Amendment Agreement made effective April 1, 2024 ("Amendment Agreement Effective Date")

BETWEEN:

ASSOCIATION OF DOCTORS OF BC
115 – 1665 West Broadway
Vancouver, BC V6J 5A4

("Doctors of BC")

AND:

WORKERS' COMPENSATION BOARD
6951 Westminster Highway
Richmond, BC V7C 1C6

("WorkSafeBC")

WHEREAS:

A. WorkSafeBC and the Doctors of BC entered into a Physician and Surgeons' Services Agreement made effective April 1, 2022 (the "Agreement");

B. The parties now wish to set forth their agreement to amend the rates in Schedule B, Schedule C and Schedule D.

In consideration of the mutual agreements set out herein and other good and valuable consideration, the parties agree as follows:

1. The parties agree that Schedule B attached to the Agreement is deleted and the Schedule B attached to this Amendment Agreement is substituted therefor.
2. The parties agree that Schedule C attached to the Agreement is deleted and the Schedule C attached to this Amendment Agreement is substituted therefor.
3. The parties agree that Schedule D attached to the Agreement is deleted and the Schedule D attached to this Amendment Agreement is substituted therefor.
4. Except as provided in this Amendment Agreement, all capitalized terms used in this Amendment Agreement that are not otherwise defined shall have the respective meanings ascribed in the Agreement.
5. If any provision of this Amendment Agreement is for any reason held to be unenforceable or invalid, that provision shall be considered separate and severable from this Amendment Agreement, and the other provisions of this Amendment Agreement shall remain in force and effect and continue to be binding upon the parties as though the unenforceable or invalid provision had never been included in this Amendment Agreement.
6. This Amendment Agreement constitutes the entire agreement between WorkSafeBC and the Doctors of BC with respect to its subject matter and supersedes all previous communications, representations, understandings, and agreements whether verbal or written between the parties with respect to the subject matter of this Amendment Agreement.

7. The parties agree that nothing in this Amendment Agreement amends or modifies the Agreement, including the Schedules thereto, all of which remain in full force and effect except as otherwise expressly stated herein.
8. This Amendment Agreement may be entered into by each party signing a separate copy of this Amendment Agreement (including a faxed or an electronic PDF copy), each of which shall be deemed to be an original and together constitute one and the same agreement. Delivering the signed Amendment Agreement to the other party by fax or email shall be effective delivery.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment Agreement as of the date first written above.

ASSOCIATION OF THE DOCTORS OF BC by its authorized signatory:

DocuSigned by:
Dr. Ahmer Karimuddin
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Name of Authorized Signatory:
Dr. Ahmer Karimuddin
Title: President

WORKERS' COMPENSATION BOARD by its authorized signatory:

DocuSigned by:
Tara Mudray
1BA2BF62170C4A6...

Name of Authorized Signatory: Tara Mudray
Title: Director of Procurement Services

SCHEDULE B
WORKSAFEBC UNIQUE FEE FOR SERVICE ITEMS: FORM FEES, PHYSICIAN SERVICES FEES, AND EXPEDITED CONSULTATION FEES BY SPECIALISTS AND PHYSICIANS WITH AREAS OF EXPERTISE

1.0 FORM FEES

Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Effective April 1, 2022	Effective April 1, 2023 (unless otherwise stated)	Effective April 1, 2024

19937	Form 8 - First Report of Injury (Electronically)	• Payable when a Form 8 is received Electronically by WorkSafeBC within one business day of the date of service, where the date of service is the date of the assessment and is considered day 0.
		• Payment for a Form 8 will only be made as follows:
		  ○ for the first Form 8 received by WorkSafeBC submitted by any Physician, and;
		  ○ for a Form 8 that is subsequently submitted Electronically by the Injured Worker's regular Physician if it is received by WorkSafeBC within 10 business days from the date on which the first Form 8 was received by WorkSafeBC.
		• A Physician may only submit one Form 8 per claim.
		• Any subsequent Form 8 will be paid at a Form 11 rate.
		• Billable in addition to an office visit.
			$67.40	$72.42	$74.97

		• Payable when a Form 8 is received Electronically by WorkSafeBC within two business days of the date of service, where the date of service is the date of the assessment and is considered day 0. • Payment for a Form 8 will only be made as follows: ○ for the first Form 8 received by WorkSafeBC submitted by any Physician, and;	N/A	$67.89	$70.28

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		○ for a Form 8 that is subsequently submitted Electronically by the Injured Worker's regular Physician if it is received by WorkSafeBC within 10 business days from the date on which the first Form 8 was received by WorkSafeBC. • A Physician may only submit one Form 8 per claim. • Any subsequent Form 8 will be paid at a Form 11 rate. • Billable in addition to an office visit.			
		• Payable when a Form 8 is received Electronically by WorkSafeBC within three business days of the date of service, where the date of service is the date of the assessment and is considered day 0. • Payment for a Form 8 will only be made as follows: ○ for the first Form 8 received by WorkSafeBC submitted by any Physician, and; ○ for a Form 8 that is subsequently submitted Electronically by the Injured Worker's regular Physician if it is received by WorkSafeBC within 10 business days from the date on which the first Form 8 was received by WorkSafeBC. • A Physician may only submit one Form 8 per claim. • Any subsequent Form 8 will be paid at a Form 11 rate. • Billable in addition to an office visit.	$59.02	$63.41	$65.64

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		• Payable when a Form 8 is received Electronically by WorkSafeBC within four to six business days of the date of service, where the date of service is the date of the assessment and is considered day 0.
		• Payment for a Form 8 will only be made as follows:
		  • for the first Form 8 received by WorkSafeBC submitted by any Physician, and;
		  • for a Form 8 that is subsequently submitted Electronically by the Injured Worker's regular Physician if it is received by WorkSafeBC within 10 business days from the date on which the first Form 8 was received by WorkSafeBC.
		• A Physician may only submit one Form 8 per claim.
		• Any subsequent Form 8 will be paid at a Form 11 rate.
		• If a Form 8 is received seven business days or later following the date of service, the fee paid is $0.
		• Billable in addition to an office visit.
			$41.65	$44.75	$46.33

19900	Form 8 - First Report of Injury (fax transmission)	• Payable when a Form 8 is received by fax by WorkSafeBC within three business days of the date of service, where the date of service is the date of the assessment and is considered day 0. • A Physician may only submit one Form 8 per claim. • Any subsequent Form 8 will be paid at a Form 11 rate.	$38.95	$41.85	$43.33

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		• Billable in addition to an office visit.			
		• Payable when a Form 8 is received by fax by WorkSafeBC within four to six business days of the date of service, where the date of service is the date of the assessment and is considered day 0. • A Physician may only submit one Form 8 per claim. • Any subsequent Form 8 will be paid at a Form 11 rate. • If Form 8 is received seven business days or later following the date of service, the fee paid is $0. • Billable in addition to an office visit.	$25.96	$27.90	$28.89
19927	Form 8 – First Report of Injury requested by WorkSafeBC	• Payable when a Form 8 is requested by WorkSafeBC where the form is not initially required (See Form 8 rules) and is received within 10 business days of the faxed or telephone request where the date of the request is considered day 0. • Submissions received after 10 business days of the request will not be paid. • Fee code 19904 may not be billed in addition to fee code 19927 as fee code 19904 includes copying of an existing report from an Injured Workers' file.	$59.01	$63.41	$65.64

