Billing WorkSafeBC for Physiotherapy Treatment

A guide for physiotherapy providers

How to use this guide

At WorkSafeBC, we rely on physiotherapy providers like you to help injured workers on their path to recovery. We want to make working with us as simple as possible, and that includes helping you navigate the billing process.

This guide explains when you can provide physiotherapy services and how to bill for them under our "fee for services" model, which looks like this:

Initial assessment
One visit and report

→

Treatment period
15 visits or 6 weeks

→

Extension (if needed)
Customized to the clinically appropriate number of visits/weeks

On p. 2 to 4, you'll find flow charts that explain how to:

- Determine if you can provide these three types of services
- Bill for these services

Note: By "physiotherapy services," we mean physiotherapy that focuses on musculoskeletal injuries. **You must hold a contract with us to provide these services and to bill for them.**

What else you'll find in this guide

Overall invoicing guidelines

For a smooth billing process, it's important to follow a few guidelines:

- Bill us within 90 days of the date of service.
- If your invoice is rejected, correct it either within 180 days of the date of service, or within 90 days of the first rejection (provided the service was originally billed within 90 days of the date of service).
- Bill electronically whenever possible.
- Send paper invoices only when the worker does not have a BC Personal Health Number (BC Services Card number).
- Send paper invoices on the Invoice for Treatment Services template, Form 267, available on our website. For assistance with completing this form, contact Payment Services at 604.276.3085.

WorkSafeBC

Initial assessment:
How to navigate and bill for it

Before you begin an assessment: Does the worker have a claim that's either pending or accepted? To find out, check the status of their claim online or call 1.888.967.5377.

No → Don't proceed. If the worker hasn't yet filed a claim, advise them that they must file a claim with WorkSafeBC before you can proceed.

Yes → Is the planned date of the worker's initial assessment within 60 days of their injury or claim-related surgery?

No → Prior to providing an assessment or any treatment, contact the worker's claim owner and ask: Do you approve treatment even though it's >60 days after the date of the injury/approved surgery?

No → Don't proceed.

Yes → You may continue with the initial assessment but may only provide services for the number of visits or weeks remaining in the treatment period (see p. 3).

Yes → Has the worker already begun treatment elsewhere prior to coming to your clinic?

No → Proceed with the initial assessment and accompanying report — either:

a. **Physiotherapy Treatment Initial Report**, or

b. **Post-Surgical Initial Report**

a. **Physiotherapy Treatment Initial Report**

Submit for:

- All non-surgical initial assessments
- Any post-surgical initial assessments >60 days from the date of surgery

OR

b. **Post-Surgical Initial Report**

Submit if:

- Initial assessment occurs within 60 days of the date of surgery
- Injured worker is eligible (see p. 5)

When to report

Submit the initial report:

- After you've successfully contacted the injured worker's employer, **or**
- 7 days after the injured worker's first visit

What's the DOS?

The date of service (DOS) you write on the initial report should be the date of the injured worker's first visit.

Billing date to use

The initial assessment is billed as the date of the injured worker's first visit (the same as the DOS you've written on the initial report).

Treatment period:
How to navigate and bill for it

Before you begin treatment: Is the worker's claim accepted?
To find out, check on the status of their claim online or call 1.888.967.5377.

No

Treatment is only payable on accepted claims. If the claim is pending, await a decision. If it's been denied, don't proceed.

Yes

Have you completed a recent initial assessment for this worker?

No

Follow the steps on p. 2 and complete an initial assessment as allowed.

Yes

Was the worker attending physiotherapy services at another clinic (i.e., in a treatment period) before coming to your clinic?

No

You may proceed with the treatment period.

Yes

Confirm the number of visits or weeks remaining in the treatment period; you may provide these visits.

Contact Health Care Programs for further direction on how to proceed.

How long to treat

A treatment period consist of 15 visits or 6 weeks of treatment, whichever occurs first.

How to bill

Invoice each visit using **fee code 19102**. A maximum of one visit per day may be invoiced per claim.

Transfers

A "transfer" refers to when a worker comes to your clinic after they've already started treatment at another clinic. Learn more in the FAQs on p. 5.

Extensions:
How to navigate and bill for them

If you think a worker needs further treatment, submit an Extension Request Report at least one week prior to the end of the treatment period or current extension.

Before you begin treatment: Has the claim owner approved the requested extension?

Yes

Proceed with the approved number of extension visits up to the new end date.

>1 week before the new end date, determine: Will the worker require further physiotherapy treatment at the end of the current extension?

