Home Care Services Reference Manual

How to fulfill your Home Care Services Agreement with WorkSafeBC

WorkSafeBC

Contents

Introduction

At WorkSafeBC, we are committed to fostering safe and healthy workplaces, and to providing service driven by our core values of integrity, accountability, compassion, respect, and excellence. We partner with workers and employers to save lives and prevent injury, illness, and disability. When work-related injuries or illnesses do occur, we work with health care providers like you to support injured workers in their recovery and rehabilitation and in moving toward a safe return to work.

How to use this reference manual

This Home Care Services Reference Manual is part of the Home Care Services Agreement you've signed with WorkSafeBC, so it's important you read, understand, and follow it. Reading this reference manual will also make it easier to do business with us. Wondering how to submit an invoice? Unsure if you're reporting on an injured worker's progress correctly? Curious about how to communicate with us? All this information can be found in the pages ahead.

If there are any discrepancies between this reference manual and the Home Care Services Agreement, follow the Agreement.

You'll find links to these and other webpages throughout this reference manual and listed in Appendix B. (Links in underlined blue text will take you to a webpage. Links in underlined orange text will take you to another place in this document; press **Alt + left arrow** to return to your previous place in the document.)

Where to learn more

This reference manual contains the essentials for working with us, but you'll find other important information on worksafebc.com.

- Our For health care providers webpage (to better understand our programs and services, and for resources you can download)
- Our Home Care Services - WorkSafeBC webpage (for information, forms and bulletins specific to your field)

Have a question?

We're here to help. If you can't find the answer in this reference manual, reach out to us. You'll find contact information in Appendix A.

Wondering what a term means?

Terms that are defined in your contract, like "Services," "Injured Worker," or "Provider," have the same meaning in this reference manual, even if they're not capitalized (and those terms that are capitalized, like "Agreement," also have the same meaning as in the contract). In addition, throughout this reference manual:

- "You" is used instead of "Contractor"
- "We" stands in for "WorkSafeBC," including the specific departments and roles you'll be interacting with (such as Health Care Programs or WorkSafeBC officers)
- "WorkSafeBC officer" is used in place of "Board Officer" (and refers to WorkSafeBC staff who have the authority to make decisions on an injured worker's claim)

The big picture & who you're working with

Topics covered in this section:

The big picture

To understand how to fulfill your contract with WorkSafeBC, it helps to know who we are, how we serve injured workers, and where the services you provide come into play.

WorkSafeBC: Who we are and what we do

WorkSafeBC, also known as the Workers' Compensation Board of British Columbia, is a provincial agency dedicated to promoting safe and healthy workplaces across B.C. and ensuring workers who are injured on the job receive fair compensation and help to recover.

WorkSafeBC has been responsible for administering the provincial *Workers Compensation Act* since 1917. The workers' compensation system is funded by the employers of British Columbia, who pay premiums every year. Workers themselves do not pay into the system.

WorkSafeBC has several responsibilities, including a key role in preventing workplace injuries. When a worker sustains a work-related injury or illness, WorkSafeBC assists them in their recovery and return to work. We partner with health care providers to ensure injured workers get the treatment they need to resume their normal routines as fully as possible, and we pay for that treatment.

The services you provide under the Home Care Services Agreement are just one set of benefits we may offer an injured worker to meet these goals and responsibilities.

Learn more about who we are on worksafebc.com, and learn about our other health care programs and services in Appendix J.

What happens when a worker is injured at work?

When a worker sustains a work-related injury or illness, the injured worker, the employer, and a primary health care provider report it to WorkSafeBC to start a claim.

The life of a WorkSafeBC claim

Phase 1: Initial adjudication	Phase 2: Recovery	Phase 3: Resolution or plateau
The claim is allowed or disallowed. If it's allowed, a "Claim owner" adjudicates it for initial entitlement to benefits. They determine what medical care is necessary for recovery and whether the injured worker is eligible for other benefits, such as wage-loss benefits.	The injured worker receives benefits. These may include wage-loss benefits, medical and rehabilitation services, or other health care benefits. This is typically the phase where you provide services to the injured worker.	Ideally, the injured worker makes a full recovery and returns to regular work duties. In some cases, phase 3 benefits may include vocational rehabilitation assistance. If the injured worker does not fully recover, they may be entitled to certain permanent benefits, which may include on-going Home Care Services.

Who decides which benefits an injured worker is entitled to?

Claim owners at WorkSafeBC do. They are trained in law and policy and weigh all information in a claim file when making decisions. They also have advisors to help them understand medical details in the file. To learn more, see the claim owners section of this reference manual.

What rights does the injured worker have?

The injured worker can appeal any claim decision through a formal appeals process.

Are Home Care Providers involved in claim decisions?

No. As a service provider, you can't be involved in making decisions about benefit entitlement or claim management. It's also not appropriate for you to get involved in any appeal an injured worker launches.

Where you fit in

- You play an important role by providing care services to an injured worker.

The primary goals of your services are:

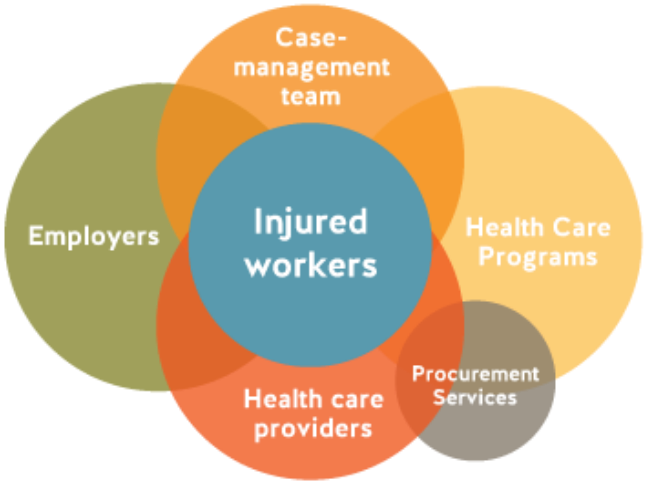
- To assist the injured worker with a timely and enduring return to work wherever possible
- To assist the injured worker with a return to their pre-injury physical, cognitive, and/or mental health status wherever possible
- Where a return to work or pre-injury status is not possible, to assist the injured worker to remain in their community and attain the highest possible level of functional independence

To learn more, see Your role in the claims process on worksafebc.com.

Who you're working with

You're working with many stakeholders, including distinct departments and roles within WorkSafeBC. Together, these stakeholders create an interdisciplinary team that supports the injured worker to return to work and lead an independent and productive life.

WorkSafeBC Stakeholders



Health Care Programs at WorkSafeBC

The Health Care Programs department develops and manages all contracted health care services and programs available to the injured worker, including Home Care Services. Health Care Programs consults with internal and external stakeholders to outline what services are needed and how these services should be provided. The program manager and the quality assurance supervisor for each contracted health care service or program also manage the quality of the services being provided.

Procurement Services at WorkSafeBC

The Procurement Services department initiates and maintains contracts with service providers throughout the province. Procurement Services manages contracts with all kinds of vendors, including health care service providers.

WorkSafeBC case-management teams

WorkSafeBC claims are managed by a case-management team of administrative and clinical specialists focused on understanding the injured worker's situation.

Claim owners

The case-management team always includes a "claim owner". There can only be one claim owner at a time for each claim; however, there may be multiple WorkSafeBC officers involved in a claim. Depending on how complex the claim is and what phase it has reached, the claim owner may change.

Several different roles at WorkSafeBC may take on the role of claim owner. Return-to-work specialists and case managers can both be claim owners.

Return-to-work specialist (RTW specialist)

- Develops effective, evidence-based return-to-work plans
- Visits jobsites to assess job demands
- Develops relationships with workers, employers, and health care providers
- Liaises with health care providers to assist with injury recovery and the development of injury-management plans
- Educates injured workers, health care providers, and others on recovery, return to work, and effective and meaningful disability management

Case manager (CM)

- Manages adjudicated claims with extended period of disability where return to work (RTW) is more challenging
- Assists workers in their recovery and coordinates graduated RTW and RTW process
- May visit jobsites or health care facilities
- Liaises with health care providers to understand recovery and entitle health care benefits
- Provides referrals to community care for injured workers' recovery and return to work

Need to find a claim owner or clinical specialist nurse?

If you're uncertain who the claim owner is for an injured worker's claim, contact the Claims Call Centre at 604.231.8888 (Lower Mainland) or 1.888.967.5377 (toll-free) from 8 a.m. to 6 p.m. PT, Monday to Friday. An agent will direct you to the current claim owner.

Other case-management team members

A case-management team may also include a clinical specialist nurse and/or service coordinator.

Clinical specialist nurse

The clinical specialist nurse (CSN) reviews severely injured workers' home care needs, responds to the claim owner's and other team members' clinical questions, and is responsible for entitling allowances like the Independence and Home Maintenance Allowance for severely injured workers. CSNs may also conduct visits in injured workers' homes and prepare clinical recommendations for injured workers' care.

Service coordinator

The service coordinator assists with referrals to external programs and with travel and other arrangements for the injured worker.

Getting started & communicating effectively

Steps covered in this section:

Sign up for emails and Information Bulletins from Health Care Programs
Access the WorkSafeBC Provider Portal (and learn how to use it)
Mandatory online training for Home Care Services

Topics covered in this section:

Communication channels
When to communicate with WorkSafeBC
How to communicate with attending physicians or nurse practitioners and specialists

Getting started

Sign up for emails and Information Bulletins from Health Care Programs

Health Care Programs regularly sends emails and Information Bulletins with information on:

- Amendments and updates to this reference manual
- New forms and new invoices
- Updated processes
- WorkSafeBC staff changes
- Patterns in claims
- Updates on service matters
- Payment issues and billing FAQs
- Clinical reminders

Remember: Any updates to this reference manual are also updates to the Home Care Services Agreement. Plus, it's vital to use the most up-to-date forms and processes when working with us. So, ensure:

- At least one person at your organization, preferably the contractor representative, signs up right away to receive emails and Information Bulletins
- Personnel who deliver services under the Agreement read relevant Information Bulletin

If you would like to be added to the Home Care Services email distribution list, or if you already receive our emails and Information Bulletins and would like to change the recipient email address or be removed from the list, email hcsinqu@worksafebc.com. There's no limit to the number of people at your organization who can be included on the distribution list.

