



Physiotherapy Services Reference Manual

September 2011

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1.0 Introduction

This manual is intended to assist with specific business processes related to doing business with WorkSafeBC (Workers' Compensation Board of BC). This is not a stand-alone document and it is intended that this manual be used in conjunction with the Physiotherapy Services Memorandum of Agreement, and all the related Schedules. Please ensure that you and your staff understand the content of this manual.

1.1 Confirming a WorkSafeBC Claim Status

When booking an initial appointment with an Injured Worker, please ask for the claim number.

If the Injured Worker does not yet have a claim number, please ask the worker to provide the number as soon as s/he receives one.

You may confirm a WorkSafeBC claim status by:

- Checking online at www.worksafebc.com. Click on the "view claim status", "access claim status" and enter the worker's claim number; or
- Calling the WorkSafeBC Call Centre.

1.2 Contact Information

Health Care Service (Physiotherapy Network):

604 232-7787 or
Toll-free 1 866 244-6404

Fax Physiotherapy reports and invoices:

604 276-3195 or
Toll-free 1 888 922- 3299

Payment Services:

604 276-3085 or
Toll-free 1 888 422-2228

The WorkSafeBC Call Centre:

604 231-8888 or
Toll-free 1 888 967-5377

HIBC (MSP) Billing Support:

250 952-2654

HIBC (MSP) for Teleplan questions:

250 952-2668 or toll free 1 800 663-7206

1.3 Forms

Forms are available for download at <http://www.worksafebcstore.com> under “Forms” and “Health Care Providers”.

Physiotherapists may also order forms in one of the following ways:

- Website: <http://www.worksafebcstore.com>
- Fax: 604 232-9703 or toll-free fax: 1-888-232-9714
- Phone: 604 232-9704 or toll-free 1 866 319-9704

1.4 WorkSafeBC Online Information

WorkSafeBC has a Health Care Provider Centre site that can be accessed online at: <http://www.worksafebc.com>. The Health Care Provider Centre is designed to help health care providers better understand our programs, services and business process.

Physical Therapists and other health care providers can access useful information tailored specifically to their practice, including:

- Post operative protocols
- Injury coding tables
- Instructions and forms for billing & reporting
- Contact information
- Resources such as brochures and post surgical rehabilitation guidelines
- Links to related sites
- The status of a claim

2.0 Service Description

The goal of physiotherapy treatment is to assist Injured Workers reach the functional levels required to return to pre-injury work in a safe, durable, and timely manner. This requires the Physical Therapist to have an understanding of the Injured Worker’s pre-injury work hours and duties. Return to work and physiotherapy treatment may occur concurrently.

There are four (4) treatment categories:

- Stream 1: Standard Treatment
- Stream 2: Exceptions to Standard Treatment
- Stream 3: Home Visits
- Stream 4: CNS Disorder Treatment

2.1 Physician Referral

A Physician's referral is not required for injuries treated under Stream 1; the worker may be self-referred or employer-referred and their claim must be either accepted by WorkSafeBC or pending on the date of the Initial Visit.

A Physician's referral is required for injuries treated under Stream 2, 3 and 4 and must be received before the Physical Therapist can treat a worker.

If a worker is transferred from Stream 1 to Stream 2 and there was no Physician referral for Stream 1, the worker must obtain and submit a Physician referral to the Board Officer before they can be treated under Stream 2.

If the assessment identifies findings that are inconsistent with the injury on the accepted claim, the Physical Therapist should notify the Board Officer and the referring physician. The Board Officer will determine whether or not the new findings are part of the claim or not.

2.2 Treatment Duration

Stream 1: Standard Treatment

- Maximum of twenty-two (22) visits, including the Initial Visit within an eight (8) week period.

Stream 2: Exceptions to Standard Treatment, Stream 3: Home Visits **and** Stream 4: CNS Disorder Treatments

- As approved by Board Officer based on the submitted treatment plan.
- There are no pre-determined treatment timelines for Stream 2, 3, or 4.

2.3 Transferring a Worker from Stream 1 to Stream 2:

- Only warranted by the worker's medical conditions and may occur due to a change in the worker's diagnosis or condition.
- If identified within the first six (6) visits of treatment to the Board Officer, the Physical Therapist should:
 - ❖ Recommend the transfer to the Board Officer and complete and submit Form 268 Physiotherapy Report with an explanation as to why the worker is recommended for Stream 2 and bill either 19185 or 19186.
 - ❖ Advise the worker that they shall require a Physician's referral (if one is not submitted to the Board Officer already) and ensure the referral is submitted to the Board Officer in writing.
 - ❖ The Physical Therapist can then process with treatment in accordance with Stream 2 Exceptions to Standard Treatment unless the Board Officer advises the Physical Therapist otherwise.

- If no Physician referral is submitted, the Physical Therapist may not treat under Stream 2, but may continue to treat under Stream 1 until the Physician referral is submitted.
 - ❖ If identified after the first six (6) visits of treatment to the Board Officer: The worker may be referred to a Board Program or other service as determined by the Board Officer.
 - ❖ If the Stream 1 to Stream 2 transfer is **approved by the Board Officer**, the Physical Therapist shall then initiate the transfer process as detailed above.
- The Physical Therapist should only invoice for Stream 2-Exception to Standard-Subsequent Visit (19184).
- The Physical Therapist shall not invoice for Stream 2-Exception to Standard Initial Visit (19181) because the Initial Visit occurred in Stream 1.

2.4 Worker Education

The Physical Therapist should provide education on the following topics:

- what the worker can expect from the treatment
- pain control
- self-management of the injury
- prevention of re-injury
- the concept of early re-activation
- the benefits of a return-to-work program
- the payment procedure for physiotherapy service(s)

To help you educate your clients, WorkSafeBC has prepared an information brochure “Your Physiotherapist and You”. Physical Therapists should review the brochure with the worker during the initial visit.

The brochure is available, at no cost, to all Physical Therapists at: www.worksafebc.com under Physiotherapist resources, or by ordering copies in one of the following ways:

- Website: <http://www.worksafebcstore.com>
- Fax: 604 232-9703 or toll-free fax: 1-888-232-9714
- Phone: 604 232-9704 or toll-free 1 866 319-9704

3.0 Reporting and Communication Requirements

3.1 Reporting

3.1.1 Physiotherapy Initial Notification Form (83W5)

- **Only required for Stream 1: Standard Treatment**
- The Physiotherapy Initial Notification Form must be completed and received by WorkSafeBC within three (3) business days of the Stream 1 Initial Visit in order to invoice fee code 19178. Initial visit being day zero (0).

- Fee code item 19179 is to be invoiced if the form is received after three (3) business days from the Stream 1 Initial Visit.

3.1.2 “Physiotherapy Report” (Form 268) shall be used for the following reports:

3.1.2.1 Stream 1 Physiotherapy Standard Treatment Report

- Report is only required if the worker is not expected to return to full pre-injury hours and duties at the end of the eight (8) week treatment duration.
- The report must be received by WorkSafeBC at least five (5) business days prior to treatment end date.

3.1.2.2. Transfer from Stream 1 to Stream 2 Report:

- This report must be completed and submitted, explaining why the Injured Worker meets the criteria for Stream 2 within five (5) business of the Physical Therapist first identifying this need. Fee code 19185 should be invoiced.
- The Physical Therapist shall only invoice for Stream 2-Exception to Standard-Subsequent Visit and NOT invoice for Stream 2-Exception to Standard-Initial Visit because the Initial Visit occurred in Stream 1.

