

FEE SCHEDULE

Physician

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Description of Reports

This section provides a list of reports that may be requested by the WSIB, and a brief description of each report.

CANNABIS INITIAL ASSESSMENT FORM (FORM 0210A)

A cannabis initial assessment form is requested by the WSIB when clinical information is required regarding the initial request for coverage of medical cannabis.

FOLLOW-UP CANNABIS ASSESSMENT FORM (FORM 0211A)

A follow-up cannabis assessment form is requested by the WSIB when clinical information is required regarding the continued coverage of medical cannabis.

Note Form 8:

1. The Form 8 can also be completed when the worker reports a recurrence of a previous work-related injury/illness.
2. Provide a copy of page 2 only to the worker to give to the employer

COMPLEX REPORT

A Complex Report is requested when a worker has been treated for a substantial period of time with different treatment modalities (including several surgical procedures) without resolution. WSIB staff will pose, in writing, a number of detailed questions for you to respond in narrative form and submit on your letterhead.

CONSULTATION REPORT

Only bill for a Consultation Report in conjunction with a consultation visit as defined in the General Preamble of the Ministry of Health and Long Term Care Schedule of Benefits for Physician Services. Consultation reports will be requested by the WSIB, or submitted in situations where you believe the injury/illness is work-related. These reports may be written in narrative form and submitted on your letterhead.

HEALTH PROFESSIONAL'S REPORT (FORM 8)

In all cases, complete and submit a Form 8 following the initial visit where a worker has been treated for a workplace injury/illness. Submit only one Form 8 for each worker. This report must not be used as a progress report.

HEALTH PROFESSIONAL'S REPORT FOR OCCUPATIONAL MENTAL STRESS (FORM CMS8)

For occupational mental stress conditions (e.g., chronic mental stress) complete and submit a Form CMS8 following the initial visit. Submit only one Form CMS8 for each worker. This report must not be used as a progress report.

HOSPITAL EMERGENCY DEPARTMENT CONSULTATION REPORT

Only bill for a hospital emergency department consultation report, in conjunction with an emergency room physician consultation visit. This is defined in the General Preamble of the Ministry of Health and Long Term Care Schedule of Benefits. Complete and submit a report covering the details of an emergency room physician consultation done in the Hospital Emergency Department if the injury/illness is considered to be work-related. Include in the consultation report only information pertaining to the work-related injury/illness.

OPERATIVE REPORT

An operative report will be specifically requested by the WSIB, or may be submitted whenever the surgeon believes that the surgical procedure was performed for a work-related injury or illness.

PYHICIAN'S DRUG UTILIZATION REPORT

A drug utilization report is requested by the WSIB when information is required about a worker's medication, including dosage, strength and duration. The prescribing physician should provide the medical information in narrative form.

PYHICIAN'S COMPLEX DRUG UTILIZATION REPORT

A complex drug utilization report is requested when information concerning medical indications for a prescription drug and therapeutic benefit is required. The prescribing physician should provide the medical information in narrative form.

OPIOID ASSESSMENT FORM

An Opioid Assessment Form is requested by WSIB when information is required regarding the medical indications and the therapeutic benefit associated with prescription opioid drug(s).

PYHICIAN'S ORTHOTIC REPORT

The WSIB may request information on the continued use of an orthotic device. The prescribing physician should provide medical information regarding the ongoing need, therapeutic benefit, and appropriate use of the device. An orthotic report may be written in narrative form and submitted on a physician's letterhead.

PROGRESS REPORT (FORM 26)

The WSIB sends this form to the worker when a progress report is required. When a worker provides this form, complete it and submit it to the WSIB.

Note:

1. A previously completed Progress Report (Form 26) must not be altered or reused as a new report.
2. If you fax your report to the WSIB, DO NOT SEND THE ORIGINAL REPORT.

NARRATIVE REPORT

A progress report may be submitted on letterhead when you become aware of new or significant clinical information relevant to a workplace injury/illness.

PYHICIAN'S REPORT - HOME OXYGEN THERAPY (FORM 0389A)

The WSIB sends this form to the worker when home oxygen therapy is prescribed. Complete the Form 0389A and return it to the WSIB. This form is required to determine the initial and ongoing entitlement to home oxygen therapy.

PYHICIAN'S REPORT ON OCCUPATIONAL DISEASE - 8D (FORM 0307A)

The WSIB sends this form to the worker when the worker reports a work-related occupational illness. Complete this form and return it to the WSIB.