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Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Effective April 1, 2022	Effective April 1, 2023 (unless otherwise stated)	Effective April 1, 2024
19940	Form 11 - Progress Report (Electronically)	• Payable when a Form 11 is received by Electronically by WorkSafeBC within three business days of the date of service, where the date of service is the date of the assessment and is considered day 0. • Billable in addition to an office visit.	$48.13	$51.71	$53.54
		• Payable when a Form 11 is received Electronically by WorkSafeBC within four to six business days of the date of service, where the date of service is the date of the assessment and is considered day 0. • If a Form 11 is received seven business days or later following the date of service, the fee paid is $0. • Billable in addition to an office visit.	$21.85	$23.48	$24.30
19902	Form 11 - Progress Report (fax transmission)	• Payable when a Form 11 is submitted by fax transmission and received by WorkSafeBC within three business days of the date of service, where the date of service is the date of the assessment and is considered day 0. • Billable in addition to an office visit.	$35.06	$37.67	$39.00
		• Payable when a Form 11 is submitted by fax transmission and received by WorkSafeBC within four to six business days four to six business days of the date of service, where the date of service is the date of the assessment and is considered day 0. • If a Form 11 is received seven business days or later following the date of service, the fee paid is $0. • Billable in addition to an office visit.	$17.52	$18.82	$19.49

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Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Effective April 1, 2022	Effective April 1, 2023 (unless otherwise stated)	Effective April 1, 2024
19559	Form 11 - Progress Report requested by WorkSafeBC	• Payable when a Form 11 is requested by WorkSafeBC where the form is not initially required (see Form 11 rules) and is received within 10 business days of the faxed or telephone request, where the date of the request is considered day 0. • Submissions received after 10 business days of the request will not be paid. • Fee code 19904 may not be billed in addition to fee code 19559 as fee code 19904 includes copying of an existing report from an Injured Worker's file.	$48.13	$51.71	$53.54
19909	Standardized Assessment Form – received **within** 15 business days	• To be completed by a Physician only when requested by WorkSafeBC or a surgeon. • Service is to be provided for specific assessments upon request, for example for the completion of the Pre-operative Assessment Form (83M1) and the Opioid Extension Form (68D80). • Standard Assessment Fee includes physical examination and completion of the report form. • The Physician shall not complete a Form 11 for the examination when a Standard Assessment Form is requested. • Payable when the Standard Assessment Form is completed and received by WorkSafeBC and/or the surgeon (if applicable) within 15 business days of the request where the date of the request is considered day 0.	$88.88	$95.50	N/A
19910	Standardized Assessment	• To be completed by a Physician only when requested by WorkSafeBC or a surgeon.	$82.96	$89.15	N/A

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Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Effective April 1, 2022	Effective April 1, 2023 (unless otherwise stated)	Effective April 1, 2024
	Form – received **after 15** business days	• Service is to be provided for specific assessments upon request, for example for the completion of the Pre-operative Assessment Form (83M1) and the Opioid Extension Form (68D80). • Standard Assessment Fee includes physical examination and completion of the report form. • The Physician shall not complete a Form 11 for the examination when a Standard Assessment Form is requested. • Payable when the Standard Assessment Form is completed and received by WorkSafeBC and/or the surgeon (if applicable) **after** 15 business days of the request where the date of the request is considered day 0.			
19977	Opioid Extension Form – received **within** 15 business days	• To be completed by a Physician or a Surgeon only when requested by WorkSafeBC. • Service is to be provided for the completion of the Opioid Extension Form (68D80). • Form Fee includes physical examination and completion of the form. • The Physician shall not complete a Form 11 for the examination when an Opioid Extension Form is requested. • Payable when the Opioid Extension Form is completed and received by WorkSafeBC within 15 business days of the request where the date of the request is considered day 0.	N/A	$95.50 (Effective March 1, 2024)	$98.87

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Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Effective April 1, 2022	Effective April 1, 2023 (unless otherwise stated)	Effective April 1, 2024
19977 (same as above)	Opioid Extension Form – received **after** 15 business days	• To be completed by a Physician or a Surgeon only when requested by WorkSafeBC. • Service is to be provided for the completion of the Opioid Extension Form (68D80). • Form Fee includes physical examination and completion of the form. • The Physician shall not complete a Form 11 for the examination when an Opioid Extension Form is requested. • Payable when the Opioid Extension Form is completed and received by WorkSafeBC after 15 business days of the request where the date of the request is considered day 0.	N/A	$89.15	$92.29
19978	Standardized Assessment or Pre-Operative Assessment Form – received **within** 15 business days	• To be completed by a Physician only when requested by WorkSafeBC or a surgeon. • Service is to be provided for specific assessments upon request, including the completion of one of the following forms: ○ Pre-Operative Assessment (Form 83M1) ○ WorkSafeBC Standardized Assessment of Patients with Cervical Pain (Form 10D12) ○ WorkSafeBC Standardized Assessment of Patients with Low Back Pain (Form 10D13) • Form Fee includes physical examination and completion of the report form. • The Physician shall not complete a Form 11 for the examination when a Standard Assessment or Pre-Operative Assessment Form is requested. • Payable when the Form is completed and received by WorkSafeBC and/or the surgeon	N/A	$238.76 (Effective March 1, 2024)	$247.18

Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Effective April 1, 2022	Effective April 1, 2023 (unless otherwise stated)	Effective April 1, 2024
		(if applicable) **after** 15 business days of the request where the date of the request is considered day 0.			
19978 (same as above)	Standardized Assessment or Pre-Operative Assessment Form – received **after** 15 business days	• To be completed by a Physician only when requested by WorkSafeBC or a surgeon. • Service is to be provided for specific assessments upon request, including the completion of one of the following forms: ○ Pre-Operative Assessment (Form 83M1) ○ WorkSafeBC Standardized Assessment of Patients with Cervical Pain (Form 10D12) ○ WorkSafeBC Standardized Assessment of Patients with Low Back Pain (Form 10D13) • Form Fee includes physical examination and completion of the report form. • The Physician shall not complete a Form 11 for the examination when a Standard Assessment or Pre-Operative Assessment Form is requested. • Payable when the Form is completed and received by WorkSafeBC and/or the surgeon (if applicable) **after** 15 business days of the request where the date of the request is considered day 0.	N/A	$222.86 (Effective March 1, 2024)	$230.72

ADDITIONAL PROVISIONS TO FORM FEES:

1. Eligibility for Form 8 Fee (See Schedule A section 6.1.3): WorkSafeBC will reimburse the Physician for a Form 8 First Report of Injury and an office visit for the first visit where the Physician suspects the Injured Worker may be disabled beyond the day of injury or if the claim is for a hernia, back condition, shoulder or knee strain/sprain, occupational disease, or mental disorder. Note: WorkSafeBC will pay the full cost of the office visit, if the injury is compensable and the injury is the primary reason for the office visit and where applicable, a form fee (See Agreement section 7.7).

2. Expedited Consultations Not Eligible (See Schedule A section 6.1.4: A Specialist billing for an Expedited consultation must not bill for a Form 8 First Report of Injury.

3. Electronic and Fax Submission Only (See section 7.6): WorkSafeBC will only compensate Physicians for invoices and forms for Form 8 First Report of Injury and Form 11 Progress Report submitted Electronically (through MSP Teleplan) or by fax transmission. WorkSafeBC will not compensate Physicians that submit invoices or forms for Form 8 First Report of Injury and Form 11 Progress Report by mail.

4. Form 8 and Regular Physician (See Schedule A section 5.1): Payment for a Form 8 First Report of Injury will only be made (a) for the first Form 8 received by WorkSafeBC submitted by any Physician and (b) If a second Form 8 is subsequently submitted Electronically by the Injured Worker's regular Physician and it is received by WorkSafeBC within 10 business days from the date on which the first Form 8 was received by WorkSafeBC.