3.1.2.2 Stream 2 Physiotherapy Exceptions to Standard Treatment Report;

- Report to be received by WorkSafeBC within three (3) business days of the Stream 2 Initial Visit in order to invoice fee code item 19203. Fee code 19187 is to be invoiced if the report is received after three (3) business days of the Stream 2 Initial Visit.

3.1.2.3 Stream 3 Physiotherapy Home Visit Report;

- Report to be received by WorkSafeBC within three (3) business days of the Stream 3 Initial Visit in order to invoice fee code 19173. Fee code 19189 is to be invoiced if the report is received after three (3) business days of the Stream 3 Initial Visit.

3.1.2.4 Stream 4 Physiotherapy CNS Disorders Visit Report;

- Report to be received by WorkSafeBC within three (3) business days of the Stream 4 Initial Visit in order to bill fee code 19175. Fee code 19197 is to be invoiced if the report is received after three (3) business days of the Stream 4 Initial Visit.

3.1.2.5 Physiotherapy Requested Report.

- This can be requested for all streams. The report is to be received by WorkSafeBC within three (3) business days of the request from a Board Officer.

3.2 Communication

All reports sent to the worker's Attending Physician must be copied to WorkSafeBC.

If the Physical Therapist's assessment identifies findings that are inconsistent with the injury on the accepted claim, the Physical Therapist must notify the Board Officer and Attending Physician within one (1) business day of the assessment. The Board Officer will then determine whether or not the findings are part of the claim.

The Physical Therapist will promptly report to WorkSafeBC any injury to an Injured Worker occurring during treatment.

Where the Physical Therapist submits a treatment plan for Stream 2, 3, and/or 4, the Board Officer will inform the Physical Therapist when a claim decision has been made, when possible, and if any treatment will be covered by WorkSafeBC.

When a claim decision has not been communicated from the Board Officer within five (5) business days of the plan submission, the Physical Therapist may start treatment for Stream 2, 3 and 4 treatment plans and will be compensated by WorkSafeBC for the Services until communication is received from the Board Officer. Treatment shall not continue beyond the parameters outlined in the initial treatment plan.

Initial Visit > 60 Days from Date of Injury: If the Initial Visit is greater than sixty (60) business days from the date of injury, the Physical Therapist shall contact the Board Officer to clarify the claim status prior to providing Service. The Board Officer will inform the Physical Therapist if any treatment will be covered by WorkSafeBC. Any visits, **including the Initial Visit** in this case will not be reimbursed if treatment is not authorized.

3.3 Treatment Extension Requests

There are no treatment extensions for Stream 1. A worker can be transferred, where medically warranted and subject to the Board Officer's approval, from Stream 1 to Stream 2, as described above in Section 2.3.

For treatment Stream 2, if it is unlikely that the expected outcome will be achieved by the end of the initial treatment plan, the Physical Therapist shall contact the Board Officer at least ten (10) business days prior to the treatment end date to discuss the proposed recommendations and, if requested, submit a Physiotherapy Requested Report.

For treatment Streams 3 and 4, if it is unlikely that the expected outcome will be achieved by the end of the initial treatment plan, the Physical Therapist shall contact the Board Officer at least five (5) business days prior to the treatment end date to discuss the proposed recommendations and, if requested, submit a Physiotherapy Requested Report.

The Physical Therapist will only be reimbursed for treatments that have been approved by the Board Officer.

4.0 Invoicing

4.1 General

It is the Physical Therapist's responsibility to confirm the worker's claim status.

If the claim is pending at the time of the initial visit and subsequently not accepted, e.g. suspended, rejected or disallowed, the Physical Therapist must invoice the initial visit using fee code 19205 ("Pending Claim Report Fee").

When a pending status becomes accepted, the Physical Therapist must reimburse the worker 100% for all physiotherapy costs paid prior to the date the claim was accepted, and invoice WorkSafeBC directly according to the fee amounts in Schedule B of the Agreement.

A Physical Therapist must not charge any additional fees to an Injured Worker who has a claim accepted by WorkSafeBC (e.g. therabands, user fees, administrative fees, ice packs, etc.)

A Physical Therapist shall not invoice WorkSafeBC for missed, late, or cancelled appointments under any circumstances. However, a Physical Therapist may invoice an Injured Worker for a cancellation fee provided the worker has been advised and signed a form stating that missed, late or cancelled appointments will be charged to the worker.

4.2 Invoice Submission

Invoices for Physiotherapy Services must be submitted to WorkSafeBC by electronic submission via HIBC (MSP) Teleplan.

"Invoice for Treatment Services" (Form 267) shall be used if you choose to fax or mail invoices to WorkSafeBC. However each line entry on the invoice will be subject to a non e-commerce processing fee.

The non e-commerce fee does not apply in those cases where electronic business rules prohibit transmission. An example is an injured worker who does not have a Personal Health Number.

If a worker does not have a PHN, please fax the invoice directly to Payment Services at (604) 279 7590 in order to avoid the non e-commerce processing fee.

4.3 Billing the WorkSafeBC via HIBC (MSP) Teleplan

As Teleplan is an automated 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 you transmit to us. If they do not match, your invoice will be rejected and you will need to correct the information and resubmit the invoice.

To submit invoices via Teleplan, you need clinic billing software that is compatible with Teleplan. For more information, contact a medical software vendor. Alternately, you can submit through Teleplan by using a service bureau.

A “BK” explanatory code tells you that the WorkSafeBC has received your submission and is currently making a decision on it. Some complex claims can take more than 60 days to make an entitlement decision, so your patience is appreciated.

A Refusal code “AA” means that the patient does not have a PHN and/or the patient is not a British Columbia resident. If the worker does not have a personal health number, please write that information on the **Form 267 “Invoice For Treatment Services”** and fax the invoice directly to Payment Services at (604) 279 7590. Otherwise you will be charged a non-electronic transaction fee for billing on paper.

Please refer to Appendix E “Explanatory Codes: A Troubleshooting Guide” for more information.

5.0 WorkSafeBC Injury Coding

WorkSafeBC has adopted the Canadian WorkSafeBC injury coding standards. This is a key element for case management and early intervention.

Injury coding consists of three components:

- Service location codes (Appendix F)
- Side of body codes (Appendix G)
- Body part codes (Appendix H)
- Nature of injury codes (Appendix I)
- Diagnostic codes (ICD-9) (access online)

This coding is mandatory on all invoices submitted via MSP Teleplan. It allows for expedited matching of invoices to claims, resulting in timely payment.

Codes can be accessed on line at <http://www.worksafebc.com> under health care providers – health care practitioners – physiotherapists – billing and reporting.

Appendix A: Physiotherapy Initial Notification Form (83W5) Reference Guide

Worker Information:

Worker last name	Enter the worker's last name. If possible, it should match the name on the worker's British Columbia CareCard.
First name	Enter the worker's first name. Initials should not be used. If possible, it should match the name on the worker's British Columbia CareCard.
Personal health number or Birth date	Worker's Personal Health Number as shown on the British Columbia CareCard. If the worker does not have a PHN, enter the worker's birth date.
WorkSafeBC claim number	Enter the WorkSafeBC claim number specific to this injury . To confirm the claim number by contacting the WorkSafeBC Call Centre, please ensure you have the correct injury date, birth date and PHN for the worker.