Contractor representative

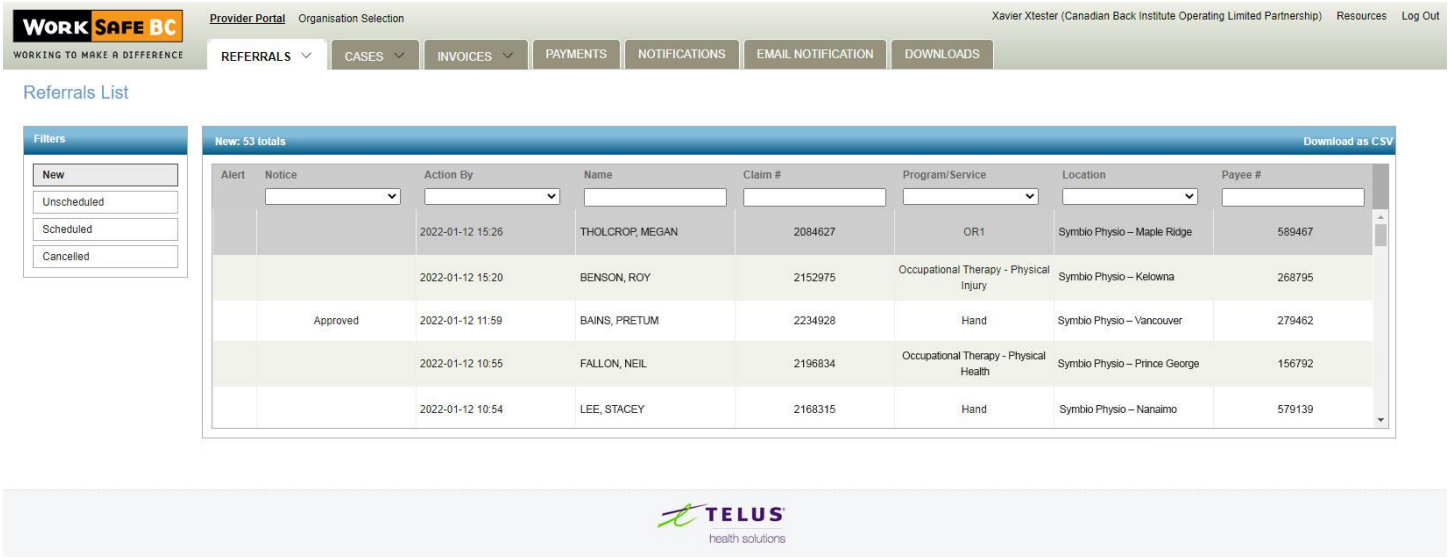
Designate one person at your organization to be the contractor representative, who will serve as the primary point of contact for Health Care Programs with respect to the administration of the Home Care Services Agreement.

The contractor representative acts as the contract expert and educator and should therefore be the first point of contact for your staff who may have questions relating to the Home Care Services Agreement.

You can change the designated contractor representative by contacting Health Care Programs at any time.

Access the WorkSafeBC Provider Portal (and learn how to use it)

The WorkSafeBC Provider Portal gives you a secure and efficient way to receive referrals from WorkSafeBC, submit reports and invoices, and check the status of payments. This is what it looks like:



You must set up Provider Portal access for any staff who need to use it. To do this:

- **Take the Provider Portal training on worksafebc.com.** It includes how-to videos and a quick reference guide. These resources come from Telus Health Solutions, our Provider Portal partner.
- **Ensure any staff who need to use the Provider Portal have their own BCeID.** They'll need it to log in to the Provider Portal. Learn more at bceid.ca.
- **Designate an employee to manage access to the Provider Portal.** This employee should regularly review who has been granted access. They should immediately cancel access for staff who no longer need it by emailing Telus Health Solutions (provider.mgmt5@telus.com).

Mandatory online training for Home Care Services

The following staff must complete the Home Care Services on-line orientation and training session (separate from the above Portal training), prior to performing any services:

- Your contractor representative;
- Staff who will complete your billing and invoicing; and
- Nurses who will be completing assessments and writing reports.

The on-line training course is hosted by WorkSafeBC at: http://homecaretraining.udutu.ca.

If you have any questions regarding the on-line training, or if you experience any technical issues, please contact Health Care Programs.

Need help with the Provider Portal?

If you have questions about the Provider Portal or problems using it, call Telus Health Solutions at 1.855.284.5900 for 24/7 support. Ask for your ticket number for reference and follow-up. WorkSafeBC staff do not offer Provider Portal training.

Communicating effectively

Knowing how and when to communicate with Health Care Programs, WorkSafeBC case-management team members, and even their attending physician or nurse practitioner helps ensure a smooth recovery and, where possible, a return to work for the injured worker. We count on receiving timely, accurate reports and communication from you on the injured worker's progress. You can expect regular communication, important updates, and helpful information from us.

Communication channels

By now, you should have signed up to receive communications from Health Care Programs via the Home Care Services email distribution list.

You may communicate with Health Care Programs and WorkSafeBC staff by phone and email under certain circumstances. It's important to understand when it's okay to use email in particular.

Expectations for communicating with us are outlined below. Follow any communication guidelines from your college and/or regulatory association as well.

Emails about specific claims: Wait for us to initiate

Email can only be used to communicate with a WorkSafeBC officer about a claim if the injured worker has given their consent. The WorkSafeBC officer must be the one to get this consent, so only email a WorkSafeBC officer about a claim if you receive an email from the officer about the claim first. All emails about specific claims must be encrypted if they contain any identifiers other than the claim number. The worker can withdraw their consent at any time; if this happens, the WorkSafeBC officer will let you know.

Emails about providing services in general: Go ahead

General communications that do not include details about an injured worker's claim can be emailed to the program manager and/or quality assurance supervisor for Home Care Services in Health Care Programs. For example, you can email them to:

- Communicate changes to staffing, or licensing/registration
- Ask contract or program-related questions, including about key performance indicators
- Communicate about a general service matter

Who is a "WorkSafeBC officer"?

A number of WorkSafeBC employees are considered WorkSafeBC officers, including case managers, adjudicators, clinical specialist nurses, and return-to-work specialists. When a "WorkSafeBC officer" is mentioned in this reference manual, it generally means the clinical specialist nurse. If there is not a clinical specialist nurse assigned to the claim, it will be the claim owner.

When to communicate with WorkSafeBC

As a routine part of your work

In broad strokes, you need to:

- Respond to the referrals we send you
- Send us your care plan for approval
- Send us reports on each injured worker's progress
- Submit your invoices

You'll find more information on these processes in later sections of this reference manual (Providing your services — Part 1: The basics and Part 2: The details).

Examples of times to reach out

Circumstance	Who to contact	How to contact
You are starting care services, with concerns about the injured worker's suitability for home care, or the injured worker is not participating in the care services as anticipated **You want to make a recommendation or there is an anomaly with the provision of care** When delivering services, you may make recommendations that fall within your scope of practice under the Agreement for care services, further medical investigations or clinical referrals, medical supplies or equipment, etc. These recommendations should be discussed with us before you advise the injured worker or document the recommendations in a report. There is a change in care services requiring: • additional shifts to be added; • a change or increase in profession coverage (instead of Health Care Assistant (HCA)-only care, now requires nursing care). **You want to request to change to quarterly Progress Reporting**	WorkSafeBC officer (typically the clinical specialist nurse or the claim owner)	By phone or, if WorkSafeBC officer has initiated email communication about the claim, by email. If you get a voicemail, provide a detailed message including: • your name & number • injured worker's name & claim number • details about the proposed recommendations, such as "I am waiting for a phone call back so I can get approval [discuss this further]" if required; or, "I will implement these changes, assuming your permission, unless I hear back from you within two business days." Document in your records the date and time of the voicemail. If the timeframe passes, make the adjustment in care. If the WorkSafeBC officer's voicemail says they are on vacation, their voicemail should provide an alternative contact (or the general Nurse's line).

You have a question about your contract **You have a unique contract scenario that you do not know how to navigate**	Health Care Programs (quality assurance supervisor or program manager for Home Care Services)	By phone, or email
A WorkSafeBC officer has requested or approved a service that is outside the scope of the Agreement **You need to discuss an exception to billing** **You'd like to make an exception to how you provide services under the Agreement** You must request approval from Health Care Programs. After you reach out, Health Care Programs will respond with a decision and recommendations in writing. The decision will apply specifically to the scenario in question. The same decision/recommendations cannot be applied to another injured worker without prior written approval from Health Care Programs.	Health Care Programs (quality assurance supervisor or program manager for Home Care Services)	By phone or email
You've had staffing changes This includes updates to the contractor representative or the clinicians providing the services under the Agreement.	Health Care Programs (quality assurance supervisor or program manager for Home Care Services)	By phone or email

When incidents or threats occur

If a situation arises that creates an immediate safety hazard or injury to anyone, including the injured worker, you, or your personnel, you must report it to us. This includes:

- Any physical or psychological trauma sustained by an injured worker, including critical incidents (e.g., the injured worker fell while being transferred by personnel, the injured worker develops a pressure sore as a result of lack of repositioning, etc.)
- Any implicit or explicit threat toward a WorkSafeBC staff member or WorkSafeBC property
- Any statement or action of harm directed toward another person

Call the claim owner, and be clear about how serious the threat or incident was. Submit a Health Care Programs Incident Report (Form 83M380) within one business day.