PYHICIAN'S REPORT ON OCCUPATIONAL CHEST DISEASE - 8S (FORM 0407A)

The WSIB sends this form to the worker when the worker reports a work-related occupational chest illness. Complete this form and return it to the WSIB.

REPORT OF DEATH

The WSIB will request a report of death when the worker has died as a result of a work-related injury/illness.

PHYSICIAN'S REPORT ON SKIN DISEASE - 8D2 (FORM 0353A)

The WSIB sends this form to the worker when the worker reports a work-related skin condition. Complete this form and return it to the WSIB.

REVIEW OF MEDICAL RECORDS/MEDICAL LITERATURE

WSIB staff may request a review of medical records/medical literature. This request will involve the review of a worker's records and preparation of a response to specific questions. The request may involve a review of medical literature relevant to the worker's case. This review will usually only be requested where there is no concurrent clinical assessment of the worker.

PHYSICIAN'S SPECIAL REPORT (FORM 0043A)

The WSIB sends this form to the worker when the worker is to be rated for a permanent disability, and his/her accident precedes January 1, 1990. Complete this form and return it to the WSIB.

PHYSICIAN'S REPORT VIBRATION INDUCED WHITE FINGER DISEASE - 8W (FORM 0425A)

The WSIB sends this form to the worker when the worker reports a work-related vibration induced white finger illness. Complete this form and return it to the WSIB.

X-RAY REPORT

An x-ray report covering several radiological examinations is considered by the WSIB to be one report. X-ray reports should only be submitted when specifically requested by the WSIB.

Note:

On the worker's initial visit, ONLY the Form 8 will be paid. A Functional Abilities Form (FAF) will not be paid if completed on the same date.

PHOTOCOPIES

A fee may be billed when the WSIB specifically requests copies of a worker's medical records. A fee may also be billed when the WSIB asks for additional copies of reports that have already been submitted. Only submit copies of your own medical records.

The WSIB will request the necessary reports from other physician(s) involved in the case.

IN-OFFICE INTERVIEW

A WSIB representative may request an appointment with you to discuss a worker's work-related injury/illness.

The following report may be requested by the worker's employer or the worker:

FUNCTIONAL ABILITIES FORM FOR PLANNING EARLY AND SAFE RETURN TO WORK (FORM 2647A)

The Functional Abilities Form for Planning Early and Safe Return to Work may help workers and employers achieve early and safe return to work by highlighting what a worker can do after a workplace injury/illness and the limitations that would apply. Complete this form when requested to do so by the employer or worker; you cannot initiate completion of this form. Do not include medical or diagnostic information.

ACUPUNCTURE GUIDELINES

The WSIB may allow a trial period of acupuncture for up to 6 treatments. Requests for an extension of treatment must be made in advance, in writing, and pre-approved by the WSIB.

Reports

| SERVICE CODE | DESCRIPTION | FEE |
|--------------|---|-------------------|
| 8M | Health Professional's Report (paper submission) | \$65.00 |
| 8ME | Health Professional's Report (electronic submission) | \$85.00 |
| CMS8 | Health Professional's Report for Occupational Mental Stress (paper submission) | \$85.00 |
| 26M | Health Professional's Progress Report (paper submission) | \$45.00 |
| 26ME | Health Professional's Progress Report (electronic submission) | \$60.00 |
| 26 | Narrative Progress Report | \$23.54 |
| M630 | Cannabis Initial Assessment Form | \$85.00 |
| M631 | Follow-up Cannabis Assessment Form | \$65.00 |
| M639 | Opioid Assessment Form | \$65.00 |
| M641 | Hospital Emergency Department Consultation Report | \$47.09 |
| M642 | X-ray report | \$23.54 |
| M644 | Operative Report | \$23.54 |
| M645 | In-office interview with WSIB representative | \$29.15 |
| M647 | Consultation Report | \$47.09 |
| M648 | Medical Clearance for Functional Abilities Evaluation (FAE) (Form 0298A) | \$23.54 |
| M649 | Complex Report | \$112.10 |
| M650 | Photocopies of Medical Report (1 to 5 pages) Each additional page | \$23.54 \$1.12 |
| M651 | Review of medical records/medical literature (per 15 minute unit) - or major part thereof | \$56.05 |
| M652 | Physician's Report of Death | \$23.54 |
| M653 | Physician's Special Report | \$23.54 |
| M654 | Physician's Report on Occupational Disease 8D | \$23.54 |
| M655 | Physician's Report on Skin Disease 8D2 | \$23.54 |
| M656 | Physician's Report - Occupational Chest Disease 8S | \$23.54 |
| M657 | Physician's Report - Vibration Induced White Finger Disease 8W | \$23.54 |
| M658 | Physician's Drug Utilization Report | \$23.54 |
| M659 | Physician's Report - Home Oxygen Therapy | \$39.53 |
| M758 | Physician's Complex Drug Utilization Report | \$56.05 |
| M890 | Physician's Orthotic Report | \$23.54 |
| FAF | Functional Abilities Form for Planning Early and Safe Return to Work (FAF) | \$45.00 |