Yes

Submit a new Extension Request Report at least one week prior to the end of the current extension. (Return to top of this page and repeat process.)

No

Submit a Discharge Report. The date of service on the Discharge Report should be the last visit the worker attended for treatment.

No

If the claim owner has declined the request, don't proceed.

If you haven't yet received an answer, wait for approval before proceeding.

When to request

Only request an extension if it's clinically appropriate to assist the worker in their recovery and/or return to work.

Fee codes to use

Invoice each visit using **fee code 19102**. A maximum of one visit per day may be invoiced per claim.
Invoice the Extension Request Report using **fee code 19103**.

Billing date and DOS

The date of service (DOS) you write on the Extension Request Report **and** the date you record on your invoice should be the date the report was submitted.

Frequently asked questions

Q: How do I determine if a worker is eligible for a post-surgical initial assessment?

A: The following conditions must be met:

- The worker must have undergone surgery (injections and nerve-root blocks are not considered surgeries)
- The surgery must be claim related and approved by the claim owner
- The worker must be starting or restarting physiotherapy within 60 days of the date of the surgery*

* If the initial visit occurs more than 60 days after the date of surgery, get claim owner approval for the assessment before proceeding. If physiotherapy is approved by the claim owner, assess the worker and submit a Physiotherapy Treatment Initial Report (not a Post-Surgical Initial Report).

Q: How should I bill for a worker who transfers to our clinic after attending treatment at another physiotherapy clinic or a rehabilitation program (occupational rehabilitation, hand therapy, etc.)?

A: If it's within 60 days of the date of injury or surgery, complete an initial assessment (see p. 2). Following the assessment, you may provide the remaining visits or weeks available in the physiotherapy treatment period. If necessary, contact Health Care Programs to confirm the number of visits or weeks remaining in the treatment period: 604.232.7787 (press 2 to speak to reception).

If it's been more than 60 days since the date of injury or surgery, request approval from the claim owner to complete an initial assessment. If the claim owner approves the request, you may conduct an initial assessment and proceed with the physiotherapy treatment period, unless directed otherwise by the claim owner.

Q: When does a treatment period begin?

A: The treatment period begins with the first treatment visit, which is the next visit following the assessment visit.

Q: What should I do if the worker misses treatment time due to an illness or pre-planned absence (e.g., vacation or shift work)?

A: If the worker will be absent for more than one week for any reason, tell the claim owner immediately by phone or, if permitted, by email.

If the absence is likely to be longer than three weeks, discuss with the claim owner whether continuing treatment afterward is clinically appropriate. If it is, get approval from the claim owner for a program interrupt. Submit an Interrupt Report and update the treatment end date, if appropriate, to complete the remaining treatment visits.

Frequently asked questions (continued)

Q: What should I do if I find out a worker has a WorkSafeBC claim after I've already begun treatment?

A: If you learn a worker has a WorkSafeBC claim within 90 days of when they began treatment with you, backdate reports and billings to the start date of their treatment at your clinic.

For help accurately backdating reports, contact Health Care Programs at 604.232.7787.

If you learn a worker has a WorkSafeBC claim more than 90 days after they began treatment with you, the worker can submit their receipts to WorkSafeBC for direct reimbursement. If treatment is ongoing when you find out, begin billing and reporting to WorkSafeBC as of the worker's next visit.*

*First, check with the claim owner that ongoing physiotherapy treatment is approved, and then contact Health Care Programs for help with billing.

Dates on invoices: A cheat sheet

Common reports	Date to use when invoicing (and as date of service on report)
Physiotherapy Treatment Initial Report or Post-Surgical Initial Report	Date of worker's first visit
Extension Request Report	Date you submit the report* *Report must be submitted before the end of the current treatment period or extension
Interrupt Report	Date of worker's last treatment visit (before their absence)
Discharge Report	Date of worker's final treatment visit

Other types of physiotherapy we may cover

Hydrotherapy (can only be provided under contract)

If clinically appropriate, you may provide up to six hydrotherapy visits per claim, although the claim owner can approve fewer units. Up to four workers per physical therapist or physical therapist delegate are allowed per session.

If a worker is attending your clinic for physiotherapy services and hydrotherapy and additional hydrotherapy visits are warranted **during the physiotherapy treatment period**, contact the claim owner by phone or, if permitted, by email to discuss the rationale and the number of additional visits requested for the remainder of the physiotherapy treatment period.