A Health Care Programs Incident Report (Form 83M380) may also be required in other circumstances. Examples could include:

- A trip, slip, or fall that results in no injury
- Concerns voiced by an injured worker about equipment malfunctions
- A "near miss" incident (e.g., nearly getting into a motor vehicle accident on the way to the injured worker)
- Loss or theft of an item while services are being delivered
- A procedural error, such as a missed dose of medication
- Any personnel misses a shift without prior notice to the injured worker and/or the WorkSafeBC officer and there is a negative, clinical impact to the injured worker as a result
- You are unable to continue providing services to an injured worker (e.g., due to scheduling or injured worker behavioral challenges)
- Any other situation that creates an immediate safety hazard to the injured worker or contractor personnel, or places the injured worker in potential danger

The table below lays out exactly how to respond to different types of incidents and threats.

How to respond to and report incidents and threats

Type of incident or threat & response	Who to contact at WorkSafeBC	When and how to contact WorkSafeBC
An incident results in an injured worker needing emergency care 1. Call 911. Ensure injured worker receives care. 2. Contact WorkSafeBC. 3. Contact attending physician or nurse practitioner, as appropriate (unless injured worker withholds permission to do this).	✓ Claim owner ✓ Health Care Programs (quality assurance supervisor or program manager for Home Care Services)	Verbally report on same day as incident (unless situation prevents this), and within one business day at the latest. Submit Form 83M380 within one business day of incident.
You or any personnel are aware of a threat to a WorkSafeBC employee or property 1. Call police immediately to report threat. 2. Contact WorkSafeBC. A WorkSafeBC officer will gather information from you to complete a Threat Report, and Corporate Security staff will follow up with you.	✓ Claims Call Centre: 1.888.967.5377 (1.888.WORKERS) ✓ Claim owner	Verbally report as soon as possible. (Claims Call Centre is open Monday to Friday, 8 a.m. to 6 p.m. PT) Submit Form 83M380 within one business day of threat.
An injured worker harms or directly threatens you or any personnel 1. Call police immediately. Report threat or act of violence. 2. Contact WorkSafeBC. A WorkSafeBC officer will gather	✓ Claim owner ✓ Health Care Programs (quality assurance supervisor or program manager	Verbally report and submit Form 83M380 within one business day of incident.

information from you to complete a Threat Report, and Corporate Security staff will follow up with you. 3. Contact attending physician or nurse practitioner.	for Home Care Services)	
All other types of incidents 1. Contact WorkSafeBC. 2. Contact attending physician or nurse practitioner, as appropriate.	✓ Claim owner ✓ Health Care Programs (quality assurance supervisor or program manager for Home Care Services)	Verbally report and submit Form 83M380 within one business day of incident.

In other specific circumstances

You'll also want to reach out to the appropriate WorkSafeBC officer in these cases:

Other Circumstances
You believe information you're documenting for us could pose an immediate risk of harm to the injured worker (if the worker were to read the document)
An injured worker withdraws from services/treatment early or you are considering discharging them early
An injured worker misses appointments
Your clinic is planning non–public holiday closures or interruptions to your services. Note: call both the WorkSafeBC officer and Health Care Programs
To request interpretation services if you need them to communicate with the injured worker

You may also find this resource helpful to pass on to injured workers in need:

WorkSafeBC Crisis Line
Contact the Crisis Line if you or your family is in emotional crisis and you've been injured at work. Our counsellors can provide support to you and your family, refer you to other services in your community, and alert us so we can follow up with you. • Phone toll-free: 1.800.624.2928 • Hours of operation: 7 days a week, 24 hours a day You don't need a WorkSafeBC claim to call us for help. However, if you have been injured at work and would like to start a claim, please contact our Claims Call Centre for help with the claims process.

How to communicate with attending physicians or nurse practitioners and specialists

You're encouraged to contact the attending physician or nurse practitioner or specialist as appropriate. For example, reach out:

- To obtain wound care or IV orders
- If you've made findings that are inconsistent with the injured worker's initial diagnosis
- If there's been a significant change in the injured worker's condition

Providing your services — from basics to details

Steps covered in this section:

Detailed processes covered in this section:

Providing your services — Part 1: The basics

Your journey with an injured worker begins with receiving a referral from us. Once you accept the referral, you'll have access to a disclosure with important medical and other information about the injured worker. You'll book your first appointment with the worker for an initial Assessment or medical escort and develop a care plan. If service progresses, you'll provide Progress Reports to us and invoice us regularly. When services wrap up, you'll submit a Discharge Report.

Receive and respond to referrals

The first step to providing care for an injured worker is receiving a referral from us through the WorkSafeBC Provider Portal.

To ensure you are receiving referrals as early as possible, sign up for email notifications in the "email notification" tab in the Provider Portal.

Referrals contain basic information about the injured worker's claim and care plan needs. If you are unclear about any of the information provided in a referral, contact the WorkSafeBC officer for clarification.

If an external referral source (for example, a physician or nurse practitioner, or another provider) contacts you directly, contact a WorkSafeBC officer to process the referral through the Provider Portal.

How to handle referrals

1. Acknowledge the referral.
2. Assess the referral.
3. Accept or decline the referral.
4. If you accept the referral, book your first appointment with the injured worker.

Check the WorkSafeBC Provider Portal Quick Reference Guide or watch the referrals training video for instructions on how to complete these steps.

Referral timelines

Acknowledge the referral (open and review it) within one business day of it being sent.

- The date that you acknowledge the referral is known as the **referral date** and all contractual timelines that follow are based on this date.

Accept, or decline (if appropriate) the referral within one business day of the referral date.

- Our expectation is that you will fully attempt to accept all referrals within your contracted area(s).

Schedule the initial assessment appointment to take place within 2 business days of the referral date.

- If you are unable to schedule the appointment within this timeframe due to reasons outside of your control (the injured worker has not yet been discharged from hospital, etc.), place the referral on "hold" within the Provider Portal and schedule the appointment at the earliest opportunity (upon discharge, etc.).

  **Note: A referral must either be "scheduled" or put on "hold" within 2 business days, or the referral may be redistributed by WorkSafeBC to another provider.*

If the injured worker is unable to keep the scheduled initial assessment appointment, try to reschedule it within five business days of the original appointment date.

- Rescheduled appointments do not require a new referral, just be sure to notify the WorkSafeBC officer and update the Provider Portal with the new date and time.

Referrals outside of your contracted area

If you erroneously receive a referral for an area (location code) in which you are not approved to provide services (which may occur due to BC's postal codes not aligning exactly with the Home Care service regions), unless it is an extenuating referral, please immediately decline the referral, selecting the reason:

- "Provider Exceptions" → "Program Fit" → "Not Contracted to deliver program at referred location"

For a list of your contracted areas (location codes), please refer to Schedule C of your Home Care Services Agreement.

To view all the Location Codes in BC, please refer to Appendix C: Map of Home Care Service Regions and Location Codes and Appendix D: List of Home Care Service Regions and Location Codes.

Note: WorkSafeBC may withdraw a referral that is sent to you in error. If you have already initiated any services (reviewed the medical disclosure, contacted the injured worker to schedule the initial assessment, etc.) you may invoice a referral fee under the applicable fee code and rate provided in Schedule B.

Extenuating referrals

From time to time, you might be requested to provide services outside of your contracted area. These referral exceptions (extenuating referrals) may arise if the contracted providers for that area are unable to provide the necessary services.

Extenuating referrals will be sent through the Provider Portal as usual; however, they will be accompanied by a phone call (or voicemail) from Provider Referrals to indicate that it is an exception referral, which will distinguish it from one that was sent in error, which you should decline, as above.

If you can accept the extenuating referral, please refer to the travel for extenuating referrals section of this manual for applicable travel billings to/from outside of your contracted area.

If you are unclear as to whether a referral was sent in error or by exception, please contact Provider Referrals.

Let Health Care Programs know if at any time you do not wish to receive Extenuating Referrals.

Access disclosures

A disclosure contains documents or records related to an injured worker's claim with WorkSafeBC. We give you disclosures to support your treatment and care of injured workers. Disclosures may include anything from the injured worker's medical history to treatment plans and reports.

Find disclosures on the Provider Portal

In most cases, you'll automatically receive a disclosure on the WorkSafeBC Provider Portal shortly after accepting a referral. The disclosure should be reviewed by your nurse before conducting the initial assessment.

In some cases, you may need to request a disclosure via the Provider Portal. For example, if new information is added to a disclosure package after you've already received the package, you'll need to request the disclosure.

See our Accessing disclosures online PDF for instructions on how to access and request disclosures on the Provider Portal.

Obtain approval for your care plan

Once your nurse has conducted an initial assessment with the injured worker, it's time to make a care plan.

All recommendations in your initial assessment and care plan, and throughout your work with us, must be:

- Based on the compensable injury
- Medically required and based on objective findings
- Reasonably necessary
- The least costly, equally effective option for addressing the relevant issue (you should indicate which option, in your opinion, is the preferred option)

When seeking approval for care services (or proposing changes to the original care plan and/or service recommendations), you must contact the relevant WorkSafeBC officer to discuss and to get their approval.

- Note: Approval is usually given verbally but may also be provided in writing.

Remember: Home Care Services are intended to complement and supplement, not replace, the efforts of an injured worker to care for themselves. Care is directed towards improving the injured worker's physical and functional levels and educating the injured worker (and others involved in their care) in order to assist them in functioning as independently as possible.

If you don't receive a timely response from the WorkSafeBC officer on an issue that requires an answer:

1. Contact the service coordinator.
2. If the service coordinator can't assist:
   a. Call our Claims Call Centre to be directed to the client services manager.
   b. Call the quality assurance supervisor in Health Care Programs.