Clinical Status:

Date of initial visit	The date of the first physiotherapy visit with the worker.
Date of injury	The date when the work-related injury occurred. In the case of occupational diseases, this is the date when medical attention was first sought – you may wish to check this date by accessing Online Claim Status.
Referring Physician's name	The name of the Physician who referred the worker for treatment.
Injury recorded on claim	This describes the diagnosis for the injury recorded on the WorkSafeBC claim. Where findings from a physiotherapy diagnosis differ from the original medical diagnosis, contact both the referring Physician and the Board Officer handling the worker's claim.
Is worker currently working?	Indicate the worker's employment status at the time of the initial assessment.

Assessment Outcome:

Initiate physiotherapy treatment	Check this box if physiotherapy treatment is indicated.
Physiotherapy treatment not indicated	Check this box if physiotherapy treatment is not indicated. Please contact the WorkSafeBC Board Officer to discuss your findings and recommendations.

Provider Information:

Physiotherapist's name	Enter the name of the Physical Therapist who provided service to the worker.
Practitioner number	Enter the MSP practitioner's number of the Physical Therapist who provided service to the worker.
Clinic payee number	Enter the Payee number for the clinic where service was provided to the worker.
Clinic name	Enter the name of the clinic where the service was provided to the worker (if applicable).
Clinic phone number	Enter the telephone number, including the area code, of the clinic where service was provided to the worker or the number of the Physical Therapist if there is no associated clinic.
Clinic fax number	Enter the fax number, including the area code, of the clinic where service was provided to the worker or the fax number for the Physical Therapist if there is no associated clinic.
Physiotherapist's mailing address/stamp	Please provide the current mailing address of the treating Physical Therapist.

Appendix B: Physiotherapy Report (268) Reference Guide

Physiotherapy report type (check only one of the report options)

Standard Treatment (PS)
Exceptions to Standard Treatment (PE)
Requested (PR)
Home Visit (PH)
CNS Visit (PC)

Worker information

Worker's last name	Enter the worker's last name. If possible, it should match the name on the worker's British Columbia CareCard.
First name	Enter the worker's first name. Initials should not be used. If possible, it should match the name on the worker's British Columbia CareCard.
Personal health number	Worker's Personal Health Number as shown on the British Columbia CareCard. If the worker does not have a PHN, indicate this on the form. Otherwise, you will be charged a transaction fee for billing on paper.
Date of Birth	Provide the worker's date of birth by mm/dd/yyyy
Worker's Occupation	Provide the worker's self-reported job title.
WorkSafeBC (WCB) Claim number	Enter the WorkSafeBC claim number <i>specific to this injury</i> . To confirm the claim number by contacting the WorkSafeBC Call Centre, please ensure you have the correct injury date, birth date and PHN for the worker.

Clinical status

Date of injury	The date when the work-related injury occurred. In the case of occupational diseases, this is the date when medical attention was first sought – you may wish to check this date by accessing Online Claim Status.
Injury accepted on claim	This describes the diagnosis for the injury reported on the claim. Where findings from a physiotherapy diagnosis differ from the claim-accepted medical diagnosis, contact both the referring physician and the Board Officer handling the worker's claim.
Is worker currently working?	Indicate whether worker is or is not working based on worker's report.
Date of initial visit	The date of the first physiotherapy intervention with the worker.
Reassessment date	The date that a physiotherapy reassessment was provided. This should remain blank if you are submitting this form following an Initial Assessment.

Number of visits to date	This field is to report the number of visits provided to the worker since beginning treatment, including the initial visit
Initial objective findings	Provide objective measurements of the status of the injury at the time of Initial assessment. Describe the most prominent or most critically limited characteristic of the injury, and the most representative objective measure of the injury.
Current objective findings if applicable	Provide the objective measurements of the status of the injury at the time of reassessment. Describe the most prominent or most critically limited characteristic of the injury, and the most representative objective measure of the injury (e.g. <i>knee strain with swelling reduced of +5 cm to +2cm with activity increased from 10 min to 2 hrs since initial assessment three weeks ago.</i>)
Critical job demands as reported by the worker	Identify tasks worker must be able to do to return to work.
Current functional abilities related to critical job demands	Provide descriptive parameters such as activity type (sit, lift, carry, squat, etc.), intensity (weight, distance), frequency (reps per hour or day) and duration (hours per day) to indicate what the worker can do relative to each critical job demand.
Factors delaying recovery	Provide details about factors or conditions that may affect injury, recovery or disability (e.g. pre-existing or non-compensable).

Treatment goals

Expected improvements	Enter weekly or bi-weekly objective treatment benchmarks. These may be physical or functional measures. For post-surgical conditions reference the specific post-surgical rehabilitation guideline or, if referencing another guideline, attach a copy of that guideline to the Report and submit to WorkSafeBC.
Can modified or regular duties be performed concurrently with physiotherapy treatment?	Indicate if RTW can be initiated concurrently with physiotherapy. <ul style="list-style-type: none"> • If “Yes”, provide expected start date. • If “No”, Please indicate the reasons.

Recommendations (Stream 2, 3, or 4 only)

Start date	This is the date of the first day of treatment extension
Number of weeks	This is the number of weeks requested during the extension.
Expected number of visits	This is the number of visits requested during the extension.

Expected outcome at end of treatment

	<p>Indicate the anticipated treatment outcome by checking the appropriate box.</p> <p>If Further medical investigation is recommended, specify the nature of the investigation and discuss the rationale with the referring Physician and Board Officer.</p>
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Provider information

Physical Therapist's Name	Enter the name of the Physical Therapist who provided service to the worker
Practitioner Number	Enter the MSP practitioner's number of the Physical Therapist who provided service to the worker.
Clinic Payee Number	Enter the Payee number for the clinic where service was provided to the worker.
Clinic Name	Enter the name of the clinic where the service was provided to the worker, (if applicable).
Clinic Phone Number	Enter the telephone number, including the area code, of the clinic where service was provided to the worker or the number of the Physical Therapist if there is no associated clinic.
Clinic Fax Number	Enter the fax number, including the area code, of the clinic where service was provided to the worker or the fax number for the Physical Therapist if there is no associated clinic.
Date	Provide the date that the form was completed and submitted to WorkSafeBC
Signature	The treating Physical Therapist should sign the form prior to submission to WorkSafeBC
Physical Therapist's mailing address/stamp	Please provide the current mailing address of the treating Physical Therapist.

Appendix C: Invoice For Treatment Services (267) Reference Guide

Form Field Name	Description
Payment Information	
<i>Invoice Date</i>	Enter the date of the invoice.
<i>Payee Number</i>	Enter the Payee number for the clinic contracted to provide service. The treating physiotherapist's practitioner number may be the same as the payee number. Payment cannot be made without this information.
<i>Provider Name</i>	Enter the name of the clinic that provided service to the worker.
<i>Practitioner number</i>	Enter the practitioner number of the physiotherapist who provided service to the worker. The practitioner number may be the same as the payee number.
<i>Mailing address for payment</i>	Enter the mailing address of the clinic where the physiotherapist provided service to the injured worker. Include street location, city, province and postal code. You may use a stamp if filling out a paper form.
<i>Telephone Number</i>	Enter the telephone number, including the area code, of the clinic where service was provided to the worker.
<i>Fax Number</i>	Enter the fax number, including the area code, of the clinic where service was provided to the worker.
<i>Claim Number</i>	Enter the WorkSafeBC claim number <i>specific to this injury</i> . If you confirm the claim number by contacting the WorkSafeBC Call Centre , please ensure you have the correct injury date, birth date and PHN for the worker.