If the worker is attending your clinic for physiotherapy services and hydrotherapy and additional hydrotherapy visits are warranted **to accompany an extension**, request approval by completing the hydrotherapy section, in addition to the other sections, when submitting your Extension Request Report. Outline the clinical rationale for additional hydrotherapy in the report.

If the worker is **attending your clinic for hydrotherapy services only** and additional hydrotherapy visits are warranted, contact the claim owner by phone or, if permitted, by email to get approval for the visits and, if requested by the claim owner, submit a Requested Report to support the extension.

Vestibular, neurological, and home physiotherapy (don't require a contract with us)

Sometimes injured workers require physiotherapy that's not strictly focused on musculoskeletal injuries.

Click the links below to learn when these therapies may be provided and how to bill for them.

Therapy type	How to bill	Important to know
Vestibular physiotherapy	See the fee schedule	You need approval from the claim owner prior to a vestibular assessment or treatment.
Neurological physiotherapy	See the fee schedule	You need approval from the claim owner prior to a neurological assessment or treatment. Neurological physiotherapy and physiotherapy clinic visits (contracted physiotherapy services) can't occur concurrently.
Home physiotherapy	See the fee schedule	Home physiotherapy and physiotherapy clinic visits (contracted physiotherapy services) can't occur concurrently.

Tips for other types of billing

Billing for telephone consultations

Bill the **telephone consultation fee code (19204)** only when you've communicated meaningful details about a worker's treatment, return-to-work plans, or other related issues with the worker's health care provider, a claim owner or medical advisor, or the worker's employer (outside of the initial assessment). Bill for the date of the phone call and keep a record of this communication.

Please don't bill us for routine, administrative, or quality assurance issues.

Billing for clinical records

When you're asked to provide a copy of a worker's clinical chart notes, ensure the chart notes are:

- Legible
- Provided within two business days of the date of the request
- Billed for the date of the request, **not** the date the chart notes were sent to WorkSafeBC

Billing for supplies/equipment

All durable medical supplies, durable equipment, braces, and splints must be approved by the claim owner **prior** to billing.

Please note you can't charge WorkSafeBC, nor the worker, for basic clinic supplies or non-durable medical supplies such as TheraBands, tape, gel, electrotherapy pads, ice packs, and hot packs.

You can get the appropriate fee codes for supplies/equipment from Payment Services upon approval of the item(s).

Note: Please discuss equipment requests with the claim owner prior to discussing with the worker to better manage expectations around approvals.

How to fix rejected invoices

Invoice rejections indicate an error was made in the way that the service was billed. Depending on the rejection code, you may be able to determine what the error is.

If you're unable to determine the error in the billing based on the rejection code you receive, please follow the steps below.

1. Confirm the **basic information** for the service billed:

- Worker's personal, claim, and injury information/codes
- Clinic's information

2. Confirm **approval** of the services billed (by referring to chart/file notes):

- Is the claim accepted?
- Did the claim owner provide pre-approval of this service?
- If extenuating circumstances were at play, did Health Care Programs provide pre-approval of the billing(s)?

3. Confirm the **billing information** for the service billed:

- Is the fee code correct?
- Is the date of service correct? If applicable, check the corresponding report for the date of service to be sure. (You should be billing for the date of service on the report, not the date you sent us the report.)
- If there is a corresponding report, was it successfully submitted to WorkSafeBC?

4. Confirm the **payee number** is correct:

- Is the MSP payee number that is being used to invoice the same payee number as on Schedule C of your contract?
- If your contract has recently started, ensure the date of service billed is after the effective start date of your contract.

5. Still encountering a rejection code? Call **Payment Services** at 604.276.3085 for assistance.

Contact us

Claims Call Centre

Call the Claims Call Centre for:

- Claim status
- Basic claim information (e.g., date of injury, injury codes)
- Claim owner contact information

604.231.8888

Toll free: 1.888.967.5377

Payment Services

Call Payment Services for:

- Help with invoicing
- Help with billing rejections
- Help understanding invoice correction letters

604.276.3085

Health Care Programs

Call Health Care Programs for:

- Help understanding the Physiotherapy Services contract and fee schedules
- Clinical questions
- Quality assurance issues

604.232.7787

Claim owner

Contact claim owner for:

- Treatment approval
- Discussing client's condition and progress
- Discussing return-to-work plans and recommendations
- Notification of program interrupt (≤3 weeks), or approval for an extended program interrupt (>3 weeks)

Additional resources

- WorkSafeBC physiotherapists provider information page
- Physiotherapy Services Agreement
- Physiotherapy Services Reference Manual
- Physiotherapy Services Agreement fee schedule
- Online claim status checker