Implement services

Once you have received approval for the care plan, including the level of required care services, contact the injured worker to confirm the time and place of their first service.

Care services should begin as soon as possible, or within five business days of the referral date. Notify the WorkSafeBC officer if services are, for any reason, unable to be initiated.

Submit your invoices and reports

Submit invoices and reports through the WorkSafeBC Provider Portal. Check the Provider Portal Quick Reference Guide or watch our training videos on invoicing and clinical reporting for instructions.

In some cases, you'll need to submit a report before you can submit an invoice. Refer to Schedule B of the Home Care Services Agreement for details.

To learn more about reporting and invoicing, see Providing your services — Part 2: The details.

Follow the do's and don'ts of treating injured workers

While every injured worker is unique, a few general rules apply.

Do treat accepted conditions only

Only treat conditions that WorkSafeBC has accepted are a compensable consequence of the claim. By law, WorkSafeBC can't authorize treatment for pre-existing physical, cognitive, or psychological conditions or concurrent issues in the injured worker.

If you discover issues that have not been accepted under the claim but that are affecting progress of care services, reach out to the appropriate WorkSafeBC officer. You may be able to help the injured worker find other community resources to assist with their non-compensable issues. However, this must be discussed with the WorkSafeBC officer before discussing the possibility with the injured worker or documenting it in a report.

Do tell the injured worker how their information may be used

All injured workers must be reminded of the limitations of confidentiality and how clinical records are disposed of.

Under the *Workers Compensation Act*, WorkSafeBC is empowered to collect and share any and all information deemed relevant to the adjudication and management of a claim. WorkSafeBC can obtain copies of hospital records, clinical records, employment and school records, and any other information needed to perform its duties under the Act. This includes access to all treatment records, including your clinical notes.

When a worker applies for a claim, they consent to the collection and use of personal information for the purposes of adjudicating and managing the claim.

Before beginning care services, you may remind the injured worker that if a decision on the file is appealed by either the injured worker or the employer they were working for at the time of their workplace injury, the contents of the entire claim file are disclosed to both parties. This includes information in provider treatment records submitted to WorkSafeBC. Your clinical notes could be disclosed in this way if WorkSafeBC has requested them and the notes form part of the injured worker's claim file.

Don't act as an advocate

Most professional codes of conduct address the issue of clinical advocacy. As a contracted Home Care Services provider, you must give a well-reasoned clinical opinion based on objective assessments and observations of the injured worker's needs. You must refrain from advocating for the injured worker in legal, adjudicative, entitlement, and benefit matters, and you must not advocate for needs that are not a compensable consequence of the claim.

WorkSafeBC officers use the information in your reports to understand an injured worker's clinical status. Claim owners weigh this information when making decisions. If you take a claim advocacy stance, your opinions are no longer clinically objective. Your role as a provider is to assist with activities of daily living and recovery of function and independence. Claim advocacy can place you in a dual relationship and seriously undermine the claims-management process. Advocating for an injured worker or selectively omitting information about the impact of non-injury–related needs in reports or other correspondence with WorkSafeBC is a serious breach of the Home Care Services Agreement.

Advise any injured worker in your care to contact the claim owner and/or the Workers' Advisers Office, which is independent of WorkSafeBC, if they have concerns about how their claim is being managed.

Don’t give information to the injured worker that could cause immediate harm

Injured workers can access documents on their claim file through an online portal. In addition, an injured worker may request a copy of a specific document from a WorkSafeBC officer or a complete copy of their claim file at any time.

The information you provide to WorkSafeBC about the injured worker can be accessed by the injured worker.

If you believe the information you provide will pose an immediate risk of harm should the injured worker access the information, contact the case manager or appropriate WorkSafeBC officer before submitting the document.

Monitor injured worker attendance

To benefit from your services, the injured worker needs to be present for your visits. Let us know if this isn’t happening.

Appointment scheduling

Be sure to contact the injured worker the day or two preceding a new appointment to confirm the details, or with any changes to standing appointments.

- Fees related to missed visits are not billable if the appointment is not confirmed in advance.

What if an injured worker doesn’t show up to appointments?

If an injured worker is not home for a scheduled and confirmed visit, personnel must wait for 30 minutes before they may leave the home and for this to be considered a missed visit. In these circumstances, you may invoice an ‘injured worker not available’ fee under the applicable fee code and rate provided in Schedule B.

Similarly, if an injured worker cancels a visit within 24 hours of the appointment start time, and if you are unable to find replacement work for your staff, you may invoice the ‘injured worker not available’ fee.

In your clinical records, determine and document the reason for all missed or cancelled visits (including whole or part shifts). These also must be included within the service deviations section of your monthly Progress report.

Clinical judgment should be used when determining whether a missed or cancelled visit should be reported to the WorkSafeBC officer; however, patterns of missed or cancelled visits must be reported.
If an injured worker declines services for 3 three successive visits, declines any one appointment that may lead to immediate risk to self or others, or does not engage with services following the initial assessment, report it to the WorkSafeBC officer.

Similarly, any absences or service interruptions of more than 3 visits or 1 week (whichever is greater), for reasons such as illness, surgery and/or hospitalization, pre-planned vacation, etc., must be reported to the WorkSafeBC officer.

If a service interruption continues for more than 30 days, the injured worker should be discharged from services. If the injured worker is referred back to you at a later date, all steps of the referral process must be followed again, including a new assessment and submission of the Initial Assessment and Care Plan forms.

Note: the exception to this is when an injured worker receives foot care services only, which are typically provided every 4-6 weeks, so these files shall not be discharged every 30 days.

What if a caregiver doesn't show up to an appointment?

If any personnel miss a shift without prior notice to the injured worker and/or the WorkSafeBC officer and there is a negative clinical impact to the injured worker, you must complete and submit a Health Care Programs Incident Report (form 83M380) to WorkSafeBC within one Business Day of the missed shift.

You may not invoice WorkSafeBC for any related fees where an appointment is cancelled or missed by personnel.

Can an injured worker withdraw or be discharged early from services?

You may discharge an injured worker who is not benefitting from Home Care Services because of poor attendance. Details of the attendance issues and a functional summary must be included in your Discharge Report.

Tell a WorkSafeBC officer immediately if an injured worker has refused services or if you're considering a discharge for the reasons above.

The injured worker can voluntarily withdraw from Home Care Services, and a WorkSafeBC officer can withdraw the injured worker from Home Care Services, at any time.

If you are unable to continue providing services to an injured worker, ensure that a Health Care Programs Incident Report (form 83M380) has been submitted documenting the reason(s) that services cannot continue, including all remedies you have attempted to maintain services, and then contact the WorkSafeBC officer and Health Care Programs for further instructions.

Handle transfers, closures, and more

Your office may occasionally need to close (expectedly or unexpectedly), or an injured worker may be transferred to or from your care. Here's how to handle these situations.

An injured worker is transferred

Sometimes an injured worker is transferred from one provider to another. When this happens, the second provider shall request relevant clinical information from the WorkSafeBC officer and shall review the medical disclosure on the Provider Portal. Any pertinent information must be relayed by telephone before the injured worker's first day of service with the new provider.

The Discharge Report must be submitted by the first provider within 5 business days of the date of discharge.

An injured worker initiates an interruption to services

The appropriate WorkSafeBC officer must approve all interruptions to services.

Type of interruption	Who to contact	What to document
Fewer than 3 consecutive days	No one (Continue to monitor for patterns.)	✓ Reason and duration of the interruption (in a Progress Report).
3 to 30 consecutive days — e.g., injured worker is: • On vacation (pre-approved by WorkSafeBC officer)	WorkSafeBC officer	✓ Reason and duration of the interruption (in a Progress Report)

• Absent due to compensable or non-compensable medical conditions (e.g., hospitalization)		
More than 30 consecutive days • (Foot care only excluded)	WorkSafeBC officer (they must be consulted about the discharge in this case)	✓ Reason for the interruption, last date of service, etc. (in a Discharge Report)

You temporarily close your office or suspend services (due to weather, holidays, etc.)

Type of closure or suspension	Who to tell	Important to note
Unexpected closure — e.g., • There are no available personnel • There's an extreme weather event	✓ Affected injured worker(s) ✓ WorkSafeBC officer for each injured worker ✓ Health Care Programs	Contact as soon as possible
Planned closure for a public holiday • New Year's Day • Family Day • Good Friday • Easter Monday • Victoria Day • Canada Day • B.C. Day • Labour Day • National Day for Truth and Reconciliation • Thanksgiving Day • Remembrance Day • Christmas Day • Boxing Day	✓ No one (if office closure) ✓ WorkSafeBC officer for each injured worker (if service is required, but you are unable to deliver them)	Public holidays are not counted as business days, but you may choose to remain open. You may provide services to injured workers on public holidays where it is clinically indicated, and where it has been approved in advance by the WorkSafeBC officer (e.g., where daily care services are required), billable under the applicable stat holiday uplift fee code and rate provided in Schedule B.
Planned closure that's not a public holiday	✓ WorkSafeBC officer for each injured worker ✓ Health Care Programs	Contact as soon as possible

Use telehealth treatment appropriately

In some cases, you may use video-call technology — aka telehealth, to conduct re-assessments, where determined clinically appropriate by your nurse and as approved by the appropriate WorkSafeBC officer. In your Progress Report, include your reasons for using telehealth delivery, how often you'll provide re-assessments this way, and noting the WorkSafeBC officer's approval.

You're expected to conduct the initial assessment in person, as well as perform an in-person re-assessment (Progress report) at least once per year. In-person assessment visits are preferred whenever possible and telehealth should typically only be conducted where the injured worker lives in a remote area, or under other extenuating circumstances (a pandemic, etc.).

Assessments/re-assessments should not be done over the telephone; any exceptions to this would require approval from Health Care Programs.

When using telehealth services, you must comply with our Telehealth treatment guidelines (Appendix I).