Note:

New Service Code for FAF

Note:

A bill is not required for telephone consultations

Telephone Consultations

| | | |
|---------------|---|---------|
| WSIB use only | A telephone consultation fee is paid automatically when the call is initiated by WSIB staff and/or treating health care partners (e.g. Regional Evaluation Centres, Medical Consultants, and Low Back Expert Examiners) | \$75.00 |
|---------------|---|---------|

Acupuncture

| | | |
|------|-----------------------------|---------|
| 5130 | Acupuncture (per treatment) | \$43.34 |
|------|-----------------------------|---------|

CANCELLED/MISSED APPOINTMENTS

The WSIB does not pay for cancelled or missed appointments.

BILLING OF FEES

As stated in Section 33 (5) of the Workplace Safety and Insurance Act, "No health care practitioner shall request a worker to pay for health care or any related service provided under the insurance plan."

LATE ACCOUNTS

Under Section 33 (4) of the Workplace Safety and Insurance Act, the WSIB may impose a percentage reduction penalty for late submissions of accounts. Accounts received after the 6th month from the date of service may be reduced as follows:

- 7th - 9th month → reduced by 25%
- 10th - 12th month → reduced by 50%
- over 1 year → reduced by 100%

The WSIB may waive the late penalty charge if an acceptable reason is provided for the delay.

Billing Instructions & Illustrations

BILLING ON A WSIB FORM

Most WSIB forms have a billing section located at the bottom of the form. For prompt payment, complete according to the following instructions:

The following service codes will automatically be billed when you complete the billing section of the following WSIB forms:

| | | |
|----------|---|---|
| 8M/8ME | Health Professional's Report | Note: <i>If the WSIB requests photocopies of a Form 8 or Form 26, place a payment label over the billing section on these forms, or cross out the fee code and enter photocopy fee code M650. If this is not done, the Form 8 or Form 26 may be flagged as a duplicate report and payment may be rejected</i> |
| CMS8 | Health Professional's Report for Occupational Mental Stress | |
| 26M/26ME | Progress Report (Form 26) | |
| M652 | Report of Death | |
| M653 | Special Report (Form 0043A) | |
| M654 | Report on Occupational Disease - 8D (Form 0307A) | |
| M655 | Report on Skin Disease - 8D2 (Form 0353A) | |
| M656 | Report - Occupational Chest Disease - 8S (Form 0407A) | |
| M657 | Report - Vibration Induced White Finger Disease - 8W (Form 0425A) | |
| M659 | Report - Home Oxygen Therapy (Form 0389A) | |
| FAF | Functional Abilities Form for Planning Early and Safe Return to Work (Form 2647A) | |

BILLING ON A WSIB MEDICAL REPORT

| Your HST Registration number | Amount of HST | Your 9 digit-billing number assigned by the WSIB | |
|---|--|--|------------|
| Health Professional Designation <input type="checkbox"/> Chiropractor <input type="checkbox"/> Physician <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Registered Nurse (Extended Class) | | Service Code WSIB Provider ID 8M | |
| HST Registration No. | HST Amount Billed (if applicable) \$ | Service Date | dd mm yyyy |
| Health Professional Name (please print) | Address | Date on which the worker was assessed | |
| Telephone | Fax | Your invoice number (maximum 11 characters alpha or numeric) | |

INSTRUCTIONS

- Include your WSIB Provider Billing Number. This is a mandatory field. Payment of your report cannot be processed without your WSIB Provider Billing Number.
- Specify the date the worker was assessed as the Service Date. This is a mandatory field.
- Include, as an option, your Own Invoice Number.
- Ensure that your name, address, and telephone number are legible and that all reports are signed.