5. One Form 8 (See Schedule A section 5.3): A Physician may only submit one Form 8 per claim and any subsequent Form 8 First Report of Injury will be paid at a Form 11 Progress Report rate, unless submitted by the Injured Worker's regular Physician, in which case point 4 above applies.

6. Form 11 Requirements (See Schedule A section 6.1.7) : A Form 11 Progress Report must only be submitted for a change of medical condition or as an accompaniment to fee codes 19509, 19510, 19511 and 19950. A Form 11 Progress Report where there is no change in the Injured Worker's medical condition, treatment plan, or return to work status is not payable unless an interval of at least four weeks has passed since the Physician last invoiced for a Form 11 Progress Report.

7. Missing Information (See Schedule A section 5.4): Any submitted Form 8 First Report of Injury and/or Form 11 Progress Report that is missing mandatory field(s) or is illegible will be rejected without any cost to WorkSafeBC.

8. Follow Up Visits (See Schedule A section 6.1.8): Follow-up examination visits will be paid regardless of whether a Form 11 has been submitted.

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2.0 PHYSICIAN SERVICES FEES

Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Effective April 1, 2022	Effective April 1, 2023	Effective April 1, 2024
19904	Copy of existing report requested by WorkSafeBC	• Payable when WorkSafeBC requests a copy of an existing report, received within three business days of request. • Where a Physician is required to review a chart or a report for the purpose of severing and separating confidential information not related to the claim, the Physician must bill fee code 19953.	$47.40	$50.93	$52.73
19953	Copy of chart notes requested by WorkSafeBC that requires Physician to review notes for the purpose of **isolating specific information**	• Payable when WorkSafeBC requests a copy of chart notes and where complying with that request requires the Physician to review the chart or report prior to the submission of the copy for the purpose of: ○ severing identified personal information not relevant to the claim prior to submission of copy; or ○ identifying previous injury or illness relevant to the current claim; or ○ identifying an area of injury in question from prior records and separating that information from other clinical information. • An additional unit of this Fee Code may be invoiced on an exception basis as outlined in the Physicians and Surgeons' WorkSafeBC Services Reference Guide on worksafebc.com, provided that this exception has been pre-approved by the Health Care Program Manager in their sole discretion. • Must be received by fax within 10 business days of request.	$142.23	$152.83	$158.22

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Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Effective April 1, 2022	Effective April 1, 2023	Effective April 1, 2024
		• Fee code 19953 includes all courier charges. • Fee code 19904 cannot be billed in addition to 19953.			
19907	Written Summary Or Reasoned Medical Opinion Requested By WorkSafeBC	• Payable when a written summary or reasoned medical opinion is requested by WorkSafeBC. • This is to pay for the generation of a new report and not to pay for a copy of an existing report.	$302.24	$324.76	$336.21
19908	Non-Expedited Specialist Consultation Report – Initial Or Repeat	• Non-Expedited Specialist consultation report, initial or repeat, for consultation Services that do not include a report in the fee item description. • Report must be received by WorkSafeBC within 10 business days of the date of service or the date of the request, where the date of service is the date of the assessment and is considered day 0 and the date of request by WorkSafeBC is day 0.	$47.75	$51.31	$53.11
19930	Telephone or Office Consultation	• Payable for any telephone or office consultation between the treating Physician and: ○ A WorkSafeBC Medical Advisor. It is expected that such a call or consultation takes place within 24 hours if initiated by the Medical Advisor; or ○ A Board Officer or designate; or ○ A WorkSafeBC-sponsored treatment program Physician or other program staff, a community Physician and/or a community allied health provider. Community allied health care	$84.15 /15 minutes	$90.42 /15 minutes	$93.61/15 minutes

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		providers are providers involved in the care of an Injured Worker, such as a physiotherapist, occupational therapist, or psychologist. • Can be billed for multidisciplinary team conferences. • Billed in 15 minute increments up to a maximum of 45 minutes, or three units, per day per claim. • Cannot be invoiced for administrative inquiries.			
00129	Emergency Call-Out	• Payable for an emergency call-out when a Physician (Family Practice or Specialist) has to immediately leave the Physician's home or office (outside of hospital) to attend an Injured Worker. • This fee is billed over and above MSP Medical Services fees. • This fee cannot be billed with MSP fee codes: 01200, 01201, 01202, 01205, 01206, 01207, 01210, 01211, 01212, 01215, 01216, 01217	$79.64	$85.57	$88.59
19942	WorkSafeBC Job-Site Meeting	• Payable when a Physician attends a job-site meeting. • Flat fee that includes travel time and all other costs associated with a job-site meeting/visit.	$349.65	$375.70	$388.94
19922	Cost Of Materials	• Applies for materials used in conjunction with sterile tray fees. • Bill the actual cost of materials.	Actual cost	Actual cost	Actual cost

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19929	Prolonged or Complex Case Review and Report Requested By WorkSafeBC	• Payable at the request of WorkSafeBC for a Physician to review the file(s), examine the Injured Worker, and develop a report on an Injured Worker whose recovery is prolonged or complex. • Unless it is not practical, such cases should be referred to WorkSafeBC Medical and Return to Work Planning (MARP) program for appropriate review, assessment and case planning. • In situations where WorkSafeBC requires information about an Injured Worker who is not under active treatment but who continues to have an injury claim, WorkSafeBC may request a Physician who had treated the Injured Worker to review the file(s) and develop a report describing the details of the injury, diagnosis, and treatment. • Report must be received within 20 business days of service. • Submissions received after 20 business days will not be paid.	$190.69	$204.90	$212.12
19931	Consultation after Surgery	• Payable to an office visit and a consultation report (for Surgeons) or a Form 11 (for Family Physicians who are exclusively responsible for follow up post-operative care) within 42 calendar days following the surgery to: ○ assess an Injured Worker's potential to return to work; or ○ refer an Injured Worker to an appropriate treatment program; or	$99.60	$107.03	$110.80

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		○ if neither of the foregoing are appropriate, to recommend a treatment plan with an estimate of recovery and return to work. • Report (consultation or Form 11) must be received within 5 business days of service.			
19950	Return to Work Consultation	• Can be initiated by Board Officer or delegate, WorkSafeBC Medical Advisor, employer or by treating Physician to facilitate a safe, early return to work. • Must include consultation by Physician with the employer and follow up to discuss return to work with the Injured Worker. • One further consultation cycle may be billed if initial attempt at return to work is unsuccessful. • Fee code 19950 includes the office visit and phone calls related to the return-to-work planning in order to complete the return-to-work plan. • A Form 11 is billable in addition to fee code 19950 if the return-to-work consultation is completed on the same day as the office visit.	$335.62	$360.62	$373.33
19976	Return to Work planning request	• Payable on request by a Board Officer or designated rehabilitation provider to endorse a 1-page return to work planning request form.	$48.98	$52.63	$54.48
19558	Activities and Limitation Form	• Payable when the Activities and Limitation Form is completed by a WorkSafeBC Board Officer or Medical Advisor over the phone with the treating Physician and the treating	$153.60	$165.04	$170.86