Use interpretation services as needed

To help you communicate with injured workers with limited English proficiency, WorkSafeBC has contracted interpreters who provide in-person, video, and telephone interpretation services throughout B.C.

Approved interpretation providers will bill WorkSafeBC directly for interpretation services. If your organization has an in-house interpreter, interpretation provided by the in-house interpreter must not be billed to WorkSafeBC.

The Contractor shall attempt to schedule care personnel who speak the same language as the injured worker wherever possible; no additional fees are billable to WorkSafeBC in this scenario.

Who books the interpreter?

If you're aware of or anticipate the need for interpretation services for an appointment, let us know.

How to work with us to book an interpreter

Contact the claim owner and service coordinator.	If an interpreter is deemed necessary for the appointment to take place, the service coordinator will arrange the appointment with the interpretation provider.
Tell them exactly what's needed.	Tell the claim owner and service coordinator: • The type of appointment required (in-person, telephone, or videoconference interpretation) • How many hours you'll need the interpreter for • The length of any breaks that will be included
Notify them if the appointment needs to be cancelled or rescheduled (ideally with >24 hours' notice).	The service coordinator will reschedule with the interpreter and can help you communicate the new appointment details to the injured worker if necessary (date, location, time, number of hours required, and length of any breaks that may be expected).
Tell Health Care Programs about any quality concerns.	E.g., report if: • The interpreter is late • The interpreter does not attend the scheduled appointment

Learn more on our Interpretation, translation & sign language services webpage.

Other important information

Stay safe when visiting an injured worker's home

Your nurse's initial assessment visit also acts as a safety and risk assessment of the care environment in consideration of your staff attending. During this assessment, the nurse should consider anything that may put personnel at risk, including but not limited to location, time of day for the shift(s), streetlights, road conditions, access to the home, bus routes, interior cleanliness, pets, and other safety hazards (roommates, evidence of drug or alcohol abuse, etc).

Make sure you comply with the Occupational Health and Safety Regulation while providing care services. Ensure all personnel are aware of the safety risks and hazards at the site of care provision and that they have any personal protective equipment (PPE) that may be required (gloves, masks, gowns, etc).

Take care whilst driving between clients as well; some of our most serious claims come from motor vehicle accidents.

Providing your services — Part 2: The details

Now that you understand in broad strokes how to work with us, it's time to get into the nitty-gritty — especially when it comes to completing and submitting reports and invoices. (For a quick summary of which tools to use to submit reports and invoices, see Providing your services — Part 1: The basics.)

Reports – why are they important?

You are our eyes and ears…

A home care nurse acts as an external source of expert opinion. WorkSafeBC officers rely on evidence in the form of health care provider's reports (both verbal and written) to determine which health care benefits will be funded for the injured worker. WorkSafeBC officers make findings based on evidence (reports), apply law and policy, and decide upon what action to take.

As such, timely and high-quality reports are very valuable to WorkSafeBC officers and are in the best interest of the injured worker so that they may receive the health benefits that they may be entitled to.

How to send us reports

Follow three steps

We provide you with detailed forms and guidelines to report on different aspects of the services you provide the injured worker.

1. **Download the right form**

   You'll find links to the specific forms you need to submit in Appendix E. Re-download forms any time you receive an Information Bulletin about updates to them. This will ensure you're using the most up-to-date version of each form.

2. **Complete the report**

   Be sure each page of the document includes:
   - Injured worker's name
   - Injured worker's claim number
   - Document name and page number
   - Document ID (the five- to six-digit code provided in the Agreement for each specific type of report you'll be completing)

   Wherever possible, use photographs in your report to document the status/progress, such as for wounds.

   Appendix E in the back of this reference manual includes detailed guidelines which will help you to complete reports correctly.
   - To learn the difference between a "restriction" and a "consideration" when making recommendations, see Appendix H.

3. **Send the report to us on time, using the correct tool**

   Reports must be submitted electronically through the WorkSafeBC Provider Portal.

   Only reports sent through the Provider Portal will be used to determine report timeliness for the purposes of invoicing.

Reporting requirements and timelines

The following table summarizes the required report forms, whom they are to be completed by and when they are to be submitted. For more details, see the Other important information for reporting and Form specific information sections below.

Form	Completed by	Submission Notes	Submission Timeline (Excluding any "holds")
Referral and Services Confirmation Form 83M377	Any personnel.	Only submitted in cases where an initial assessment is **not** required, in lieu of the Initial Assessment and Care Plan forms.	3 business days from the referral date.
Initial Assessment Form 83M378	Any Nurse (Registered Nurse (RN), Registered Psychiatric Nurse (RPN) or Licensed Practical Nurse (LPN)), unless RN is requested.	Submitted following an in-person assessment. Must be submitted alongside the Care Plan Form 83M375.	5 business days from the referral date.
Care Plan (initial) Form 83M375	Any Nurse (RN, RPN or LPN), unless RN is requested.	Submitted following an in-person assessment. Must be submitted alongside the Initial Assessment Form 83M378.	5 business days from the referral date.
Care Plan (subsequent) Form 83M375	Any Nurse (RN, RPN or LPN), unless RN is requested.	Submitted following an in-person re-assessment, unless the progress visit was pre-approved by the WorkSafeBC officer to be conducted via Telehealth. Must be completed in person annually at minimum. Must be submitted alongside a Progress Report Form 83M379.	Submitted alongside a Progress Report if there have been any significant changes to the services and/or care plan. Required annually at minimum, within 7 business days of the anniversary of the date of the last care plan submitted.
Progress Report Form 83M379	Any Nurse (RN, RPN or LPN), unless RN is requested.	Submitted following an in-person re-assessment, unless pre-approved by the WorkSafeBC officer to be conducted via telehealth. Must be completed in-person annually at minimum.	Monthly, within 7 business days of the anniversary of the date of the preceding month's Progress Report, or with any change in status or service, or as requested by WorkSafeBC. OR Required quarterly at minimum, within 7 business days of the date

			of the preceding quarter's progress report, for those injured workers receiving foot care services only, or where pre-approved by the WorkSafeBC officer for long-term (>6 months), stable injured workers.
Discharge Report Form 83M376	Any Nurse (RN, RPN or LPN), unless RN is requested.	Submitted following an in-person re-assessment, unless pre-approved by the WorkSafeBC officer to be conducted via telehealth. In some cases a re-assessment may not be required prior to the discharge (a WorkSafeBC officer directs the discharge, the injured worker passes away, etc.), but the discharge report shall still be completed and submitted to document services ending.	7 business days from the last date of service (or from the date the injured worker is otherwise discharged).
Incident Report Form 83M380	Individual personnel most knowledgeable of the incident.	Refer to: When incidents or threats occur for details on when to submit this form and the processes surrounding it.	1 business day from the incident.

Other important information for reporting

- Reports must be completed using the appropriate WorkSafeBC form in Appendix E, shall be type-written, completed in full (i.e., no blank fields), accurate, and completed as objectively as possible.
- Assessment and re-assessments, and associated reports, may be completed by any nurse (RN, RPN or LPN) who has the scope of practice appropriate for the injured worker's clinical condition, unless the WorkSafeBC officer specifically requests that it be completed by an RN.
- In-person assessments and re-assessments are preferred whenever possible. If an assessment/re-assessment is approved to take place via telehealth (i.e., video), be sure to use telehealth treatment appropriately.
- Assessment/re-assessments and subsequent recommendations for services must:
  - be clinically appropriate/medically necessary (which may be different from what the injured worker *wants*);
  - be related to the compensable injury;
  - be directed towards improving the physical and functional levels of the injured worker and educating them (and others involved in their care) to be able to function as independently as possible; and,
  - complement and supplement, but not replace, the efforts of an injured worker to care for themselves with the assistance of others involved in their care.
- Be sure to select the appropriate form ID when submitting the report within the Provider Portal. The relevant report form must be received, and within a timely manner, for it to be paid.

- Ensure that the DOS (date of service) at the top of your report is the date the visit took place with the injured worker for the assessment/re-assessment; this date must also match the DOS of the billing to ensure smooth payment processing.
- If a report is incomplete, or otherwise does not meet WorkSafeBC's requirements, you may be requested to properly complete the report and re-submit it to WorkSafeBC, without any additional payment.
- If you made an error in a report that requires correction following submission, or if a report is sent to the wrong claim file, contact the WorkSafeBC officer for direction – they can remove the erroneous report from the claim file and then you can re-submit the correct report.
- Services must be approved by the WorkSafeBC officer before they are included in your reports, and before you provide them to the injured worker (other than conducting the initial assessment). As such, reports shall only include services that have been authorized by the WorkSafeBC officer.
- Be sure to incorporate service minimums within the hours being stated.
    - For example, if an injured worker requires an hour of HCA services in the morning and evening, with the 2 hour minimum per visit the hours stated within the report should be 4 per day.
- WorkSafeBC may disagree with your service recommendations and reserves the right to direct the care you provide to the injured worker. WorkSafeBC may also request an additional assessment by a third party.
    - If there are any discrepancies between your recommendations and the approved services, you can document these in the additional comments field of the reports and/or in your clinical records.
- Invoices must be in line with the current approved services being provided, as reflected within your reports. If your billings exceed the hours stated, they may be rejected and/or overpayments recovered by WorkSafeBC.

Form specific information

Below you will find some more information specific to each form. For more details regarding these forms, and how to complete them, please refer to Appendix E.

Referral and Services Confirmation (form 83M377)

- If an injured worker's required care services are less than 48 hours in duration, your nurse can determine whether an initial assessment is required or not.
- If an initial assessment is not required, complete and submit a Referral and Services Confirmation form to document the services taking place, as discussed and authorized by the WorkSafeBC officer, including the first and last DOS, location of the services, any specific travel authorizations, etc.
- No other forms are required to be completed and submitted under the scenario above.
- This form can be completed by anyone (i.e., it does not have to be completed by a nurse).