BILLING ON A PAYMENT LABEL (FORM 0150C)

For prompt payment, complete as follows:

The following service codes may be billed with a payment label:

- M641 Hospital Emergency Department Consultation
 - M642 X-ray Report (when specifically requested by WSIB)
 - 26 Progress Narrative Report (when the report is submitted on letterhead)
 - M644 Operative Report
 - M647 Consultation Report
 - M649 Complex Report
 - M650 Photocopies
 - M651 Review of Medical Records/Literature
- Note:** If billing more than 15 minutes, indicate units of time or the total amount being billed.
- M658 Drug Utilization Report
 - M758 Complex Drug Utilization Report
 - M890 Orthotic Report

The diagram illustrates the layout of Form 0150C. At the top, there are two input fields: 'Your 9 digit-billing number assigned by the WSIB' and 'Worker's claim number (if available)'. Below these is the 'wsib cspaat ONTARIO' logo. To the right of the logo is a field for 'Enter number of units or copies'. The main body of the form is a grid with the following structure:

| | |
|--|---------------------------------------|
| WSIB Provider ID/N° de fournisseur à la CSPAT | Claim No./Dossier n° |
| Your Own Invoice No./Votre n° de facture | |
| Service Date/Date du service d/j m/m y/a | Fee Code/Code d'honoraires |
| Number of units or copies/Nombre d'unités ou de copies | |
| ▼ Complete these fields if HST is applicable to this service/ ▼ Remplir ces champs si la TVH s'applique à ce service. | |
| HST Registration No./N° d'inscription à la TVH 0150C (06/10) | Service Code/Code de service ONHST |
| HST Amount Billed/Montant de TVH facturé \$ | |

Arrows point from various input fields to specific parts of the form:

- 'Your own invoice number (maximum 11 characters alpha or numeric)' points to the 'Your Own Invoice No./Votre n° de facture' field.
- 'Your HST registration number' points to the 'HST Registration No./N° d'inscription à la TVH' field.
- 'Date on which the worker was assessed' points to the 'Service Date/Date du service' field.
- 'Fee code for report being billed' points to the 'Fee Code/Code de service' field.
- 'Amount of HST' points to the '\$' field.

INSTRUCTIONS

- Place a self-adhesive payment label on your letterhead.
- Affix only one completed payment label to the bottom right-hand corner of the first page of photocopies or on a multiple page report submitted on letterhead and operative reports.
- Include your WSIB Provider Billing Number. This is a mandatory field. Payment of your report cannot be processed without your WSIB Provider Billing Number.
- Specify the date the worker was assessed as the Service Date. This is a mandatory field.
- Include the worker's Health Number assigned by the Ministry of Health (MOH), if the information is available.
- Include, as an option, your Own Invoice Number.
- Enter appropriate service code.
- Ensure that your name, address, and telephone number are legible and that all reports are signed.

Note:

1. Do not affix a second label to a multiple page report.
2. Do not cover pertinent information on the report with the payment label.

Provider Payment Request Form (3947A)

For prompt payment, complete as per instructions on next page.

Mail to:

200 Front Street West
Toronto ON M5V 3J1

or Fax to:

416-344-4684
OR 1-888-313-7373

Provider Payment Request

Important: Do not use this form to bill for clinical reports.

**Please complete in full
using black ink.**

Claim No.

Worker Information

| | | | |
|----------------|---------------|-------------|---|
| Worker Surname | Given Name(s) | Initial | Worker's Impairment and/or ICD 9 Code (if available) |
| Address | | | Date of Incident (mm/dd/yy) |
| City | Prov. | Postal Code | Date of Birth (mm/dd/yy) |

Provider/Facility Name and Full Address (city, province, postal code)

**WSIB Reference No.
(For WSIB use only)**

Provider Information:

WSIB Provider ID

HST Registration Number

Your Invoice No.

Treating Provider's Name (please print)

Telephone

Please complete the address above this line.

Service/Treatment Information

Please use a separate line for each service code. Do not include previously billed services.