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		Physician receives a copy to validate or completed directly by the treating Physician. • Billable in addition to an office visit with the Injured Worker if the visit is required in order to complete the Activities and Limitation Form. • Billable in addition to fee code 19930 if completed over the phone.			
19509	Complex Spinal Cord Injury - initial visit or **yearly assessment**	• Payable only for an Injured Worker with a spinal cord injury. • Visit to include a complete physical exam and updated care plan documented and presented on a Form 11. • Only payable once per Injured Worker per year to noted regular Physician. • Form 11 is payable in addition to fee code 19509.	$174.30	$187.28	$193.88
19510	Complex Spinal Cord Injury **office visit**	• Payable only for an Injured Worker with a spinal cord injury. • Cannot be billed in addition to a yearly assessment fee (fee code 19509) on the same day. • Form 11 is payable in addition to fee code 19510 if there are changes in the Injured Worker's condition.	$116.20	$124.86	$129.26
19511	Complex Spinal Cord injury **home visit**	• Payable only for a home visit with an Injured Worker with a spinal cord injury. • Physician must also complete and bill for a Form 11. • Cannot be billed with office visit fee code 19510.	$232.40	$249.71	$258.51

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Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Effective April 1, 2022	Effective April 1, 2023	Effective April 1, 2024
19556	Image-guided diagnostic and therapeutic injection	• Payable only for an injection that requires imaging guidance (e.g., CT, fluoro, ultrasound) regardless of the location where the injection is performed. • Billable if the procedure is performed at a hospital, WorkSafeBC-contracted private surgical facility or in the Physician's office.	$257.70	$276.90	$286.66
19557	Usage of Physician's own imaging equipment for image-guided diagnostic and therapeutic injection.	• Payable for the usage of Physician's own imaging equipment in addition to fee code 19556 when an injection requires imaging guidance (e.g., CT, fluoro, ultrasound). • Cannot be billed if the procedure is performed at a hospital or a WorkSafeBC-contracted private surgical facility.	$150.91	$162.15	$167.87
19932	Medical-Legal **Report – All Physicians**	• Payable only with prior approval by a Board Officer, Review Officer or WCAT Vice Chair. • Medical Legal Report fee code 19932 is applicable to all Physicians. • Report must recite symptoms, history and records and give diagnosis, treatment, results and present condition, and be a factual summary of all information about when the Injured Worker will be able to return to work and may include whether there will be a permanent disability. • Fee code includes examination, review of records, and other processes leading to completion of the written report.	$1,197.03	$1,286.20	$1,331.54

SCHEDULE B
WORKSAFEBC UNIQUE FEE FOR SERVICE ITEMS: FORM FEES, PHYSICIAN SERVICES FEES, AND EXPEDITED CONSULTATION FEES BY SPECIALISTS AND PHYSICIANS WITH AREAS OF EXPERTISE

Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Effective April 1, 2022	Effective April 1, 2023	Effective April 1, 2024
19933	Medical-Legal **Opinion - Specialists**	• Payable only with prior approval by a Board Officer, Review Officer or WCAT Vice Chair. • Medical-Legal Opinion fee code 19933 is applicable only to Specialists with relevant qualifications, or other Physicians with recognized expert knowledge. • Medical-Legal Opinion will usually include the information contained in the Medical-Legal Report, and will differ from it primarily in the field of expert opinion. This may be an opinion as to the course of events when these cannot be known for sure, the long-term consequences and possible complications in the further development of the condition or other matter. There will be the extensive exercise of expert knowledge and judgment with respect to the known facts set out in the opinion with a detailed prognosis. • Fee code includes examination, review of records, and other processes leading to completion of the written opinion.	$2,002.90	$2,152.12	$2,227.98

SCHEDULE B
WORKSAFEBC UNIQUE FEE FOR SERVICE ITEMS: FORM FEES, PHYSICIAN SERVICES FEES, AND EXPEDITED CONSULTATION FEES BY SPECIALISTS AND PHYSICIANS WITH AREAS OF EXPERTISE

3.0 EXPEDITED CONSULTATION FEES BY SPECIALISTS AND PHYSICIANS WITH AREAS OF EXPERTISE

Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Effective April 1, 2022	Effective April 1, 2023	Effective April 1, 2024
19911	Initial Expedited Comprehensive Consultation - Specialists. (except Anesthesiologists)	• Payable for an initial Expedited Comprehensive Consultation from Specialists • Report must be received within 15 business days of the referral. • Includes a physical examination and a written report.	$415.34	$446.29	$462.02
19912	Repeat Expedited Comprehensive Consultation - Specialists (except Anesthesiologists)	• Payable for one repeat Expedited Comprehensive Consultation when the repeat consultation takes place within 12 weeks of the initial Expedited Comprehensive Consultation for which fee code 19911 was billed • Includes a physical examination and a written report. • Report must be received within 5 business days of the consultation.	$202.15	$217.21	$224.86
19934	Initial Expedited Comprehensive Consultation - Anesthesiologist	• Payable for an initial Expedited Comprehensive Consultation from an Anesthesiologist for diagnostic opinion and/or therapeutic management • Report must be received within 15 business days of the referral. • Includes a physical examination and a written report. • If followed by a diagnostic or therapeutic nerve block, the consultation may be	$403.06	$433.08	$448.35

SCHEDULE B
WORKSAFEBC UNIQUE FEE FOR SERVICE ITEMS: FORM FEES, PHYSICIAN SERVICES FEES, AND EXPEDITED CONSULTATION FEES BY SPECIALISTS AND PHYSICIANS WITH AREAS OF EXPERTISE

Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Effective April 1, 2022	Effective April 1, 2023	Effective April 1, 2024
		charged in addition to the nerve block fees on the first occasion.			
19935	Repeat Expedited Comprehensive Consultation – Anesthesiologist	• Payable for one repeat Expedited Comprehensive Consultation from an Anesthesiologist when the repeat consultation takes place within 12 weeks of the Initial Expedited Comprehensive Consultation for which fee code 19934 was billed • Includes a physical examination and a written report • Report must be received within 5 business days of the consultation	$196.00	$210.61	$218.03
19945	Initial Expedited Comprehensive Consultation - Physician With Areas of Expertise	• Payable for an Initial Expedited Comprehensive Consultation by a Physician with Areas of Expertise • Report must be received within 15 business days of the referral • Includes a physical examination and a written report	$324.35	$348.52	$360.80
19946	Repeat Expedited Comprehensive Consultation - Physician With Areas of Expertise after fee code 19945.	• Payable for one Repeat Expedited Comprehensive Consultation by Physician with Areas of Expertise when the repeat consultation takes place within 12 weeks of the Initial Expedited Comprehensive Consultation for which fee code 19945 was billed. • Includes a physical examination and a written report • Report must be received within 5 business days of the consultation	$157.90	$169.66	$175.65

SCHEDULE B
WORKSAFEBC UNIQUE FEE FOR SERVICE ITEMS: FORM FEES, PHYSICIAN SERVICES FEES, AND EXPEDITED CONSULTATION FEES BY SPECIALISTS AND PHYSICIANS WITH AREAS OF EXPERTISE

Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Effective April 1, 2022	Effective April 1, 2023	Effective April 1, 2024
19936	Expedited Consultation Cancellation Fee	• May be invoiced if an Expedited Consultation is cancelled by the Injured Worker within 24 hours of the assessment, or in the case that the Injured Worker does not arrive for the consultation with no forewarning (i.e., a 'no-show').	$86.06	$92.47	$95.73

ADDITIONAL PROVISIONS TO EXPEDITED SPECIALIST CONSULTATIONS

1. Return to Work Exception (See Schedule A section 7.2.1.4): Despite the timelines for reports set out in the table above, where following a consultation the Physician concludes the Injured Worker is fit to return to work, the report must be received within three business days of the consultation.