Reviewing of reports

Note: Any WorkSafeBC staff may review your reports too (i.e., someone other than the WorkSafeBC officer you are communicating with). As such, every report should include enough detail for a layperson to get an understanding of the injured worker's compensable injury, current health status, current function (related to compensable injury), details of the services you are providing and an objective, clinical rationale for the level of care that is in place.

- If the service requirements and/or service details change following the submission of this form, submit a revised Referral and Services Confirmation form outlining the revised services. If the change means that services are now required for a longer duration than originally anticipated (i.e., greater than 48 hours), the usual steps of a referral should take place, including the completion of the initial assessment and care plan forms.
- There is no payment for the submission or re-submission of a Referral and Services Confirmation form; rather, it is included within the Referral Fee.

Initial Assessment (form 83M378)

- Within 2 business days of the referral date (excluding any referral "holds"), you should:
  - Review the injured worker's medical disclosure.
  - Schedule a nurse visit to conduct the initial assessment, which must take place in person.
  - Your nurse contacts the WorkSafeBC officer to discuss their findings and recommendations and to receive approval for the care services.
  - Contact the injured worker to confirm the date and location of their first service.
- Contact the WorkSafeBC officer if you are unable to reach the injured worker or if, for any reason, you are unable to initiate the services listed above.
- The initial assessment and care plan is:
  - only payable where in-person assessment took place and where both the initial assessment and care plan forms are received concurrently;
  - billed as a flat fee, inclusive of the time for your nurse to conduct the in-person assessment with the worker, the phone call to the WorkSafeBC officer, the time to complete and submit both report forms, etc.;
  - paid at a reduced fee if the forms are received later than the required timelines; and
  - only billable once per referral (i.e., at the start of services, or upon the re-starting of services following a previous discharge).
- Be sure to submit the initial assessment form as its own document, selecting the appropriate form ID, when submitting it alongside the care plan form.
- Any subsequent re-assessment shall be completed and billed as a progress report or a discharge report, as applicable.

Care Plan (form 83M375)

- The care plan shall be completed by the same nurse that conducted the initial assessment, or re-assessment, in collaboration with other health care providers responsible for the injured worker's care and should be submitted at the same time as the initial assessment form (for the initial care plan) or progress report (for subsequent care plans).
- Be sure to submit the care plan form as its own document, selecting the appropriate form ID, when submitting it alongside an initial assessment or progress report form.
- Provide a copy of a care plan to the injured worker and request that they keep it in the home, being sure that an updated care plan is always in the home.
- Submit an updated care plan form alongside a Progress Report when:
  - there are significant changes to the injured worker's care plan and services;
  - it is requested by the WorkSafeBC officer; or
  - it has been one year since the last care plan was submitted.
- If the care plan changes following the submission of the initial assessment and care plan forms, you should submit a progress report with the details and outlining the changes and the updated services to be provided. If these changes are significant, the progress report should be accompanied by an updated care plan form, as noted above.

- There is no additional payment for the submission of an updated care plan; rather, it is included within the progress report fee.

Progress Report (form 83M379)

- Progress reports are completed after an in-person re-assessment has taken place by your nurse, unless pre-approved by the WorkSafeBC officer to be conducted via telehealth, to review the current care services being provided to the injured worker (since the last assessment) and any recommended changes to the care plan and/or care services, which have been discussed with and authorized by the WorkSafeBC officer.
- Submit a progress report if there has been any change in health status or change to their care services, and no less frequently than monthly (unless the below circumstances apply), or at any time upon request by a WorkSafeBC officer.
- You may submit quarterly reports (i.e., every 3 months) if:
  - the injured worker is only receiving foot care services from you; or
  - you have been providing care services to an injured worker for more than 6 months and the WorkSafeBC officer has approved a reduction in the frequency of progress reporting to quarterly, provided that:
    - if the injured worker's medical status declines, your nurse assesses the need to resume monthly progress reports until such time that the injured worker's medical status has stabilized; and
    - you resume monthly progress reports at any time if requested by WorkSafeBC.
- Where a progress report was completed in person, bill the progress report fee – with visit, which is a flat fee inclusive of the time for your nurse to conduct the in-person re-assessment with the worker, the phone call to the WorkSafeBC officer, the time to complete and submit the report form, etc.
- If a progress report was completed via telehealth, use the appropriate telehealth fee code (based on the designation of the nurse) to bill for the time it took to complete the video assessment (i.e., the actual time spent on the video call, to the nearest 15 minutes) and bill this concurrently with the progress report fee – without visit for the time to complete and submit the updated report.
- Both the progress report fee – with visit, and the progress report fee – without visit, must be billed using the appropriate fee code and rate matching the designation of the nurse that conducted the re-assessment and completed the report, and are only payable where a progress report form has been received, and in a timely manner.

Discharge Report (form 83M376)

- An injured worker shall be discharged from care services when:
  - they return to work or otherwise recover from their compensable injury and no further care services are indicated;
  - they pass away;
  - they are transferred to another Home Care Services provider;
  - service has been interrupted for more than 30 days;
  - they withdraw from services; or
  - as otherwise directed by WorkSafeBC.
- Be sure to notify the WorkSafeBC officer immediately if an injured worker withdraws from services, otherwise, where your nurse has assessed that an injured worker can be discharged, contact the WorkSafeBC officer to discuss the discharge plan and recommendations for the injured worker at least 5 business days prior to discharge.

- A discharge report needs to be submitted for every injured worker who received care services from you (unless the care services were less than 48 hours in duration, as noted above in the Referral and Services Confirmation form section).
- Where a discharge report was completed following an in-person re-assessment by a nurse, bill the discharge report fee – with visit, which is a flat fee inclusive of the time for your nurse to conduct the in-person re-assessment with the worker, the phone call to the WorkSafeBC officer, the time to complete and submit the report form, etc.
- If a discharge report was completed following a nursing re-assessment via telehealth, use the appropriate telehealth fee code (based on the designation of the nurse) to bill for the time it took to complete the video assessment (i.e., the actual time spent on the video call, to the nearest 15 minutes) and bill this concurrently with the discharge report fee – without visit for the time to complete and submit the report.
- If the WorkSafeBC officer directs the discharge, and/or a nursing assessment was not otherwise required, bill the discharge report fee – without visit for the time to complete and submit the report.
- Both the discharge report fee – with visit, and the discharge report fee – without visit, must be billed using the appropriate fee code and rate matching the designation of the nurse that completed the report, and are only payable where the discharge report form has been received, and in a timely manner.

Incident Report (form 83M380)

- Refer to: When incidents or threats occur for details on when to submit this form and the processes surrounding it.

How to submit invoices

Follow four steps

1. **Select the right invoice**

   You will be submitting your invoices electronically through the Provider Portal, along with any necessary supporting documents (e.g., receipts).

2. **Complete the invoice**

   Ensure the following information about the injured worker is on the invoice:
   - Injured worker's name
   - Date of birth
   - WorkSafeBC claim number

3. **Double check before you submit**

   Is the date of service correct?

Stick to the fee schedule

WorkSafeBC officers don't have the authority to approve services or charges that deviate from the Agreement and fee schedule. If a WorkSafeBC officer has requested or approved a service that is outside of the parameters of the Agreement, remember to contact Health Care Programs for approval.

For example, if you're invoicing for completing a Progress report for us, the date of service on the invoice must match the date of service on the report, which is the date the re-assessment visit took place (not the date you wrote the report or submitted it, nor the date you submitted the invoice).

Am I using the right fee codes?

Incorrect or missing fee codes are among the most common reasons for delays in payment. Please refer to Schedule B of the Home Care Services Agreement.

Do I have approval for the services I'm invoicing?

If you provide any services to an injured worker without approval, or if you provide services that are outside of the scope of the approved care plan (without prior approval from the WorkSafeBC officer), you are not entitled to submit an invoice or receive any payment for such services.

Do the services I'm invoicing match what is stated within our reports?

The services being invoiced must align with the current approved services being provided as reflected within your reports. If your billings exceed the hours stated, the billings may be rejected and/or the overpayments recovered by WorkSafeBC.

Am I invoicing the correct (actual) service hours?

WorkSafeBC only pays for the actual length of the service visit that took place, not the scheduled length of the visit, in quarter hour increments after the minimum charge.

Have I attached supporting documents (receipts) for the fee codes that require them?

If you are invoicing for reimbursement of Disposable Medical Supplies or Pre-Authorized Travel Expenses, you must attach a copy of the original receipt to the invoice.

4. **Send the invoice to us on time, using the correct tool**

   Submit your invoice to us through the Provider Portal within 90 days of the date of service. Invoices received more than 90 days from the DOS may not be paid.

Correct the invoice promptly if necessary

Sometimes we're not able to accept an invoice because of an inconsistency or error. In these cases, you can follow up, resolve the issue, and still get paid — provided you rectify the error within **180 days of the date of service, or within 90 days of the date of the first rejection** (whichever is longer).

If you're following up on an issue with an invoice, please contact Payment Services at 604.276.3085 or toll-free at 1.888.422.2228. We're happy to help.

Other important invoicing information

To avoid payment issues, or future payment adjustments, be sure to:

- Follow the Guidelines for using Schedule B document in Appendix F, which includes instructions and examples of how to bill each fee code.
- Watch out for fee codes that should not be billed concurrently (on the same DOS), such as nursing services on the same DOS as an assessment/re-assessment.
- Invoice in line with the current approved services being provided, as reflected within your reports.
- Invoice the hours on the correct DOS, based on a 24-hour clock. The hours billed on a given DOS must only reflect the hours worked within 00h00 and 24h00 (i.e., midnight to midnight) of that day.