Injury Information: All the codes required for completion of this section can be found in the Reference Manual. Entry into all of the code fields is mandatory for payment to be processed.

Worker Information	
<i>Worker's last name</i>	Enter the worker's last name. If possible, it should match the name on the worker's British Columbia CareCard.
<i>Worker's first name</i>	Enter the worker's first name. Initials should not be used. If possible, it should match the name on the worker's British Columbia CareCard.
<i>Gender</i>	Select male or female.
<i>Birth Date</i>	Enter the birthday of the injured worker.
Personal health number	Enter the worker's Personal Health Number as shown on the British Columbia CareCard. If the worker does not have a PHN, indicate this on the form. Otherwise, you will be charged a transaction fee for billing on paper.
<i>WorkSafeBC (WCB) Claim number</i>	Enter the WorkSafeBC claim number <i>specific to this injury</i> . To confirm the claim number by contacting the WorkSafeBC Call Centre, please ensure you have the correct injury date, birth date and PHN for the worker.
Injury Information	
<i>Date of Injury</i>	The date when the work related injury occurred. In the case of occupational diseases, this is the date when medical attention was first sought – you may wish to check this date by accessing Online Claim Status.
<i>Diagnostic Code (ICD-9 code)</i>	These codes can be found on online at: http://www.worksafebc.com/health_care_providers/health_care_practitioners/physiotherapists/billing_and_reporting/default.asp
<i>Side of Body Code</i>	See Appendix G
<i>Body Part Code</i>	See Appendix H
<i>Nature of Injury Code</i>	See Appendix I
Service Information	
<i>Service Location Code</i>	See Appendix F
<i>Date of Service</i>	Indicate the specific date(s) physiotherapy service was provided to the injured worker.
<i>Fee Code</i>	Indicate the fee code(s) for the specific physiotherapy service(s) provided, as outlined in Schedule C of the <i>Agreement</i> .
<i>Amount</i>	Indicate the fee amount(s) for the specific physiotherapy service(s) provided, as outlined in Schedule C of the <i>Agreement</i> .
<i>Number of service units*</i>	The number of service units are only required for Home Visits (item 19163) and CNS Disorders (item 19165).
<i>Description</i>	Describe the specific type of treatment provided to the Injured Worker for each treatment date of service.

Appendix D: Fee Schedule

Standard Treatment – Stream 1	Fee Item Code	WorkSafeBC Business Rules	July 1, 2011-June 30, 2013
Initial Visit with PT Initial Notification Form received <u>within</u> three (3) business days	19178	<ul style="list-style-type: none"> • Limit ONE (1) Initial Notification Form per payee per claim. • Will be reimbursed only for accepted claims*. • Billable if 'Initial Notification Form' received within THREE (3) business days of Initial Visit. • Form Required. 	\$62.75
Initial Visit with PT Initial Notification Form received <u>after</u> three (3) business days	19179	<ul style="list-style-type: none"> • Limit ONE (1) Initial Notification Form per payee per claim. • Will be reimbursed only for accepted claims*. • Billable if "Initial Notification Form" received after THREE (3) business days of Initial Visit. • Form Required. 	\$56.75
Standard Treatment - <i>Subsequent Visit</i>	19202	<ul style="list-style-type: none"> • Limit ONE (1) Subsequent Visit per payee per day per accepted claim. • Service date must be later than that of Initial Visit. • No concurrent treatments are allowed unless approved by a Board Officer. 	\$41.98
Standard Treatment Report	19185	<ul style="list-style-type: none"> • Limit ONE (1) Report per payee per accepted claim. • Received at least five (5) business days prior to the treatment end date if the Worker is not expected to return to pre-injury hours and duties. • When using in conjunction with a transfer from Stream 1 to Stream 2 the timeliness of the report must be received within FIVE (5) business days of the transfer. 	\$37.62
Late Standard Treatment Report	19186	<ul style="list-style-type: none"> • Limit ONE (1) Report per payee per accepted claim. • Received less than five (5) business days prior to the treatment 	\$32.42

		<p>end date if the Worker is not expected to return to pre-injury hours and duties.</p> <ul style="list-style-type: none"> • When using in conjunction with a transfer from Stream 1 to Stream 2 the timeliness of the report must be received within FIVE (5) business days of the transfer 	
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*For claims which are pending on the date of the Initial Visit refer to “Pending Claim Report” fee item code 19205.

Exceptions to Standard Treatment – Stream 2	Fee Item Code	WorkSafeBC Business Rules	June 1, 2011-June 30, 2013
Exceptions to Standard Treatment - <i>Initial Visit</i>	19181	<ul style="list-style-type: none"> • Limit ONE (1) Initial Visit per payee per accepted claim. • Will be reimbursed only for accepted claims*. • Not billable for Injured Workers that have been transferred from Stream 1. 	\$51.75
Exceptions to Standard Treatment - <i>Subsequent Visit</i>	19184	<ul style="list-style-type: none"> • Limit ONE (1) Subsequent Visit per payee per day per accepted claim*. • Service date must be later than that of Initial Visit. • No concurrent treatments are allowed unless approved by a Board Officer. 	\$41.98
Exceptions to Standard Treatment Physiotherapy Report	19203	<ul style="list-style-type: none"> • Limit ONE (1) Report per payee per accepted claim. • If using in conjunction with the Initial Visit, the timeliness of the report must be received within THREE (3) business days of the “Exceptions to Standard Treatment” Initial Visit. • Report required for Stream 2 Initial Visit only. 	\$37.62
Exceptions to Standard Treatment Late Physiotherapy Report	19187	<ul style="list-style-type: none"> • Limit ONE (1) Report per payee per accepted claim. • Billable if using in conjunction with the Initial Visit and the timeliness of the report is received later than THREE (3) business days of Initial “Exceptions to Standard Treatment” Visit. • Report required for Stream 2 Initial Visit only. 	\$32.42

*For claims which are pending on the date of the Initial Visit refer to “Pending Claim Report” fee item code 19205.

Home Visits – Stream 3	Fee Item Code	WorkSafeBC Business Rules	January 1, 2010 to December 31, 2010
Home Visit – <i>Initial Visit</i>	19182	<ul style="list-style-type: none"> • Limit of ONE (1) Initial Home Visit per payee per accepted claim. • Will be reimbursed only for accepted claims*. • ONE (1) Service-Unit equals FIFTEEN (15) minutes of treatment. • Maximum of EIGHT (8) Service - Units per visit. 	\$27.15 per Service-Unit
Home Visit – <i>Subsequent Visit</i>	19163	<ul style="list-style-type: none"> • Limit of ONE (1) Subsequent Home Visit per payee per accepted claim per day. • Service date must be later than that of the Initial Home Visit. • ONE (1) Service-Unit equals FIFTEEN (15) minutes of treatment. • Maximum of EIGHT (8) Service - Units per visit. 	\$27.15 per Service-Unit
Physiotherapy Report for Home Visit	19173	<ul style="list-style-type: none"> • Limit ONE (1) Home Visit Report per payee per accepted claim. • Report must be received within THREE (3) business days of the Initial Home Visit. • Limit of ONE (1) item per payee per claim. • Report required. 	\$37.62
Late Physiotherapy Report for Home Visit	19189	<ul style="list-style-type: none"> • Limit ONE (1) Home Visit Report per payee per accepted claim. • Limit ONE (1) item per payee per claim. • Billable if report received after THREE (3) business days of the Initial Home Visit. • Report required 	\$32.42
Travel for Home Visit	19198	<ul style="list-style-type: none"> • ONE (1) Service-Unit equals up to SIXTY (60) kms of travel. • ONE (1) Service-Unit does not require pre-approval. • More than ONE (1) Service-Unit must be pre-approved. 	\$27.15 per Service-Unit

*For claims which are pending on the date of the Initial Visit refer to “Pending Claim Report” fee item code 19205.