2. Initial Expedited Comprehensive Consultation (See Schedule A section 7.3): A Physician is entitled to the Initial Expedited Comprehensive Consultation fee as applicable for the first consultation on each claim and a subsequent Initial Expedited Comprehensive Consultation as applicable only when both of the following conditions occur:

   (a) more than six months lapsed since the Physician last saw the Injured Worker; and

   (b) the consultation is as a result of a new referral in accordance with Schedule A.

3. Emergency (See Schedule A section 7.3.2): A Physician is entitled to the Initial Expedited Comprehensive Consultation fee as applicable where the consultation occurs as a result of an emergency (e.g. trauma).

SCHEDULE C
SERVICES PROVIDED TO WORKSAFEBC ON A SESSIONAL AND EXPEDITED BASIS

1.0 SESSIONAL SERVICES

1.1 WorkSafeBC will seek appropriate solutions to address specific service needs under which WorkSafeBC will enter into agreements with individual Physicians to provide services to WorkSafeBC on a sessional basis.

1.2 WorkSafeBC has the sole responsibility to determine the programs, location, number and type of service arrangements according to caseload needs and to varying regional conditions affecting care.

1.3 The programs in number and scope shall be sufficient to meet the needs as determined by WorkSafeBC and notwithstanding section 1.8 of Schedule C, Sessional Services agreed upon during negotiations for this Agreement with respect to Physicians, may include only non fee-for-service funding arrangements and individual contracts for services.

1.4 The specific terms and conditions for the provision of the services shall be described in the individual contract(s) between WorkSafeBC and the individual Physician or group of Physicians who are providing the service(s). Any Sessional Agreements entered into shall equal or exceed fee-for-service payment levels for comparable services delivered in similar settings.

1.5 Individual service contracts, while similar in detail, do not constitute identification of a group of Physicians.

1.6 The format, language, and content of individual agreements will be consistent with standard WorkSafeBC contracts.

1.7 Individual contracts must contain the following standard WorkSafeBC terms and conditions:

- A statement the individual contract is subject to the terms and conditions contained in this Agreement;
- Names and contact information for the Parties to the contract;
- The term of the contract, including any renewal option;
- Statement of services to be provided (by whom, where and when);
- Terms of payment and invoicing;
- A provision requiring WorkSafeBC, when it is defending against an action involving the contracted Physician, to take into consideration, and to take appropriate steps, to avoid any adverse impact on the professional status or reputation of the Physician(s) involved by its decision with respect to settlement; and
- Language incorporating WorkSafeBC's policies and processes with respect to confidentiality and the *Freedom of Information and Protection of Privacy Act*, records and audit rights, technology and data requirements, criminal records check, conflict of interest and harassment, right of set-off, occupational health and safety, threats and hazards, registration and assessment with WorkSafeBC, compliance with laws and regulations, insurance requirements, indemnification, force majeure, independence, assignment, scheduling, standards of conduct, dispute resolution, general notice, termination, laws, headings, singular/ plural, survivability, severability, entire agreement, corporate ethics statement and a confidentiality agreement, privacy protection schedule.

1.8 WorkSafeBC shall pay the Physician a sessional rate based upon three and a half (3.5) hours per session, according to the WorkSafeBC-Doctors of BC Agreement in effect at

the time the Physician provides Services. Each three and a half (3.5) hour session shall not include any breaks or meal periods.

1.9 For Services provided that are greater or less than a 3.5 hour session, WorkSafeBC shall pay the Physician a prorated sessional rate to the nearest 30 minutes for the actual period of time the Physician provides the Services.

1.10 For Services that are pre-arranged and agreed upon with a Physician prior to the scheduled sessions, WorkSafeBC shall pay the Physician the prorated session rate to the nearest 30 minutes for the actual period of time the Physician provides the Services.

1.11 Medical Advisors shall not deviate from a three and a half hour session without prior approval from their direct report at WorkSafeBC. Upon approval, prorating detailed in sections 1.10 and 1.11 of Schedule C shall apply.

2.0 MEDICAL ADVISORS

2.1 WorkSafeBC will exercise its sole discretion in identification of the number and nature of Medical Advisor assignments.

2.2 Refer to Schedule D – Fee Schedule for Sessional and Expedited Services for the rate for Medical Advisors.

2.3 WorkSafeBC will determine the rate available for individual agreements with due consideration as to individual qualifications and the nature of the assignment of Medical Advisor services.

3.0 EXPEDITED SERVICES

3.1 **Scope of Services**

3.1.1 There are circumstances under which WorkSafeBC will enter into Sessional Agreements with individual Physicians that may include but not be limited to surgical, anesthetic, diagnostic and medical Services.

3.1.2 For those Physicians providing consultation and procedures to Injured Workers on an Expedited basis (i.e. "visiting specialists") rates may, with the prior approval of WorkSafeBC, be "blended" in response to a combination of procedural and consulting services within one sessional period.

3.1.3 Expedited surgical procedure rates will be available to all interested community Physicians/surgeons. Non-VSC individuals will not be required to enter into an agreement with WorkSafeBC. They will however need to identify themselves and participate in the business processes so they can be educated in program parameters/requirements around documentation, billings and payment.

3.1.4 No additional surgical/consult fees will be levied to any WorkSafeBC Injured Workers during this Agreement.

3.1.5 For Expedited consultation Services, only Specialists providing Services within WorkSafeBC designated VSC site(s) are able to bill sessionally; all others must bill fee-for-service for Expedited consultation Services.

3.2 **Expedited Consultation Service Fees**

3.2.1 Refer to Schedule D – Fee Schedule for Sessional and Expedited Services, section 1.0, for the Expedited consultation sessional rate for VSC.

3.2.2 Refer to Schedule B – Fee Schedule for WorkSafeBC Unique Fee for Service Items, for the Expedited consultation rate for non VSC Physicians.

3.2.3 Expedited consultation sessional payments for VSC Specialists shall be processed in the current WorkSafeBC format.

3.3 **Expedited Surgical Service Requirements and Fees**

3.3.1 Refer to Schedule D – Fee Schedule for Sessional and Expedited Services, section 2.0 for the Expedited surgical procedure rate.

3.3.2 All Expedited surgical procedures and qualifying out of office hours emergency surgery shall be billed and compensated in accordance with Schedule D section 2.0 using the Expedited Surgical Premium rate.

3.3.2.1 Expedited Surgical Procedures:
Physicians who perform Expedited surgeries for WorkSafeBC shall be entitled to a unique fee of an Expedited Surgical Premium in addition to the applicable MSP surgical procedure fee(s). The Expedited Surgical Premium will be automatically applied to payments for surgeries that meet the Expedited timelines as described below in section 3.3.3. With this model, Physicians may bill for multiple procedures that are consistent with the current practice of MSP billing for surgical procedure fee codes in the public system.

The Expedited Surgical Premium is as follows:

- Effective April 1, 2023: 224.47%
- Effective April 1, 2024: 232.39%

3.3.3 All surgical procedures that are performed on WorkSafeBC Injured Workers will be billable at the Expedited procedural rates set out in Schedule D provided that:

- The prescribed Authorization for Surgery Form (Form 83D6 – Authorization Request for Surgery) is submitted within five business days following WorkSafeBC's receipt of the comprehensive consultation report recommending surgery. WorkSafeBC will provide written authorization confirming its approval of the surgery via the Form 83D6.
- A surgery is considered Expedited if performed within 40 business days from the date on which the physician receives written authorization for surgery from WorkSafeBC Board Officer. The Expedited Surgical Premium will be applied automatically provided that the physician bills fee code 19326 (zero dollars) when the surgeon receives the written approval and records the authorization date as the date of service of fee code 19326 while electronically billing it to WorkSafeBC prior to surgery. If the physician does not bill fee code 19326, the Expedited Surgical Premium will only be applied automatically if the surgery is performed within 40 business days from the date of the last consultation.
- Where it is not possible to schedule a surgery within the 40 business days, the surgeon may seek approval from Health Care Services to extend the

time frame in order to ensure that the surgery will be performed on an Expedited basis and will be billable as such, if approved.