If your staff complete an overnight shift spanning across 2 DOS at midnight, be sure to bill the hours respectively per DOS. For example:
    - If your staff completed a shift from 7:00 pm – 7:00 am, the billing should be 5 hours on the first DOS (i.e., 7:00 pm – midnight) and then 7 hours on the next DOS (i.e., midnight to 7:00 am).
- Only bill only 1 line item for a given service/fee code per DOS, with the total amount billable under that fee code for the day. For example:
    - If 3 HCA visits of 2 hours each took place on one DOS, bill the total amount of 6 hours on one line.
    - If 2 different staff travelled to visit an injured worker on the same day, bill the total travel time for the day under their respective designation (i.e., RN, HCA, etc.), but bill the total mileage for the day (i.e., for all care designations) on one line, since the fee code for mileage is the same.
- Do not include in your invoice any costs associated with your business operations, unless otherwise set out in Schedule B, including incidental supplies provided to the injured worker (such as office supplies, brochures, educational literature, etc.).
- Minimize expenses where possible, including arranging appointments with injured workers located in the same region to maximize efficiency and minimize cost. Allocate travel time equally among injured workers located in the same region and seen on the same DOS, where applicable. See the Travel - personnel section for more information regarding billing for travel.
- Do not bill overtime; you are solely responsible for your staffing and scheduling needs to comply with your service obligations.
- Check your invoice payment status through the Provider Portal.

Note: all invoices are subject to verification by WorkSafeBC after payment and payment may be adjusted if the invoice does not comply with the Home Care Services Agreement or is otherwise incorrect.

Staffing requirements and qualifications

Under the Home Care Services Agreement, the province of BC is split up into multiple contracted areas, or location codes. You may be contracted for one location code, or multiple locations codes, as per Schedule C of your Home Care Services Agreement.

For each location code, you must ensure that you maintain sufficient staff to fulfill the necessary service requirements of injured workers being referred to you, which includes having at least:

- 2 nurses, 1 of which is preferably an RN, who are available to conduct assessments and provide nursing care services to injured workers; and,
- 2 HCAs, who are available to provide direct care services to injured workers.

Nurses (RNs, RPNs and LPNs) must be registered, licensed, and in good standing with the British Columbia College of Nurses and Midwives (BCCNM). If the BCCNM imposes any restrictions or considerations on a nurse delivering services under the Home Care Services Agreement, let Health Care Programs know immediately so that we can determine (at our discretion), whether such restriction or consideration affects the ability to provide the services.

HCAs work under the direction and supervision of a nurse and have either:

- completed a Resident Care Aide or Home Support Worker Program at an accredited educational institution supplemented with on-the-job training, or

- have basic health and medical care training including current CPR and first aid certification supplemented with on-the-job training/work experience as accepted by your nurse, and with Health Care Programs approval.

A nurse must be available to provide direction and support to your HCAs on an as needed basis.

We may request the names, experience, and qualifications of your staff at any time.

Other staffing requirements

In addition to the above, you must ensure that:

- You have staff available to provide care services up to 24 hours per day, 7 days per week.
- Alternate personnel are available to provide services if any scheduled personnel are unable to attend (or complete) a shift with an injured worker, and/or should the needs of the injured worker change (increase).
- Your business location has sufficient staff to fulfill your administrative duties, including referral management, invoicing, communication with WorkSafeBC officers, Health Care Programs, and others.
- You operate a call service line which is available to injured workers 24 hours per day, seven days per week, which has a nurse available for consultation as needed to address emergency situations and/or clinical issues arising in connection with the services, including schedule changes, staff changes, and general injured worker support.
    - Be sure to provide the telephone number for the call service line to every injured worker before their first service.
- Criminal record checks are completed and are up to date for all applicable personnel (those with access to children or vulnerable adults).

Service delivery and subcontracting

Service delivery

Services must be delivered in a manner that respects the injured worker and their privacy. Personnel are expected to be courteous and professional, and to refrain from inappropriate or obscene language while in the company of an injured worker. Personnel shall not discuss their hourly wages or complain about shift schedules or work duties with injured workers.

Use your best efforts to ensure the continuity of services for injured workers and minimize rotation and/or turnover of personnel. If you are struggling to fulfill an injured worker's service requirements, consider alternatives such as borrowing personnel from other areas, subcontracting with other care agencies, etc.

Subcontracting

If you are unable to manage all services required for an injured worker in their entirety, wish to continue to provide what services you are able to the injured worker, and therefore need the assistance of another agency, the services shall be delivered as a subcontracting relationship, with you (the primary contractor) remaining responsible for the performance of all of the services and compliance with the Home Care Services Agreement as well as for the billing, reporting, etc. As such, you must enter into written agreements with subcontractors which incorporate all terms and conditions of this Agreement applicable to all personnel.

Subcontracting arrangements require approval from the WorkSafeBC Director of Procurement Services prior to implementation, so reach out to Health Care Programs to discuss and request any subcontracting arrangements in advance (Health Care Programs will coordinate approval from Procurement Services).

Care services

Nursing services (RN, RPN or LPN)

Nursing services are billable where direct nursing care is provided to the injured worker (wound care, catheter care, home IV services, etc.) in accordance with the approved care plan.

- Nursing services **excludes foot care services**, which is treated and billed as a separate, flat rate service - see the Foot Care (RN, RPN or LPN) section below.

Nursing services may be provided by an RN, RPN, and/or LPN, who has the scope of practice appropriate for the injured worker's clinical condition. Nurses providing services to injured workers must be registered, licensed, and in good standing with the British Columbia College of Nurses and Midwives.

RPN services are invoiced under the same fee codes and rates as RN services. LPN services are invoiced under different fee codes and rates.

The minimum service visit for nursing services is 2 hours. Following that, nursing services are billable to the nearest 15 minute increment based on the **actual** time spent on the direct care provided (not the *scheduled* length of a visit).

Examples:

- Your RN was scheduled for 2 hours to provide home IV services; however, the actual service time was 1 hour and 25 minutes.
  - Billable as: 2 hours of RN services (i.e., the minimum charge).
- Your LPN is scheduled for 1 hour to provide a dressing change; however, the actual service time was 35 minutes:
  - Billable as: 2 hours of LPN services (i.e., the minimum charge).
- Your RN was scheduled for 3 hours to provide complex wound care for multiple wounds; however, the actual service time was 2 hours and 40 minutes.
  - Billable as: 2.75 hours of RN services (i.e., the actual service time, to the nearest 15 minute increment).

The regular nursing services fee codes are not billable concurrently with an assessment/re-assessment visit - see the Concurrent Nursing Services section below.

Your nurses must direct and supervise the care services being provided by an HCA and must be available to provide direction and support to them on an as needed basis at any time of day. Standard supervision and training are not billable to WorkSafeBC. For more information, and for some exceptions to this rule, please see the Training/supervision section below.

On rare occasions, WorkSafeBC may ask the nurse treating an injured worker to attend multidisciplinary and/or hospital discharge meetings to discuss the injured worker's care. If so, you can bill this under the applicable nursing services fee code and rate in Schedule B, according to the designation of the nurse that attended.

Supervising nurse

Assign a supervising nurse for each injured worker receiving care from you, who is responsible for conducting assessments, coordinating services, and contacting the WorkSafeBC officer. Unless you tell us otherwise, the last nurse to conduct an assessment for a particular injured worker will be deemed as the supervising nurse for that injured worker.

Keep the injured worker (and/or their representatives), any relevant clinicians involved in the injured worker's care, and the WorkSafeBC officer apprised if the supervising nurse changes and be sure that there is a smooth transition of care for the injured worker, or similarly, if the role of the supervising nurse is shared between nurses.

Level of care required vs. scheduled
All reasonable efforts should be made to schedule the level of care that the care plan/task requires, which means delegating applicable nursing tasks to LPNs, where appropriate, and scheduling HCAs for tasks that are delegable to HCAs.

- If the injured worker requires **HCA services** and you send a nurse to complete the shift, the services are to be billed under the HCA services fee code and rate, unless:
  - your nurse is conducting an in-person assessment visit and provides the necessary HCA services whilst they are there. In this case, you may invoice based on the designation of the nurse conducting the assessment, as concurrent nursing services. 2 hours is the maximum billable in this situation (HCAs should be scheduled for any services of a longer duration, or if the nurse stays longer than 2 hours, the additional hours must be invoiced under the HCA services fee code and rate).
- If the injured worker requires **nursing services**, you may invoice using the applicable fee code for the designation of the nurse who provided the services, presuming that you have taken all reasonable effort to fill the shift with the designation of care specified in the care plan (e.g., scheduling an LPN for basic dressing changes), or if it makes more sense financially (e.g., if an RN lives closer to the injured worker and it would cost more to send an LPN who lives farther away).

Concurrent nursing services
Where nursing services (excluding foot care – see below) are required while a nurse is visiting the injured worker for an assessment visit (an initial assessment, progress report or discharge report), the nurse shall keep track of the actual time spent on the nursing task(s) required, separate from the assessment time. This direct nursing care portion of the visit is billable to the nearest 15 minute increment, using the applicable concurrent nursing services fee code provided in Schedule B.

The minimum service visit of 2 hours is not applicable for concurrent nursing services since the flat fee for the assessment visit will be a synchronous billing.

Example:
- An injured worker requires a dressing change on the same DOS as the initial assessment. The nurse conducting the assessment is an RN. The assessment itself took 35 minutes and the wound care took 10 minutes.
  - Billable as: the initial assessment and care plan fee and 0.25 hours (15 minutes) of concurrent nursing services – RN

To reiterate: when it comes to invoicing the concurrent nursing fee codes, the term "concurrent" means that nursing services (excluding foot care) are provided on the same DOS as an in-person assessment/re-assessment visit.

Foot care (RN, RPN or LPN)

Where an injured worker requires (and has been approved for) foot care services, it is to be provided by an appropriately trained foot care nurse.