CNS Disorder Treatments – Stream 4	Fee Item Code	WorkSafeBC Business Rules	January 1, 2010 to December 31, 2010
Central Nervous System (CNS) Disorders Visit – <i>Initial Visit</i>	19183	<ul style="list-style-type: none"> • Limit of ONE (1) CNS Disorders Initial Visit per payee per accepted claim. • Will be reimbursed only for accepted claims*. • ONE (1) Service-Unit equals FIFTEEN (15) minutes of treatment. • Maximum of EIGHT (8) Service-Units per visit. 	\$27.15 per Service-Unit
Central Nervous System (CNS) Disorders Visit – <i>Subsequent Visit</i>	19165	<ul style="list-style-type: none"> • Limit of ONE (1) CNS Disorders Subsequent Visit per payee per accepted claim per day. • ONE (1) Service-Unit equals FIFTEEN (15) minutes of treatment. • Maximum of EIGHT (8) Service-Units per visit. 	\$27.15 per Service-Unit
Physiotherapy Report for CNS Disorders	19175	<ul style="list-style-type: none"> • Limit ONE (1) CNS Disorders Visit Report per payee per accepted claim. • Report date must be received within THREE (3) business days of the Initial CNS Disorders Visit. • Report required. 	\$37.62
Late Physiotherapy Report for CNS Disorders	19197	<ul style="list-style-type: none"> • Limit ONE (1) CNS Disorders Visit Report per payee per accepted claim. • Billable if report received after THREE (3) business days of the Initial CNS Disorder Visit. • Report required. 	\$32.42

*For claims which are pending on the date of the Initial Visit refer to “Pending Claim Report” fee item code 19205.

Hydrotherapy	Fee Item Code	WorkSafeBC Business Rules	January 1, 2010 to December 31, 2010
Hydrotherapy Session- <i>Small Group</i>	19199	<ul style="list-style-type: none"> • Up to three (3) patients maximum. • ONE (1) Service-Unit equals FIFTEEN (15) minutes of treatment. • Limit FOUR (4) Service-Units per payee per accepted claim per day. • Hydrotherapy cannot be invoiced with any other treatment service. • One (1) Hydrotherapy Session equals one (1) Subsequent Visit and is counted toward the maximum Subsequent Visit count. • Service date must be later than that of Initial Visit. • No concurrent treatments are allowed unless approved by a Board Officer. • Includes the cost of pool admission and all other associated costs. • Service Unit of fifteen (15) minutes. • Not billable for Home Visits. 	\$27.15 per Service-Unit
Hydrotherapy Session- <i>Large Group</i>	19201	<ul style="list-style-type: none"> • Between four (4) and fifteen (15) patients. • Limit ONE (1) Hydrotherapy Session per payee per accepted claim per day. • Hydrotherapy cannot be invoiced with any other treatment service. • One (1) Hydrotherapy Session equals one (1) Subsequent Visit and is counted toward the maximum Subsequent Visit count. • Service date must be later than that of Initial Visit. • No concurrent treatments are allowed unless approved by a Board Officer. • Includes the cost of pool admission and all other associated costs. • Not billable for Home Visits. 	\$35.91 per Session

Other Reports	Fee Item Code	WorkSafeBC Business Rules	January 1, 2010 to December 31, 2010
Requested Report	19167	<ul style="list-style-type: none"> • Requested by a Board Officer. • Must be received by WorkSafeBC within THREE (3) business days from the date of request. For invoicing purposes the date of request is considered day ZERO (0). • Only billable if the report that is requested is NOT a report that is part of the normal process for any Stream (1-4) or Transfer Request and is being requested because it was never received by WorkSafeBC or the report received by WorkSafeBC is illegible. 	\$37.62
Late Requested Report	19188	<ul style="list-style-type: none"> • Requested by a Board Officer. • Billable if the report is received by WorkSafeBC later than THREE (3) business days from the date of request. • Only billable if the report that is requested is NOT a report that is part of the normal process for any Stream (1-4) or Transfer Request and is being requested because it was never received by WorkSafeBC or the report received by WorkSafeBC is illegible. 	\$32.42
Medical Review Report	19200	<ul style="list-style-type: none"> • Requested by a Board Officer • Comprehensive report, which includes but is not limited to the Injured Worker's history including: symptoms, treatment, results and present condition. The report may be requested to answer a specific question. • Must be received by WorkSafeBC within THREE (3) business days from the date of request. For invoicing purposes the date of request is considered day ZERO (0). 	\$374.54
Telephone Consultation with Board Officer	19177	<ul style="list-style-type: none"> • Initiated by a Board Officer. • To discuss treatment services, return to work and discharge planning only. Or: • Telephone consultation that is initiated by the Physical Therapist 	\$27.59 per 15 min. increment

		<p>and is contractually required to contact a Board Officer.</p> <ul style="list-style-type: none">• Telephone consultations are billable for conversation time or a detailed message regarding RTW and other related treatment matters only and must be documented in clinical notes;• Billable for consultations up to FIFTEEN (15) minutes per increment.• Not billable for routine/billing/administrative issues.	
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Other Fee Codes	Fee Item Code	WorkSafeBC Business Rules	January 1, 2010 to December 31, 2010
Telephone Consultation for Return to Work and Other Related Issues	19204	<ul style="list-style-type: none"> • For telephone communication with a Health Care Provider Limited to “Return to Work Support Services” and “Occupational Therapy Services”. To discuss return to work and/or other related issues. • Telephone consultations are billable for conversation time or a detailed message regarding RTW and other related treatment matters only and must be documented in clinical notes; • Telephone consultations are billable for conversation time only; • Billable for consultations up to FIFTEEN (15) minutes per increment. • Not billable for routine/billing/administrative issues. 	\$27.59 per 15 min. increment
Photocopies (first 5 pages)	19171	<ul style="list-style-type: none"> • Requested by WorkSafeBC. 	\$27.15
Photocopies (every page over 5 pages)	19172	<ul style="list-style-type: none"> • Requested by WorkSafeBC. 	\$1.27 per page
Non-Electronic Invoicing Fee	N/A	<ul style="list-style-type: none"> • Processing fees charged for each fee line item invoiced by paper and fax transmission. 	\$4.50
Pending Claim Report	19205	<ul style="list-style-type: none"> • Limit ONE item per payee per claim. • Claim decision date must be later than Initial Visit date. • Will be reimbursed for claims which are pending on the date of the Initial Visit and are subsequently <u>not</u> accepted. • PT Initial Notification Form or Physiotherapy Report must be received.¹ <p><u>Note:</u></p> <ul style="list-style-type: none"> • This fee code is used to re-submit an invoice if the Initial Visit fee has been rejected and the claim were pending at the time of the Initial Visit. 	