1.

| Service Code | | Description of Service/Treatment | | | | | | | | | | | | | | | | | | | | Fee per Service | No. of Serv/Trt. | Amount Billed | | | | | | | | | |
|--------------|------|----------------------------------|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|-----------------|------------------|---------------|----|----|----|----|----|----|----|----|--|
| Month | Year | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | |
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2.

| Service Code | | Description of Service/Treatment | | | | | | | | | | | | | | | | | | | | Fee per Service | No. of Serv/Trt. | Amount Billed | | | | | | | | | |
|--------------|------|----------------------------------|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|-----------------|------------------|---------------|----|----|----|----|----|----|----|----|--|
| Month | Year | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | |
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3.

| Service Code | | Description of Service/Treatment | | | | | | | | | | | | | | | | | | | | Fee per Service | No. of Serv/Trt. | Amount Billed | | | | | | | | | |
|--------------|------|----------------------------------|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|-----------------|------------------|---------------|----|----|----|----|----|----|----|----|--|
| Month | Year | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | |
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4.

| Service Code | | Description of Service/Treatment | | | | | | | | | | | | | | | | | | | | Fee per Service | No. of Serv/Trt. | Amount Billed | | | | | | | | | |
|--------------|------|----------------------------------|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|-----------------|------------------|---------------|----|----|----|----|----|----|----|----|--|
| Month | Year | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | |
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**Total
Billed**

(1 + 2 + 3 + 4 = Total)

It is an offence to deliberately make false statements to the Workplace Safety and Insurance Board. I hereby certify that the information being submitted is true, correct and complete.

| | | |
|---|------------|------------------|
| <p>Being submitted is true, correct and complete.</p> | | |
| Name (please print): | Signature: | Date (mm/dd/yy): |

Provider Payment Request Form (3947A)

INSTRUCTIONS

For prompt payment, complete as follows:

WORKER INFORMATION

1. Claim Number: enter WSIB claim number; this is necessary to process the payment.
2. Name: print surname, given name(s), and middle initial.
3. Worker's Impairment and/or ICD 9 Code: enter diagnosis or ICD 9 code for which treatment is being provided.
4. Date of Accident: enter reported date of accident.
5. Address: enter current mailing address.
6. Date of Birth: enter birth date.
7. WSIB Reference No.: please do not complete. For WSIB use only.

PROVIDER INFORMATION

8. Provider/Facility Name and Full Address: enter name and full address of the provider/facility submitting the bill.
9. WSIB Provider ID: enter your invoice number. (Your reference no. for reconciliation purposes.)
10. Your Own Invoice No.: enter your invoice number. (Your reference no. for reconciliation purposes.)
11. Treating Provider's Name: enter the name of the individual providing the service.
12. Treating Provider's ID No.: this is the individual health professional's number that WSIB assigns to you.
13. Telephone Number: provide the telephone number of the individual completing the payment request form.

SERVICE/TREATMENT INFORMATION

14. Service Code: enter appropriate service code. Refer to the WSIB Fee Schedule.
15. Description of Service/Treatment: provide a brief description of service or type of treatment provided.
16. Fee per Service: enter fee per treatment or service from the WSIB Fee Schedule.
17. No. of Serv./Trt.: enter the number of services/treatments that you are billing.
18. Amount Billed: enter the total amount for the one service code.
19. Service Date: enter month and year. Select date(s) of service by (n). For multiple months, use a separate line.
20. Total Billed: enter the total sum of fees billed.
21. Name: enter the name of the individual completing the form.
22. Signature and Date: include the signature of the individual completing the payment request form, and date, when form is completed.

For electronic billing, contact the Telus Health Solutions, Support Centre at 1-866-240-7492 or via e-mail at provider.registry@telus.com.

Contacting the WSIB

WSIB MAILING ADDRESS

Health Care Practitioners across Ontario have one central location to mail their reports and billing forms.

THE WSIB MAILING ADDRESS IS:

Workplace Safety and Insurance Board
200 Front St. West, 15th Floor
Toronto ON M5V 3J1

FAXING REPORTS

If you fax your report to the WSIB, DO NOT mail the original report as well.

The fax number is: 416-344-4684

Toll-free: 1-888-313-7373

HEALTH CARE PAYMENT INQUIRIES

For questions regarding accounts and/or remittance statements please call 1-800-387-0750.

HEALTH PROFESSIONAL ACCESS LINE

Call the Health Professional Access Line at 416-344-4526 or toll free at 1-800-569-7919 if you have questions related to:

- Registration and changes to your mailing information
- Billing the WSIB (e.g. appropriate forms, Provider ID)
- WSIB Health care programs (e.g. Occupational Health Assessment Program (OHAP) and Specialty Clinics)
- The name/number of the worker's Case Manager/Nurse Consultant

Visit the WSIB website for more information at wsib.ca.