- In the case of emergency (trauma) surgery performed, the surgeon will submit the prescribed Authorization for Surgery Form (Form 83D6 – Authorization Request for Surgery) within five business days following the emergency (trauma) surgery to the Board Officer along with the comprehensive consultation report. Physicians should also bill fee code 19326 using the surgery date as the date of service. Upon receipt of the comprehensive consultation report, the Expedited surgical procedure rates will be paid in recognition of the role of the emergency (trauma) surgery in injury outcome and of the episode of care following the surgery, including the Physician's role in facilitating return to work as set out in Schedule A.

3.3.4 Procedures performed outside the limitation period as specified in section 3.3.3 of Schedule C will only be billed at the MSP surgical fee code rates, unless the Health Care Program Manager determines otherwise.

3.3.5 Any surgery delayed due to the lack of return of the claims Authorization for Surgery form by WorkSafeBC may be directed to the Health Care Program Manager for adjudication of the Expedited fee.

3.3.6 Only the first three elective surgeries per Injured Worker will be considered for Expedited surgical procedure rates per each surgeon. This applies only to repeat surgeries performed on the same site. Any subsequent surgical consideration for additional surgery requires a second opinion by a Richmond VSC Specialist and further surgery will require authorization from the Health Care Program Manager.

3.3.7 Expedited surgical procedure rates may be extended beyond the first three elective procedures for multiple non-emergent reconstructive procedures (both surgical and Anesthesia Services) when the following process occurs:

- A letter is submitted providing early identification of the complexity by outlining the Injured Worker details, volume and proposed procedures, and timeline to completion;
- A Surgical Authorization form is directed to the Board Officer for entitlement approval; and
- A letter is directed to the Health Care Program Manager for payment approval and system activation.

3.3.8 Referrals for surgery from Family Physicians and not WorkSafeBC, must first be approved by WorkSafeBC. In that case WorkSafeBC approval will initiate the start date for calculating the number of business days until surgery. Refer to section 3.3.3 of Schedule C for service timeliness requirements.

3.3.9 Expedited consultations requiring diagnostic investigations will be Expedited using WorkSafeBC services as required.

3.3.10 The operative report must be received within 20 business days of the date of surgery, and is a requirement for WorkSafeBC to process payment.

3.3.11 All appropriate out-of-office hours Service and surcharges (as per MSP Guide to Fees) will apply to Expedited billing payments.

3.3.12 For surgery scheduled in public facilities the surgeon will not displace a booked non-WorkSafeBC patient in order to comply with the business day time limit constraint for Expedited rates. Any surgeon found violating this principle would be excluded from this Agreement.

3.4 **Anesthesia Expedited Fees**

3.4.1 Refer to Schedule D – Fee Schedule for Sessional and Expedited Services, section 3.0 for the procedural Anesthesiology rate. These fees shall be billed through Teleplan.

3.4.2 All Expedited Anesthesiology procedural Services shall be billed through Teleplan using a billing model consisting of the following fee codes per surgery performed:

a) The appropriate MSP Anesthesiology surgical fee code;

b) A time based fee code as described in Fee Schedule D, section 3.0;

c) Where applicable, the fee code 01169 and the fee code for the Out-of-Office Hours Surcharge as described in Fee Schedule D, section 3.0.

3.4.3 WorkSafeBC shall pay Expedited rates when an Anesthesiologist provides Anesthesia for an Injured Worker undergoing Expedited surgery and the surgical procedure meets the timeline requirements in section 3.3.3 of Schedule C. Otherwise, the anesthesiology Services must be billed at the MSP anesthesiology code rates only, unless the Health Care Program Manager determines otherwise.

3.4.4 Anesthesia consultations must be billed fee-for-service (fee code 19934). The consultative report shall be comprehensive.

3.4.5 The Anesthesia time includes a pre-operative assessment, as well as the time from induction until the Anesthesiologist is no longer in attendance and the Injured Worker can be safely discharged to post Anesthesia recovery (PAR). If the pre-operative and PAR times are significantly longer than 15 minutes, respectively, or a total of 30 minutes then an explanatory note shall accompany the record of Anesthesia.

3.4.6 At any time on request of WorkSafeBC, such as for audit purposes, the Anesthesiologist will provide WorkSafeBC with the requested Record(s) of Anesthesia, at no additional charge to WorkSafeBC.

3.4.7 Notwithstanding the above, WorkSafeBC will pay only once for each surgical procedure except when the Injured Worker's care warrants the attendance of more than one Anesthesiologist. The Anesthesiologist must support the need with written statements to WorkSafeBC explaining why there was a medical requirement to have two in attendance.

3.4.8 The Anesthesiologist's fee covers all Services rendered by the Anesthesiologist during the procedure.

3.4.9 Except for life or limb threatening circumstances, an Anesthesiologist may not bill for two Injured Workers during the same time period. The Anesthesiologist must support the need with a written statement to WorkSafeBC providing explanation as to the medical requirement for the circumstance.

3.5 **Surgical Assist Fees**

3.5.1 Refer to Schedule D – Fee Schedule for Sessional and Expedited Services, section 4.0, for the Expedited surgical assist rate. These fees shall be billed through Teleplan.

3.5.2 Surgical assists are to be billed electronically through Teleplan at the rates outlined in Schedule D section 4.0. The surgical assists will invoice the applicable MSP surgical assist (related to procedure) fee code plus the applicable time-based WorkSafeBC fee code for one of the following levels and where applicable, the MSP fee code 13003 and the fee code for the Out of Office Hours Surcharge as described in Fee Schedule D, section 4.0:

Level 1 Surgical Assist (surgery time up to 1.5 hours)

Level 2 Surgical Assist (surgery time 1.51 to 2.0 hours)

Level 3 Surgical Assist (surgery time 2.01 to 2.5 hours)

Level 4 Surgical Assist (surgery time 2.51 to 3.0 hours)

Level 5 Surgical Assist (surgery time 3.01 to 3.5 hours)

Level 6 Surgical Assist (surgery time 3.51 to 5.99 hours)

Level 7 Surgical Assist (surgery time 6.00 hours plus)

3.6 Expedited Extensive Spinal Surgery Fees

3.6.1 These fees are designed for surgeons performing difficult and Extensive Spine Surgery procedures requiring stabilization or multilevel procedures or revisions discectomy (one level index discectomy is not meant to be covered by these fees).

3.6.2 Pre-approval by WorkSafeBC is required.

3.6.3 The business day limitations in section 3.3.3 of Schedule C are waived for these Services.

3.6.4 Refer to Schedule D – Fee Schedule for Expedited Services, section 2.0, for the Expedited Extensive Spine Surgery rates.