¹ Amended September 14, 2006 to include additional statement

		<ul style="list-style-type: none">• This fee code may also be used if invoices have not been submitted and the pending claim has been disallowed, suspended or rejected.• Do not use this fee code for pending claims where the decision is under review by the Board Officer.	
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Appendix E: Explanatory Codes: A Troubleshooting Guide

The following is a list of codes that commonly arise in the course of billing the WorkSafeBC through Teleplan. Please check this list first for help; if the answer is not here, check the complete list of codes received from your software vendor or HIBC (MSP).

There is also a current list of WorkSafeBC explanatory codes, which includes more detailed information, on the WorkSafeBC Online™ website at www.worksafebc.com.

If you are still unable to resolve the problem, please call WorkSafeBC Payment Services at (604) 276-3085, or toll-free 1 888 422-2228.

HIBC Codes	HIBC Descriptions	WorkSafeBC Explanation
AA	PHN Number is missing or invalid	If the patient does not have a personal health number, please write that information on the form, otherwise there will be a charged transaction fee for the billing on paper
BK	Your claim submission is being held pending WorkSafeBC Notice of Approval	Waiting for WorkSafeBC Claim match Waiting for Treatment Extension Waiting for Claim decision Waiting for Payment decision Waiting for Concurrent Treatment Authorization
ET	WorkSafeBC refused payment – Fee Item Limit Exceeded.	You have exceeded the allowable limit for this fee item.
SA	WorkSafeBC refused your claim submission only one course of treatment acceptable per day. If clarification required contact WorkSafeBC Payment Services	Only one type of visit per claim is payable per day.
SB	WorkSafeBC refused your claim submission. Concurrent treatment not authorized. If clarification required contact WorkSafeBC Claim Owner	The Claim Owner did not authorize this course of treatment due to other authorized treatments
SJ	Unable to locate WorkSafeBC Form. Please verify payee number and date of service on invoice and resubmit with revised info.	The form you invoiced for was not received and registered to that claim.
WD	WorkSafeBC claim disallowed. If clarification required contact WorkSafeBC Payment Services	The claimant's WORKSAFEBC claim was disallowed.
WV	WorkSafeBC claim-treatment refused. If clarification required contact the Claim Owner.	Claims Claim Owner did not authorize this course of treatment.

WM	WorkSafeBC refused your claim submission. Treatment limit exceeded. If clarification required contact WorkSafeBC Claim Owner	This service has exceeded the authorized time limit.
XS	WorkSafeBC refused claim. Claim suspended pending further investigation. If clarification required contact WorkSafeBC Claim Owner	This claim has been suspended until the WorkSafeBC hears from the worker. No decision as to entitlement can be rendered until more information is received.
XR	WorkSafeBC refused claim. Injured Worker not covered under the WCB Act. If clarification required contact WorkSafeBC Claim Owner	Claim has been "rejected" as the worker was not covered under WCB Act. Accounts for visits and forms are not payable. Injury may be covered by another insurer.

HIBC (MSP) Teleplan Rejection Explanatory Codes and Descriptions for PT

HIBC Code	HIBC Explanatory Code Description
M5	WCB REFUSED YOUR CLAIM SUBMISSION. THE PHYSIO STREAM WAS NOT AUTHORIZED. IF CLARIFICATION REQUIRED CONTACT WCB ADJUDICATOR.
SB	WCB REFUSED YOUR CLAIM SUBMISSION. AREA OF INJURY PROVIDED DOES NOT MATCH WCB RECORDS. CLARIFY WITH PATIENT AND RESUBMIT WITH REVISED INFO IF WCB CLAIM. 364 mapped to SB. As we discussed the MSP wording for SB is – WCB refused your claim submission. Concurrent treatment not authorized. If clarification required contact WCB adjudicator.
UL	WCB REFUSED CLAIM. THE MAXIMUM NUMBER OF SERVICES HAS BEEN EXCEEDED. 366 mapped to UL.
M6	WCB REFUSED YOUR CLAIM SUBMISSION. THE FEE ITEM IS NOT APROPRIATE FOR THE WCB CLAIM DECISION.
M7	WCB REFUSED CLAIM. SEMI-PRIVATE ROOM WAS NOT BILLED WITH PER DIEM.
M8	WCB REFUSED CLAIM. PHYSIOTHERAPY HOME VISIT TRAVEL ONLY PAID WITH VISIT.
M9	WCB REFUSED YOUR CLAIM SUBMISSION. SUBMITTED FEE ITEM DOES NOT FALL UNDER PHYSIO TREATMENT STREAM ON FILE

The remainder of the codes and explanatory codes can be found on the MSP website.

Note: These aforementioned explanation descriptions are those that occur most frequently and do not comprise all of the codes that may be referenced.

Appendix F: Service Location Codes

Revised CODE	Revised DESCRIPTOR	Revised DEFINITION
C	Residential Care/Assisted Living Residence	Service is provided to a patient in a licensed residential care facility or registered assisted living residence (Note: Excludes small “group homes” where no professional health care support/care is available and includes extended care facility within a hospital).
D	Diagnostic Facility	Service is provided in a facility that primarily/exclusively provides diagnostic testing and has been granted a MSC Certificate of Approval (Note: Excludes diagnostic tests provided in a practitioner’s office. Also excludes diagnostic services provided in/by hospital and/or D&T center facilities).
E	Hospital – Emergency Room (Unscheduled Patient)	Service is provided in a hospital emergency department for a patient who presents for emergent or urgent treatment (Note: Excludes hospital outpatients who receive services on a scheduled basis within an emergency department – see <i>Hospital Outpatients</i>).
I	Hospital – Inpatient	Service is provided for a patient who is an inpatient of a hospital (Note: Excludes patients located within a designated “extended care unit” within a hospital – see <i>Residential Care/Assisted Living Residence</i>).
P	Hospital – Outpatient	Service is provided in outpatient and/or ambulatory clinics where outpatients receive scheduled services including emergency department, or any other hospital setting where outpatients receive services (Note: Excludes day care surgical patients).
R	Patient’s Private Home	Service is provided in a patient’s own home (Note: Includes service provided in a “group homes” where on-site nursing or other health professional support care is not provided, but excludes assisted living residences and other residential facilities – see <i>Residential Care/Assisted Living Resident</i>).
Z	Other (e.g. accident site or ambulance)	Service is provided in any other location such as a temporary community or school clinic, ambulance, accident site etc.
G	Hospital – Day Care (Surgery)	Service is provided within a hospital to a patient who is a day care surgery patient (Note: Includes all patients who are in hospital on a day care basis primarily to receive a “procedure”. Excludes scheduled services – see <i>Hospital – Outpatient</i>).
F	Private Medical/Surgical Facility	Service is provided within a private medical/surgical facility accredited by the College of Physicians and Surgeons of BC.
A	Practitioner’s Office – In Community	Service is provided in a practitioner’s office (Note: Excludes practitioner’s offices that are located within a publicly administered health care facility – see <i>Practitioner’s Office – In Publicly Administered Facility</i> . Includes services provided by a physician, chiropractor, dentist, optometrist, podiatrist, physiotherapist, and massage therapist).

