafeBC.com. Select "forms" or "publications"

8. **Vendor Administration Payee Number Enquiries**
   (604) 231-8574 or 1-800-661-2112, ext. 8574

9. **Mailing Information**
   WorkSafeBC
   PO Box 5350 Stn Terminal
   Vancouver BC V6B 5L5

Key External Contact Information

1. Contacting MSP Teleplan

MSP Billing Support/Teleplan transmission problems or questions
Vancouver: (604) 456-6950
Other areas of B.C. (toll-free): 1 866 456-6950

2. Medical Software Vendors (provide software for electronic submission to MSP Teleplan)

www.msva.ca
1-800-663-2094 (ask for David Zindler, President, Software Vendor Association)

3. Workers' Advisory Office - Patient Resource:

Physicians can advise Injured workers that they can obtain free claim advice or assistance from the Workers' Advisory Office (independent of WorkSafeBC).

Website: www.labour.gov.bc.ca

Contact phone numbers:

Richmond Phone: (604) 713-0360 Toll free phone: 1-888-922-8807 Fax: (604) 713-0311	Campbell River Phone: (250) 830-6526 Toll free phone: 1-888-643-0013 Fax: (250) 717-2010
Victoria Phone: (250) 952-4393 Toll free phone: 1-800-661-4066	Kelowna Phone: (250) 717-2096 Toll free phone: 1-866-881-1188 Fax: (250) 717-2010
Abbotsford Phone: (604) 870-5488 Toll free phone: 1-888-295-7781 Fax: (604) 870-5494	Kamloops Phone: (250) 371-3860 Toll free phone: 1-800-663-6695 Fax: (250) 371-3820
Nanaimo Phone: (250) 741-5504 Toll free phone: 1-800-668-2117 Fax: (250) 741-5516	

BILLING WORKSAFEBC

WorkSafeBC has an agreement with MSP Teleplan:

- To enable physicians to electronically submit invoices & Form 8/11s to WorkSafeBC. **Submission of Form 8/11s by fax will result in reduced payments. Physicians will not be paid for invoices for Form 8/11s submitted to WorkSafeBC via mail service, courier service or any like service.**

- To issue payments through electronic funds transfer (EFT). Reimbursement is made to physicians for WorkSafeBC related services, using either MSP fee codes and or WorkSafeBC Forms Fees & Unique fee codes.

Facts about Timeliness and Electronic Submission

Payment for Form 8/11 Submission

- **Only one (the first) Form 8 received for a claim will be paid as a Form 8.** The date the Form 8 is received is the determining factor for payment.

- Any subsequent Form 8 received by WorkSafeBC for the initial visit will be **paid at the appropriate Form 11 rate**.

- Form 11 will only be paid for:
    - A change in medical condition,
    - A change to the worker's treatment plan,
    - A change in Return to Work status,
    - If it has been more than four (4) weeks since the last Form 11 was sent, or
    - If a Form 11 is requested by a Board Officer.

- A **higher rate** is paid for Form 8/11s submitted electronically through MSP Teleplan **within three (3)** business days of the date of service.

- A lesser rate will be paid for Form 8/11 submitted electronically when received **between four (4) and six (6) business days** of the date of service. No payment for Form 8/11 submissions received after seven (7) days. **The Office Visit will be paid.**

- A greater payment rate will be paid for the submission of a Form 8/11 received through MSP Teleplan than via FAX to WorkSafeBC

- Following entry of Form 8/11 information into your Form 8/11 software package, please ensure that you **SUBMIT** each report to MSP Teleplan immediately. **Entry into Teleplan's system is completed only when you click submit**.

- Payments and remittance statements are provided bi-weekly.

Electronic Invoice Submission

Submission Background:

Software designed for submission through Teleplan must be used.

- Software information/installation for electronic submission of reports and invoices can be obtained from Software Vendors.
- Software vendor information can be obtained by contacting www.msva.ca or calling 1-800-663-2094 (ask for David Zindler, who is the President of the Software Vendors Association).
- After installation of software follow the instructions provided by the Software Vendor for billing.

Invoices must be submitted electronically through MSP Teleplan, unless otherwise specified. However, should invoices be submitted to WorkSafeBC via fax, WorkSafeBC will submit the invoice electronically to MSP Teleplan on your behalf through our Paper Invoice Processing System (PIPS). This may result in service charges and delayed payments. For submission via fax, please use invoice Form 11A. See Appendix O for a sample of Form11A. A sample can also be obtained from the WorkSafeBC website:
http://www.worksafebc.com/forms/assets/PDF/11a.pdf

Submission Details:

- Because Teleplan is an automatic system, the information you provide must be correct and consistent before the system will allow payment for your services.

- The date of service, payee number and form fee item submitted must exactly match the date of service, payee number and form fee item on the invoice transmitted to WorkSafeBC.

- If they do not match, your invoice will be rejected (Code SJ) and you will need to correct the differences and resubmit the invoice.