SCHEDULE D
FEE SCHEDULE FOR SESSIONAL AND EXPEDITED SERVICES

1.0 EXPEDITED SESSIONAL SERVICES

Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Effective April 1, 2022	Effective April 1, 2023	Effective April 1, 2024
1150464	Initial Expedited Consultation Service Fees / Sessional Rate (VSC ONLY)	Bill as per contract	$2,431.99	$2,613.17	$2,705.29
1150465	Repeat Expedited Consultation Service Fees / Sessional Rate (VSC ONLY)	Bill as per contract	$2,431.99	$2,613.17	$2,705.29

SCHEDULE D
FEE SCHEDULE FOR SESSIONAL AND EXPEDITED SERVICES

2.0 EXPEDITED SURGICAL PROCEDURE RATES AND OUT OF OFFICE HOURS SURCHARGE.

Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Expedited Surgical Premium Effective April 1, 2022	Expedited Surgical Premium Effective April 1, 2023	Expedited Surgical Premium Effective April 1, 2024
MSP Fee Code	For Expedited surgical procedures excluding Extensive Spine Surgery, invoice MSP fee codes applicable to the procedure. If the surgery meets the requirements for Expedited surgical procedure rates as set out in Schedule C section 3.3.3, HIBC will apply the applicable Expedited Surgical Premium in addition to the paid MSP surgery procedure fees.	Bill through Teleplan	208.91%	224.47%	232.39%
19516	Expedited Extensive Spine Surgery – Sessional fee (no MSP fee code applicable).	Bill through Teleplan	$4,429.20	$4,759.17	$4,926.94
19320	Out of Office Hours Surcharge, Operative Evening (commencing on or after 6pm up to 11pm). Applicable to emergency surgery or to elective surgery that is rescheduled due to intervening emergency surgery in an Operative Evening.	Bill through Teleplan	The greater of $69.65 or 17.50% of the paid MSP surgery procedure fees	The greater of $74.84 or 17.50% of the paid MSP surgery procedure fees	The greater of $77.48 or 17.50% of the paid MSP surgery procedure fees

SCHEDULE D
FEE SCHEDULE FOR SESSIONAL AND EXPEDITED SERVICES

Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Expedited Surgical Premium Effective April 1, 2022	Expedited Surgical Premium Effective April 1, 2023	Expedited Surgical Premium Effective April 1, 2024
19321	Out of Office Hours Surcharge, Operative Night (commencing on or after 11pm to 8am). Applicable to emergency surgery or to elective surgery that is rescheduled due to intervening emergency surgery in an Operative Night.	Bill through Teleplan	The greater of $112.53 or 28.00% of the paid MSP surgery procedure fees	The greater of $120.91 or 28.00% of the paid MSP surgery procedure fees	The greater of $125.17 or 28.00% of the paid MSP surgery procedure fees
19322	Out of Office Hours Surcharge, Operative Sat/Sun/Holidays (8am to 11pm). Applicable to emergency surgery or to elective surgery that is rescheduled due to intervening emergency surgery on Operative Sat/Sun/Holidays.	Bill through Teleplan	The greater of $69.65 or 17.50% of the paid MSP surgery procedure fees	The greater of $74.84 or 17.50% of the paid MSP surgery procedure fees	The greater of $77.48 or 17.50% of the paid MSP surgery procedure fees

SCHEDULE D
FEE SCHEDULE FOR SESSIONAL AND EXPEDITED SERVICES

ADDITIONAL PROVISIONS

1. Invoice MSP fee codes applicable to the surgical procedure, and where applicable, fee codes 19320, 19321 or 19322 for an out of office hours surcharge. If an out of office hours surcharge is claimed under fee codes 19320, 19321 or 19322, the invoice must include the time that the surgery commenced in order to be paid. For qualifying out of office hours surgeries commencing during the operative evening and continuing into the operative night (both as defined in the table above), invoice for the period in which the major portion of the surgical time is spent (operative evening or operative night).

2. Fee codes 19320, 19321 and 19322 are applicable only to emergency or elective surgery that is:
   (a) rescheduled to an out of office time period due to intervening emergency surgery or is scheduled in an out of office time period at the request of the Injured Worker; and
   (b) at least 45 minutes of surgery time or requires general, spinal or epidural Anesthesia.

3. Where applicable, fee codes 19320, 19321 or 19322 may be billed even if the surgery does not meet the requirements for Expedited surgical procedure rates as set out in Schedule C section 3.3.3.

4. Where a surgery meets the requirements for an out of office hours surcharge and for Expedited surgical procedure rates in accordance with Schedule C section 3.3.3, fee codes 19320, 19321 or 19322, as applicable, are eligible for the applicable Expedited Surgical Premium.

5. "Emergency surgery" when used in this Schedule D section 2.0 means emergency surgery that is defined, deemed or adjudicated under MSP to be emergency surgery.

6. Where applicable, fee codes 19320, 19321 or 19322 are billable in addition to MSP out of office hours surcharge fee codes 01210, 01211, and 01212.

SCHEDULE D
FEE SCHEDULE FOR SESSIONAL AND EXPEDITED SERVICES

3.0 EXPEDITED ANESTHESIA RATES FOR EXPEDITED SURGICAL PROCEDURES

Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Effective April 1, 2022	Effective April 1, 2023	Effective April 1, 2024
MSP Fee Code	Expedited Anesthesia Services: Invoice one appropriate MSP fee code, plus the MSP fee code 01169 where applicable, plus the applicable number of units of block billing time-based fee code 19507.	Bill through Teleplan			
19507	Expedited Anesthesia Time. One unit equals 15 minutes.	Bill through Teleplan	$87.56	$94.09	$97.40
19518	Expedited Extensive Spine Surgery Anesthesia – Sessional fee (no MSP fee code applicable)	Bill through Teleplan	$2,693.57	$2,894.24	$2,996.26
19405	Expedited Anesthesiology, Out of Office Hours Surcharge, Operative Evening (6 to 11 pm) -- applied to 19507	Bill same number of units as is billed for fee code 19507.	32.77%	32.77%	32.77%
19406	Expedited Anesthesiology, Out of Office Hours Surcharge, Operative Night (11 pm to 8 am) -- applied to 19507	Bill same number of units as is billed for fee code 19507.	52.54%	52.54%	52.54%
19407	Expedited Anesthesiology, Out of Office Hours Surcharge, Operative Sat/Sun/Holidays -- applied to 19507	Bill same number of units as is billed for fee code 19507.	32.77%	32.77%	32.77%

SCHEDULE D
FEE SCHEDULE FOR SESSIONAL AND EXPEDITED SERVICES

4.0 EXPEDITED SURGICAL ASSIST RATES FOR EXPEDITED SURGICAL PROCEDURES

Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Effective April 1, 2022	Effective April 1, 2023	Effective April 1, 2024
MSP Fee Code	Invoice one appropriate MSP surgical assist fee code related to surgical procedure, plus the MSP fee code 13003 where applicable, plus applicable block billing time-based fee code below.	Bill through Teleplan			
19545	Expedited Surgical Assist - Level 1 (surgery time up to 1.5 hours)	Bill through Teleplan	$263.77	$283.42	$293.41
19546	Expedited Surgical Assist - Level 2 (surgery time 1.51 to 2.0 hours)	Bill through Teleplan	$381.14	$409.54	$423.97
19547	Expedited Surgical Assist - Level 3 (surgery time 2.01 to 2.5 hours)	Bill through Teleplan	$522.89	$561.84	$581.64
19548	Expedited Surgical Assist - Level 4 (surgery time 2.51 to 3.0 hours)	Bill through Teleplan	$639.10	$686.71	$710.92
19549	Expedited Surgical Assist - Level 5 (surgery time 3.01 to 3.5 hours)	Bill through Teleplan	$761.11	$817.81	$846.64
19551	Expedited Surgical Assist - Level 6 (surgery time 3.51 to 5.99 hours)	Bill through Teleplan	$1,121.32	$1,204.86	$1,247.33
19552	Expedited Surgical Assist - Level 7 (surgery time 6.00 hours plus)	Bill through Teleplan	$1,719.76	$1,847.88	$1,913.02