Revised CODE	Revised DISRIPTOR	Revised DEFINITION
M	Mental Health Centre	Service is provided in a publicly administered mental health centre to an outpatient (Note: Excludes mental health facilities that are primarily residential in nature – see Residential Care/Assisted Living. Includes CRESST Facilities).
T	Practitioner's Office – In Publicly Administered Facility	Service is provided in a practitioner's office located within a publicly administered health care facility (e.g., Hospital, Primary Care Centre/Clinic, D&T Centre, etc.).

Appendix G: CSA Side of Body Codes for WorkSafeBC Reporting & Invoicing Purposes

Side of body codes (CSA Z795) Release 2.0

Side of body	Code	Usage Note
Left	L	
Right	R	
Left and right	B	
Not applicable	N	Use for body systems, a major body part (i.e. heart, stomach) or multiple/other parts.

A current list of WORKSAFEBC injury codes is available on the WorkSafeBC website at: www.worksafebc.com

Appendix H: CSA Body Codes for WorkSafeBC Reporting & Invoicing Purposes

Body part codes (CSA Z795) Release 2.0

Level 1	Level 2	Code	Body part — level 3	Usage note
Head				
	Cranial	01100	Brain	Includes brain stem. Use for concussion or other intracranial injuries
	Cranial	01200	Scalp	Includes skin, hair
	Cranial	01300	Skull	Includes occipital, parietal and temporal bones
	Cranial	01800	Cranial region, multiple locations	
	Ear(s)	02000	Ear(s)	
	Face	03100	Forehead	Includes eyebrows
	Face	03200	Eye(s)	Includes conjunctiva, cornea, eyeball, inside and outside of the eyelids, iris, lacrimal glands, lens, optic nerve, orbit, and retina
	Face	03300	Nose, external	
	Face	03310	Nose/nasal, internal location, other	
	Face	03400	Cheeks	
	Face	03500	Jaw/chin	
	Face	03610	Lip(s)	
	Face	03620	Tongue	
	Face	03630	Tooth (teeth)	
	Face	03800	Face, multiple locations	
Neck				
	Neck	10009	Neck (soft tissues)	Includes throat, muscle, skin, subcutaneous tissue, veins and arteries
	Neck	10001	Neck, cervical vertebrae	Includes bony structures and cartilage
	Neck	12000	Vocal cords(s)	
	Neck	13000	Larynx	
	Neck	14000	Laryngopharynx	
	Neck	15000	Pharynx	
	Neck	80001	Neck and shoulder	
Trunk				
	Chest	22000	Chest	
	Chest	22200	Esophagus	
	Chest	22300	Heart	
	Chest	22400	Bronchus	
	Chest	22500	Lung(s) pleura	
	Chest	22800	Chest, multiple internal locations	
	Back	23200	Back, thoracic region	Includes 12 vertebrae just below cervical vertebrae of the neck, the trapezius muscle, the cervico-thoracic/thoraco-lumbar regions

Level 1	Level 2	Code	Body part — level 3	Usage note
	Back	23100	Back, lumbar region	Includes 5 vertebrae in lower part on of back and lumbo-sacral region
	Back	23300	Back, sacral region	
	Back	23400	Back, coccygeal region	Includes tail bone
	Back	23800	Back, multiple regions	
	Abdomen	24000	Abdomen, external	
	Abdomen	24200	Stomach	
	Abdomen	24300	Spleen	
	Abdomen	24410	Bladder	
	Abdomen	24420	Kidney(s)	
	Abdomen	24491	Ureter	
	Abdomen	24520	Intestine, small	
	Abdomen	24530	Intestine, large/colon, rectum	
	Abdomen	24610	Liver	
	Abdomen	24620	Gallbladder	
	Abdomen	24630	Pancreas	
	Abdomen	24800	Abdomen, multiple internal locations	
	Pelvic region	25100	Hip(s)	
	Pelvic region	25200	Pelvis	
	Pelvic region	25300	Buttock(s)	
	Pelvic region	25400	Groin	
	Pelvic region	25510	Scrotum	
	Pelvic region	25520	Penis	
	Pelvic region	25530	Genital region, external female	
	Pelvic region	25610	Prostate	
	Pelvic region	25620	Testis (testes)	
	Pelvic region	25630	Ovary(ies)	
	Pelvic region	25640	Uterus	
	Pelvic region	25800	Pelvis, multiple regions	
Upper Extremities				
	Shoulder	21000	Shoulder, including clavicle, includes clavicle, collar scapula bone, humerus, scapula/shoulder blade and shoulder girdle	
	Arm(s)	31100	Arm(s), upper	
	Arm(s)	31200	Arm(s), elbow(s)	

Level 1	Level 2	Code	Body part-level 3	Usage note
	Arm(s)	31300	Arm(s), forearm(s)	
	Arm(s)	31800	Arm(s), multiple locations	
	Wrist(s)	32000	Wrist(s)	
	Hand(s)	33000	Hand(s), except finger(s) Includes knuckles and the areas between the fingers	
	Finger(s)	34000	Finger(s), fingernail(s)	Includes distal phalanx, (phalanges), medial phalanx (phalanges), and proximal phalanx (phalanges)
	Finger(s)	34001	Thumb or thumb and other finger(s)	
Lower Extremities				
	Leg(s)	41100	Leg(s), thigh(s)	
	Leg(s)	41200	Leg(s), knee(s)	
	Leg(s)	41300	Leg(s), lower	
	Leg(s)	41800	Leg(s), multiple locations	
	Ankle(s)	42000	Ankle(s)	Classifies the hinge joint area between the foot and the lower leg
	Foot (feet)	43000	Foot (feet), other except heel(s)	
	Foot (feet)	43230	Foot (feet), heel(s)	
	Foot (feet)	43800	Foot (feet), multiple locations	
	Toe(s)	44000	Toe(s), toenail(s)	
Body Systems				
	Body systems	50000	Immune and endocrine systems	
	Body systems	50001	Circulatory systems	
	Body systems	50002	Digestive systems	
	Body systems	50004	Genito-urinary system	
	Body systems	50005	Musculoskeletal system (joints, tendons etc.)	
	Body systems	50006	Nervous system (nervous shock, breakdown etc.)	
	Body systems	50007	Respiratory system	
Other				
	Other	91000	Prosthetic devices	Artificial arm(s), leg(s), dentures, hearing aids, eye glasses or corrective lenses

A current list of WorkSafeBC injury codes is available on www.worksafebc.com

Appendix I: CSA Nature of Injury Codes for WorkSafeBC Reporting & Invoicing Purposes

Nature of Injury Codes (CSA Z795) Release 2.0

Level 1	Level 2	Code	Nature of injury type–level 3	Usage note
Trauma and musculoskeletal disorders				Effects of external agents and poisoning, resulting from a single incident, event or exposure plus diseases and disorders of the musculo-skeletal system and connective
	Bones, nerves, spinal cord	01000	Bones, nerves, spinal cord, trauma, other	
	Bones, nerves, spinal cord	01100	Dislocations	Displacement or dislocation of bone or cartilage. Includes: subluxations, partial displacement and fractured or broken cartilage
	Bones, nerves, spinal cord	01200	Fractures	Includes avulsion fractures
	Bones, nerves, spinal cord	01300	Spinal cord, traumatic injuries	
	Bones, nerves, spinal cord	01400	Nerves, traumatic injuries (ex. spinal cord)	Includes traumatic carpal tunnel syndrome
	Muscles joints	02000	Muscles, tendons, joints, other injuries	Includes tears to menisci, ligaments, and articular cartilage
	Muscles joints	02100	Sprains, strains	
	Muscles joints	02101	Rotator cuff tear, traumatic	If due to repetitive motion, use rotator cuff syndrome
	Wounds	03000	Wounds, other open wounds	Includes wounds with broken skin or outward opening, beyond the superficial skin surface
	Wounds	03110	Amputations, fingertip	Includes bone loss
	Wounds	03190	Amputations, except fingertip	Includes bone loss
	Wounds	03200	Bites and insect stings	
	Wounds	03300	Wounds, avulsions	Includes ripping or tearing away not involving bone, excludes avulsion of joint capsule, ligament, muscle or tendon (use muscles, tendons, joints, other injuries)
	Wounds	03400	Wounds, cuts and lacerations	
	Wounds	03700	Wounds, punctures	
	Wounds	04000	Wounds, other closed wounds	Includes blisters and friction burns
	Wounds	04100	Wounds, abrasions and scratches	Includes traumatic conjunctivitis of the eye, use surface wounds, bruises, contusions for closed wounds
	Wounds	04300	Wounds, bruises and contusions	Use for closed wounds