- WorkSafeBC claim numbers are optional because physicians often treat patients before a WorkSafeBC claim is made. But since workers usually have a claim number within two weeks of initial treatment, physicians can help WorkSafeBC match an invoice with a valid WorkSafeBC patient claim by adding the claim number to subsequent billings.

- Physicians must bill WorkSafeBC within ninety (90) days of providing service. If the billing is for a date of service older than ninety (90) days, identify the service with a submission code 'W'. Without the 'W' submission code, your invoice will be rejected because the MSP Teleplan and WorkSafeBC systems both have a 90-day time limit.

- A remittance statement may include the explanatory code "BK". A "BK" explanatory code means that WorkSafeBC has received the submission and is currently making a decision on the injured worker's claim. Some complex claims can take more than sixty (60) days to make an entitlement decision, so patience is appreciated. Do not re-bill because payment has not been received. When a decision has been reached payment will be made or a rejection code will be provided indicating why payment will not be made.

- If you receive a refusal code of "AA", the worker does not have a PHN or is not a resident of BC. Resubmit the invoice via fax to WorkSafeBC. Indicate on the invoice that a PHN is not available.

Physician Report Form Completion & Submission

Physician Report Forms

Physicians will report using the combined Form 8/11 for either the first report or a progress report.

- **Form 8 – *Physician's First Report***

  Should be submitted only if the doctor suspects time loss beyond the day of the injury or if the claim is for a hernia, back problem, shoulder/knee strain or sprain, or occupational disease.

- **Form 11 – *Physician's Progress Report***

  A Form 11 should be submitted as a progress note, if:
  - There is a change in medical condition;
  - There is a change to the worker's treatment plan;
  - There is a change in Return to Work status;
  - It has been more than 4 weeks since the last Form 11 was sent, or
  - A Form 11 is requested by a Board Officer.

Critical Information for Completing the Physician Report - Form 8/11

Clinical Information reporting – This area provides space for complete clinical reporting. The Addendum page to Form 8/11 is used when more reporting space is required than is available in the clinical information area on Form 8/11.

Return to Work Planning – Return-to-work planning is an important reporting component of Form 8/11. The information the physician provides, along with physician participation in the return-to work consultation process assists WorkSafeBC in handling each worker's claim efficiently and appropriately.

A Requested First Report (Requested F8) should be submitted only when a Physician's First Report (F8) was **not originally required** and has subsequently been requested by WorkSafeBC (usually via a fax or phone call from a Board officer). Invoice fee code 19927.

Detailed instructions for completing the Form 8/11 can be found in the next section.

PHYSICIAN FORM 8/11 REFERENCE GUIDE

Please use this reference guide when completing Physician's reports.

Form 8/11	
Form Field Name	**Description**
Physician's First Report (F8)	This field indicates the report is a **Physician's First Report** (Form 8). It should be submitted to the WorkSafeBC if the Physician thinks there may be time loss beyond the day of the injury or if the claim is for a hernia, back problem, shoulder/knee strain or sprain, or occupational disease.
or The worker's condition or treatment has changed (F11)	This field indicates the report is a **Physician's Progress Report** (Form 11) and should be submitted if the worker's condition or treatment has changed since last report or if the worker is ready for Return to Work. A report is not necessary or desired if the worker's condition is stable and there will be a planned follow up at an appropriate future date. A report is also not necessary if the worker is enrolled in a WorkSafeBC sponsored rehabilitation program. Payment of benefits to a worker is not contingent on follow-up every two weeks if the above conditions are met.
Employer's name	The full corporate or company name of the worker's employer.
Operating location address	The address or description of where the worker was employed on the day of the injury. For example the branch address, campsite location or administrative office. This includes the address information and city.
WorkSafeBC claim number	WorkSafeBC claim number specific to this injury. **Do not** include the two-letter claim prefix. For example claim number would be 99999999 not BB99999999.
Worker's last name	The worker's legal last name or surname. If possible, it should match the surname on the worker's British Columbia CareCard.
First name	The worker's full first or given name. **Initials should not be used**. If possible, it should match the given name on the worker's British Columbia CareCard.
Telephone number	A contact area code and telephone number for the worker. Usually this would be the worker's home phone number, but could be a cellular number or work number.
Worker's PHN from health card	Worker's Personal Health Number as shown on the British Columbia CareCard.
Date of injury	The date when the WorkSafeBC related injury occurred. In the case of occupational diseases, this is the date when medical attention was first sought.
Date of service	The date when the service described on this report was performed.
Who rendered the first treatment?	Medical practitioner (name) or facility (emergency department, clinic, hospital, etc.) who provided the first treatment. This does not include first aid at the worksite.
Are you the worker's regular practitioner?	If "Yes", WorkSafeBC may contact you for medical history or to discuss claims issues.
If "Yes", how long has the worker been your patient?	Select the duration for which the worker has been your patient. This information is useful for claims information.