SCHEDULE D
FEE SCHEDULE FOR SESSIONAL AND EXPEDITED SERVICES

Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Effective April 1, 2022	Effective April 1, 2023	Effective April 1, 2024
19517	Expedited Extensive Spine Surgery Surgical Assist – Sessional fee (no MSP fee code applicable)	Bill through Teleplan	$1,727.38	$1,856.06	$1,921.49
19410	Expedited Surgical Assist, Out of Office Hours Surcharge, Operative Evening (6 to 11 pm)	Bill this percentage applied to applicable Level fee code billed.	32.77%	32.77%	32.77%
19411	Expedited Surgical Assist, Out of Office Hours Surcharge, Operative Night (11 pm to 8 am)	Bill this percentage applied to applicable Level fee code billed.	52.54%	52.54%	52.54%
19412	Expedited Surgical Assist, Out of Office Hours Surcharge, Operative Sat/Sun/Holidays	Bill this percentage applied to applicable Level fee code billed.	32.77%	32.77%	32.77%

SCHEDULE D
FEE SCHEDULE FOR SESSIONAL AND EXPEDITED SERVICES

5.0 EXPEDITED PSYCHIATRY SERVICES – PERSONAL SERVICES AGREEMENT

Where WorkSafeBC enters into a Personal Services Agreement with a psychiatrist for Expedited psychiatry services, WorkSafeBC will pay the psychiatrist in accordance with the table below for the categories of Expedited services set out in the table.

Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Effective April 1, 2022	Effective April 1, 2023	Effective April 1, 2024
PSYCHIATRY ASSESSMENT					
19949	Psychiatric Opinion Assessment	• Fee includes all services included in psychiatric opinion assessment including: ○ Injured Worker interview (medical history, drug/ treatment history, psychosocial history, etc.); ○ DSM diagnosis; ○ Treatment recommendations; Management Plan; ○ Report must be received within 10 business days of the assessment.	$1,577.46	$1,694.98	$1,754.73
19948	Psychiatric Opinion Assessment - Telehealth	• Fee includes all services included in psychiatric opinion assessment including: ○ Injured Worker interview (medical history, drug/ treatment history, psychosocial history, etc.); ○ DSM diagnosis; ○ Treatment recommendations; Management Plan; • Report must be received within 10 business days of the assessment.	$1,507.33	$1,619.63	$1,676.72

SCHEDULE D
FEE SCHEDULE FOR SESSIONAL AND EXPEDITED SERVICES

Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Effective April 1, 2022	Effective April 1, 2023	Effective April 1, 2024
OUTPATIENT PSYCHIATRY TREATMENT					
19430	Outpatient Psychiatry Treatment Per ½ hour	• Fee includes all services involved in outpatient psychiatry treatment including: ○ Individual, family or group psychotherapy; evaluation interview with family member(s); ○ Actual Injured Worker contact time; ○ Does not include psychiatric treatment or counselling by telephone; ○ Drafting of progress report; ○ Progress report must be submitted for each follow-up visit.	$187.32	$201.27	$208.37
19431	Outpatient Psychiatry Treatment Per ¾ hour		$279.81	$300.66	$311.26
19432	Outpatient Psychiatry Treatment Per 1 hour		$374.64	$402.55	$416.74
19449	Outpatient Psychiatry Treatment Per 1 ½ hours		$561.96	$603.82	$625.11
19424	Outpatient Psychiatry Evaluation Interview with Family Member(s) Per ½ hour		$187.32	$201.27	$208.37
19425	Outpatient Psychiatry Patient Management Conference Per ¼ hour		$100.68	$108.19	$112.00
19426	In-Patient Individual Treatment Per ½ hour	• Fee includes all services included in-inpatient psychiatry treatment including: ○ Hospital or institution;	$187.32	$201.27	$208.37
19427	In-Patient Individual Treatment Per ¾ hour		$280.98	$301.91	$312.55

SCHEDULE D
FEE SCHEDULE FOR SESSIONAL AND EXPEDITED SERVICES

Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Effective April 1, 2022	Effective April 1, 2023	Effective April 1, 2024
19429	In-Patient Individual Treatment Per 1 hour	○ Actual Injured Worker contact time; ○ Drafting of progress report. • Progress report must be submitted every 10 business days and within 10 business days following Injured Worker discharge.	$374.64	$402.55	$416.74
TELEHEALTH PSYCHIATRY TREATMENT					
19310	WorkSafeBC Telehealth Psychiatry Treatment – ½ hour	• Where direct interactive video link with the Injured Worker. • Telehealth office visit to include services such as chemotherapy management and/or psychotherapy.	$187. 32	$201.27	$208.37
19311	WorkSafeBC Telehealth Psychiatry Treatment – ¾ hour		$279.81	$300.66	$311.26
19312	WorkSafeBC Telehealth Psychiatry Treatment – 1 hour		$374.64	$402.55	$416.74
19444	Psychiatry Independent Medical Examination	• Fee for an independent psychiatric evaluation by a non-treating psychiatrist to address referral questions that may include an opinion on the Injured Worker's medical needs or condition or further treatment. • Fee includes all services including: ○ Patient (Injured Worker) interview (medical history, drug/treatment history,	$3,273.88 including timely completion bonus	$3,517.79 including timely completion bonus $3,287.48	$3,641.79 including timely completion bonus $3,403.37

SCHEDULE D
FEE SCHEDULE FOR SESSIONAL AND EXPEDITED SERVICES

Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Effective April 1, 2022	Effective April 1, 2023	Effective April 1, 2024
		psychosocial history, etc.); ○ DSM diagnosis; ○ Treatment recommendations; ○ Results of psychiatric opinion; and ○ Respond to referral questions. • Report must be received within 10 business days of the assessment to receive timely completion bonus.	$3,059.55 where no timely completion bonus	where no timely completion bonus	where no timely completion bonus
19445	Complex Psychiatric Opinion	• Fee is payable for a psychiatric assessment for the following conditions: ○ Complex concurrent or co-morbid psychiatric disorders may include two or more of the following: severe mental health disorder (e.g. bipolar, psychosis, TBI), active substance abuse disorder; ○ Significant pre-existing psychiatric disorders and/or significant co-morbid medical disorders requiring review of extensive psychiatric and medical documents; and ○ Acute risk assessment (suicidal/homicidal). • Fee includes all services including: ○ Patient (Injured Worker) interview (medical history, drug/treatment history,	$3,273.88 including timely completion bonus $3,059.55 where no timely completion bonus	$3,517.79 including timely completion bonus $3,287.48 where no timely completion bonus	$3,641.79 including timely completion bonus $3,403.37 where no timely completion bonus

SCHEDULE D
FEE SCHEDULE FOR SESSIONAL AND EXPEDITED SERVICES

Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Effective April 1, 2022	Effective April 1, 2023	Effective April 1, 2024
		psychosocial history, etc.); ○ DSM diagnosis; ○ Treatment recommendations; and ○ Results of psychiatric opinion. • Report must be received within 10 business days of the assessment to receive timely completion bonus.			

6.0 MEDICAL ADVISORS

Fee Code	Description	Rules Applicable to Eligibility to Invoice Fee Code and Fee Code Included Items	Effective April 1, 2022	Effective April 1, 2023	Effective April 1, 2024
Not applicable	Medical Advisor, sessional rate	Billing as instructed.	$616.39 per session	$658.00 per session	$677.87 per session
Not applicable	Specialist Medical Advisor, sessional rate	Billing as instructed.	$774.71 per session	$827.00 per session	$851.98 per session