Level 1	Level 2	Code	Nature of injury type–level 3	Usage note
	Wounds	04400	Foreign bodies (superficial splinters, chips)	Includes foreign bodies in the eye
	Burns	05100	Burns, chemical	
	Burns	05200	Burns, electrical	
	Burns	05300	Burns, scalds from heat	
	Intracranial injuries	06000	Intracranial injuries, other	
	Intracranial injuries	06200	Concussions	
	Environmental trauma	07000	Environmental conditions, other	
	Environmental trauma	07110	Frostbite	
	Environmental trauma	07120	Hypothermia	
	Environmental trauma	07200	Heat and light effects	
	Environmental trauma	07300	Air pressure effects	
	Environmental trauma	12560	Welder's flash	
	Environmental trauma	12610	Hearing loss or impairment, deafness	
	Musculoskeletal disorders	17000	Musculoskeletal/connective tissue diseases and disorders	Non-traumatic musculoskeletal system and connective tissue diseases and disorders
	Musculoskeletal disorders	17100	Arthritis (arthropathies and related disorders)	
	Musculoskeletal disorders	17210	Sciatica (not traumatic)	Use muscles, tendons, joints, other injuries for traumas
	Musculoskeletal disorders	17231	Herniated disc	Including other disc pathologies (e.g. degenerative, disc disease)
	Musculoskeletal disorders	17293	Radiculitis (not traumatic)	Use muscles, tendons, joints, other injuries for traumas
	Musculoskeletal disorders	17310	Bursitis (not traumatic)	Use muscles, tendons, joints, other injuries for traumas
	Musculoskeletal disorders	17320	Synovitis (not traumatic)	Use muscles, tendons, joints, other injuries for traumas
	Musculoskeletal disorders	17330	Tendonitis (not traumatic)	Use muscles, tendons, joints, other injuries for traumas
	Musculoskeletal disorders	17340	Tenosynovitis (not traumatic)	Use muscles, tendons, joints, other injuries for traumas
	Musculoskeletal disorders	17391	Rotator cuff syndrome (not traumatic)	Use muscles, tendons, joints, other injuries for traumas
	Musculoskeletal disorders	17393	Epicondylitis (not traumatic)	Use muscles, tendons, joints, other injuries for traumas
	Musculoskeletal disorders	17394	Capsulitis (not traumatic)	Use muscles, tendons, joints, other injuries for traumas
	Musculoskeletal disorders	17901	Fibromyalgia, fibrositis, myofascitis	Use muscles, tendons, joints, other injuries for traumas
	Other traumatic injuries	09000	Traumatic injuries and disorders, other	

Level 1	Level 2	Code	Nature of injury type–level 3	Usage note
	Other traumatic injuries	09100	Asphyxiation, strangulation, suffocation	
	Other traumatic injuries	09200	Drownings	
	Other traumatic injuries	09300	Electrocutions, electric shocks	
	Other traumatic injuries	09500	Poisonings and toxic effects, Other	
	Other traumatic injuries	09600	Traumatic complications, other	Complications peculiar to medical or surgical procedures or following traumatic injuries — includes anaphylactic shock and post-traumatic osteoarthritis
	Other traumatic injuries	09710	Crushing injuries	
	Systemic diseases and disorders			Toxic and non-toxic diseases or disorders affecting systems of the body
	Disease of blood and blood forming organs	11000	Blood and blood forming organs, diseases	
	Nervous system diseases	12000	Nervous system and sense organs diseases	
	Nervous system diseases	12410	Carpal tunnel syndrome (not traumatic)	For traumatic carpal tunnel syndrome use nerves, traumatic inj. (ex. spinal cord)
	Nervous system diseases	12500	Eye disorders (not traumatic)	Do not use for traumatic injuries
	Circulatory system diseases	13000	Circulatory system diseases, other	
	Circulatory system diseases	13310	Heart attack (myocardial infarction)	
	Circulatory system diseases	13610	Stroke	
	Circulatory system diseases	13710	Raynaud's syndrome, phenomenon: white finger	Use for vibration induced white finger disease
	Respiratory system diseases	14200	Respiratory, diseases of upper tract, other	
	Respiratory system diseases	14220	Respiratory, chronic condition of upper tract	Includes chronic sinusitis, pharyngitis
	Respiratory system diseases	14410	Bronchitis	
	Respiratory system diseases	14420	Emphysema	
	Respiratory system diseases	14440	Extrinsic allergic alveolitis, pneumonitis	
	Respiratory system diseases	14490	Chronic obstructive pulmonary disease, other	
	Respiratory system diseases	14500	Pneumoconioses, other	Includes bauxite fibrosis, graphite fibrosis and stenosis
	Respiratory system diseases	14510	Pneumoconiosis, coal workers'	Includes anthracosis, black lung, miner's asthma

Level 1	Level 2	Code	Nature of injury type–level 3	Usage note
	Respiratory system diseases	14520	Asbestosis	For cancer use cancers, neoplasms, and tumors
	Respiratory system diseases	14530	Silicosis	
	Respiratory system diseases	14900	Respiratory system diseases, other	
	Respiratory system diseases	14991	Reactive airway dysfunction syndrome (R.A.D.S.)	
	Digestive system diseases	15000	Digestive system diseases and disorders, other	
	Digestive system diseases	15390	Hernia, other	Excludes herniated disc
	Genitourinary system disease and disorder	16000	Genitourinary system disease and disorder	
	Disorders: skin and subcutaneous tissue	18200	Dermatitis, other	Classifies inflammation of the skin resulting from contact with allergens or irritant substances
	Disorders: skin and subcutaneous tissue	18900	Skin and subcutaneous tissue, diseases and disorders, other	
	Other systemic diseases and disorders	19000	Systemic diseases and disorders, other	Includes scleroderma
Infectious and parasitic diseases	Infectious and parasitic diseases	29000	Infectious and parasitic diseases	Classifies bacterial, viral, rickettsial, fungal and parasitic infections
Cancers, neoplasms, and tumors	Cancers, neoplasms, and tumors	30000	Cancers, neoplasms, and tumors	
Psychological disorders	Psychological disorders	52000	Psychological disorders or syndromes	
Other	Other	51000	Damage or loss of prosthetic devices	
	Other	99990	Not yet diagnosed	Describe symptoms in diagnosis

A current list of WorkSafeBC injury codes is available on www.worksafebc.com