Form 8/11	
Form Field Name	**Description**
Prior/Other Problems affecting injury, recovery and disability	Provide details about pre-existing or new non-occupational conditions that may affect injury, recovery or disability. If insufficient space, add remaining information to "Clinical Information" box. For example an MVA while receiving care for WorkSafeBC claim.
Diagnosis:	Provide a text description of the injury diagnosis.
BP:	This is a 5-character (numeric) code for the area of injury (body part) from the WorkSafeBC subset of CSA codes (80/80 list).
AP:	This is a 2-letter code for the anatomical position code (side) of the injury from the WorkSafeBC subset of CSA codes (80/80 list).
NOI:	This is the 5-character (numeric) code for the nature of injury from the WorkSafeBC subset of CSA codes (80/80 list).
ICD9	This is the ICD9 diagnosis code and is entered on the invoice (claim record).
From injury or since last report, has the worker been disabled from work?	If the worker has been disabled from work since the injury or the last report, select "Yes". Otherwise, select "No".
If Yes, as of what date? (if known)	If known, enter date when worker was first disabled from the work place in the format yyyy/mm/dd.
Clinical Information	This is an 800 character free form text field for the physician to describe the worker's current situation in the usual fashion clinical notes are constructed. The following information might be included: • What happened • Presented injury, disease, complaints and etc. • Subjective symptoms • Examination finding • Treatments and medications being used • The name and date of specialist referral, *if appropriate*. The text area is left large to facilitate "cut and paste" from documents.
Is the worker now medically capable of working full duties, full time?	Indicate "Yes" if the worker can return to their normal pre-injury duties. **If "No", elaborate in the "Restrictions" area**
What are the current physical and/or psychological restrictions?	Describe the physical and/or psychological restrictions related to the injury that are barriers to the patient returning to work. This information will be used by the case managers and medical advisors in working with employers to find suitable alternative/modified work.
Estimated time before the worker will be able to return to the workplace in any capacity.	Estimate the length of time before the worker can return to the workplace in ANY capacity. For example, the earliest possible return to the workplace if suitable duties were available.
If appropriate, is worker now ready for a rehabilitation program?	Enter "No" if worker is not ready for rehabilitation or if a rehabilitation program is not appropriate. If "Yes", select the type of rehabilitation program in the following field.

Form 8/11	
Form Field Name	**Description**
If "Yes", select Work Conditioning Program or Other	If "Other rehabilitation program" is selected, indicate type of program (for example, occupational rehabilitation program, pain program, etc) in the "Clinical Information" area.
If possible, please estimate date of Maximal Medical Recovery	Maximal medical recovery (full recovery or best possible recovery) date. This is sometimes also called date of "maximal medical improvement". It refers to date at which no further improvement in condition is expected. At that time the worker may still have significant impairment/disability or may be fully recovered. It is recognized that the "date" indicated is an estimate only and may change if the clinical course changes.
Payee Number	Enter the payee number issued by MSP that uniquely identifies the individual or organization who submits the associated invoice to the WorkSafeBC and who will be paid by the WorkSafeBC.
Practitioner Number	Enter the practitioner number issued by MSP that uniquely identifies the Physician who performed the service and provided the information for this report.

Injury Coding

WorkSafeBC has adopted the Canadian WorkSafeBC injury coding standards (Version 2).These codes are **mandatory fields on all Form 8/11s and invoices submitted through MSP Teleplan** either by the Physician's office or WorkSafeBC's PIPS system.

Injury coding consists of **three components**:

- Side of body (**Appendix A**)
- Body part (**Appendix B**)
- Nature of injury (**Appendix C**)

These codes are a key element for case management and early intervention. They also assist in the matching of invoices to claims, which results in more timely payment.

APPENDICES FOR PHYSICIAN REFERENCE GUIDE: A Companion Document to the Agreement Between the Workers' Compensation Board (WorkSafeBC) and the British Columbia Medical Association (BCMA)
April 01, 2006 – March 31, 2012

A - CSA Side of Body Codes for WorkSafeBC Reporting & Invoicing Purposes. Side of body codes

B - CSA Body Codes for WorkSafeBC Reporting & Invoicing Purposes. Body part codes (CSA Z795)

C - CSA Nature of Injury Codes for WorkSafeBC Reporting & Invoicing Purposes Nature of Injury Codes (CSA Z795)

D – Explanatory Codes for Teleplan Rejections

E – MSP Explanatory Codes

F – Form 6: Application for Compensation and Report of Injury or Occupational Disease

G – Form 8/11: Physician's Report

H – How to Fill Out Form 8/11: Physician's Report Form

I – How to Confirm a Patient's WorkSafeBC claim status

J – Physician/MOA Resources

K – Schedule B from the BCMA/WorkSafeBC Agreement

L – Schedule D from the BCMA/WorkSafeBC Agreement

M – BCMA/WorkSafeBC Agreement Fee Schedule Summary

N – Surgical Procedures List

O – Invoice Form 11A

P – Authorization Request for Expedited Surgery

Q – Invoice for Expedited Anaesthesia

R – Invoice for Expedited Assist