Foot care services are billed as a separate service to other nursing services, under the distinct fee code and rate provided in Schedule B. Foot care services are paid as a flat fee, regardless of the duration of the visit and regardless of the designation of the nurse providing the services (RN, RPN or LPN), and includes all the services related to the foot care.

Medical supplies required to perform the foot care services (e.g., foot care kit fees) may be reimbursed as disposable medical supplies.

Concurrent foot care services
Where foot care services are provided while a nurse is visiting the injured worker for an assessment visit (an initial assessment, progress report or discharge report), you may invoice *both* the applicable flat fee for the assessment visit, and the foot care flat fee, concurrently.

In the event that the injured worker also requires another nursing service (wound care, etc.) at the same time as the assessment and the foot care, this shall be billed under the applicable concurrent nursing services fee code, to the nearest 15 minute increment for the time spent performing that nursing task only, along with the flat fees above for the assessment and the foot care.

In the absence of an assessment visit, if an injured worker requires both foot care services and other nursing services on the same DOS, the flat fee for foot care services may be billed concurrently with appropriate units of the applicable regular nursing services fee code.

- If the **same** nurse provides the service on the same DOS, the nursing services shall be billed in 15 minute increments alongside the foot care flat fee, i.e., the 2 hour minimum service visit does not apply for the nursing services portion in this case. (The concurrent nursing services are not used in this scenario since an assessment did not take place.)
- If a **different** nurse provides the service on the same DOS (e.g., a wound care nurse is not trained for foot care or vice versa), the 2 hour minimum service visit would apply to the nursing services visit, and then you would invoice the flat fee for the foot care services.

Examples:

- An injured worker requires foot care services only. Your RN provides the foot care service at the same time as the initial assessment.
  - Billable as: the flat fee for foot care, and the flat fee for the initial assessment and care plan.
- An injured worker requires daily wound care from an LPN and foot care every 8 weeks. Your LPNs that are providing the wound care are not specially trained foot care nurses and so you send a different LPN (a specially trained foot care nurse) on the DOS that the foot care is required. The foot care takes 40 minutes and the wound care takes 45 minutes.
  - Billable as: the flat fee for foot care and 2 hours of nursing services – LPN (i.e., the minimum charge).
    **Note: the 2 hour minimum applies to the nursing services in this case.*
- An injured worker requires complex wound care by an RN every other day and foot care every 6 weeks. Your RN providing the wound care is also a specially trained foot care nurse and so provides both services on the same DOS. The foot care takes 30 minutes and the wound care takes 50 minutes.
  - Billable as: the flat fee for foot care and 0.75 hours (45 minutes) of nursing services – RN.
    **Note: the 2 hour minimum does not apply to the nursing services in this case due to the flat rate foot care fee being billed by the same nurse during the same visit.*
- An injured worker requires both a catheter change and foot care while an updated progress report is also due. You sent an LPN with the clinical skills to provide all these tasks. The re-assessment takes 30 minutes, the foot care takes 35 minutes and the catheter change takes 25 minutes.

- Billable as: the flat fee for a progress report – LPN – with visit, the flat fee for foot care, and 0.5 hours (30 minutes) of concurrent nursing services – LPN, for the catheter change. **Reminder: the 2 hour minimum does not apply to concurrent nursing services.*

Indirect time (RN, RPN or LPN):

Where your nurse (RN, RPN or LPN) spends time communicating via telehealth, telephone or email with a health care provider, WorkSafeBC officer, or medical supplies vendor for the purpose of discussing treatment, planning care services, discharge planning, and/or other related clinical service matters, you may invoice this as indirect time, under the applicable fee code and rate provided in Schedule B and in accordance with the designation of that particular nurse.

Indirect time is only billable if actual contact is made, or if a detailed phone message is left or email is sent and is only for communication that is separate from what is already included in the other fees provided in Schedule B (see examples below). Indirect time cannot be invoiced for scheduling and appointment confirmation or for routine, invoicing/payment, administrative, contract or performance issues.

Indirect time is billable in 5 minute increments, up to a maximum of 4 hours every 30 days (i.e., 4 hours per month) per injured worker, which is a combined maximum that includes RN/RPN and LPN indirect time.

Before invoicing for indirect time, make sure the relevant communication has been documented in your nurses' clinical records (which may be requested by WorkSafeBC at any time for audit purposes).

Please refer to the sample scenarios below as examples for when you may, or may not, invoice WorkSafeBC for indirect time:

Sample Scenario	Indirect Time billable? (Yes/No)	If no, reason why not
Your nurse is required to communicate with the discharging planning nurse at the hospital to discuss the injured worker's discharge plan.	Yes	n/a
Your nurse contacts the WorkSafeBC officer following an initial assessment to discuss their recommendations and to receive approval for services.	No	This is considered a part of the initial assessment and care plan flat fee.
Your nurse contacts the WorkSafeBC officer following a re-assessment (progress report visit) to provide an update on the injured worker's status and to request approval for an increase in services.	No	This is considered a part of the progress report fee.
Your nurse contacts the WorkSafeBC Clinical Specialist Nurse, or the injured worker's physician or nurse practitioner, to discuss a concern with the declining status of the injured worker's wound and further treatment options.	Yes	n/a

Your nurse contacts the quality assurance supervisor from Health Care Programs to discuss a service complaint or to respond to a billing enquiry.	No	Billing enquiries are unrelated to discussing treatment, planning care services, discharge planning, and/or other related clinical service matters. Service complaints are investigatory and not eligible for payment.
Your administrative/scheduling staff respond to a call from an injured worker who has a complaint about their schedule.	No	Indirect time is only billable for communication between your nurse(s) and a health care provider, WorkSafeBC officer, or a medical supplies vendor; it is not billable for administrative staff, nor for routine communications with an injured worker.

HCA services

Although there are many terms out there for an HCA (Personal Support Worker, Community Health Worker, Residential Care Aide, Personal Care Attendant, Home Support Worker, etc.), please be cognizant to use the term HCA when communicating with us (in your calls, emails, reports, etc.).

Care services shall be provided by and delegated to an HCA where appropriate and as determined by your nurse (personal care such as shower assist, bowel/bladder care, transfer assistance, etc.). Where a task is deemed as delegable to an HCA, but you schedule/send a nurse, it may only be invoiced as HCA services (per the level of care that the task requires), unless your nurse is conducting an in-person assessment visit on that DOS and provides the necessary care services at the same time. Please see the Level of care required vs. scheduled section above for more information.

As noted earlier, Home Care Services must be clinically appropriate/medically necessary, and so HCA services are to be focused on **Activities of Daily Living (ADLs)**, such as:

- personal hygiene activities such as bathing, grooming, oral care, etc
- bladder and bowel care
- dressing
- feeding
- ambulating/mobility
- transferring (e.g., from a bed to a chair)

You are not contracted to provide **Instrumental Activities of Daily Living (IADLs)**, such as:

- housecleaning services
- meal preparation/cooking
- shopping for groceries or personal items
- transportation services (where driving or public transport is not an option for the injured worker)
- gutter cleaning, snow-removal, or yard maintenance services
- general home maintenance/repairs
- delivery of wood to wood-heated homes

If the injured worker is assessed to require assistance with IADLs because of the compensable injury, communicate this recommendation to the WorkSafeBC officer directly and do not include it within your report. See the homemaking services section below for more information and recommendations regarding IADLs.

The minimum service visit for HCAs is 2 hours. Following that, HCA services are billable to the nearest 15 minute increment based on the **actual** time spent on the direct care provided (not the *scheduled* length of a visit), up to a maximum of 24 hours per day.
Examples:

- An HCA is scheduled for 3 hours to provide personal care assistance to an injured worker; however, the actual service time was 2 hours and 25 minutes.
    - Billable as: 2.5 hours of HCA services (i.e., the actual service time, to the nearest 15 minute increment).
- An HCA is scheduled for 2 hours to provide bowel care for an injured worker and the service only took 1 hour and 35 minutes.
    - Billable as: 2 hours of HCA services (i.e., the minimum charge).

In rare cases, an injured worker with high care needs may require more than 24 hours of HCA services on one DOS (due to a clinically required 2-person assist, etc.). If this circumstance arises, please reach out to Health Care Programs regarding the exception and to receive billing instructions.

Care services – telephone (HCA)
In the rare circumstance that an injured worker requires care services that do not require an in-person visit and rather can be provided over the telephone, namely wellness checks or medication reminders, as pre-approved by the WorkSafeBC officer as part of the care plan, you may invoice WorkSafeBC using the applicable fee code provided in Schedule B.

These services are billable in 15 minute increments for the actual time spent on the telephone with the injured worker (actual contact must be made), up to a maximum of 30 minutes per DOS.

Before invoicing for telephone HCA services, make sure the relevant communication has been documented in your clinical records (which may be requested by WorkSafeBC at any time for audit purposes).

Homemaking services
As noted above, care services under the Home Care Services Agreement does **not** include IADLs, which include general housecleaning or homemaking services (cleaning, laundry, washing dishes, making beds, meal preparation, etc.), except where it is an approved part of the care plan for the following tasks:

- Cleaning and laundry tasks related to cleaning up after personal care of the injured worker (such as cleaning a bathroom after bathing an injured worker, or laundering bed sheets following a bowel accident); or,
- Cleaning supplies after use as necessary for safety and hygienic reasons; or,
- Meal preparation where the injured worker is dependent on assistance with feeding.

In the scenarios listed above, these tasks are billed under HCA services.

Your nurse's assessment of an injured worker may include a recommendation for homemaking services if it is medically necessary and the need is because of the compensable injury. Here are some guidelines to follow in these circumstances:

- If the injured worker asks about homemaking services during the assessment, advise them that these services are not included in Home Care Services, but that you will make a recommendation to the WorkSafeBC officer for their consideration.

- Discuss the clinical recommendations for care services with the WorkSafeBC officer as usual and verbally pass along the recommendation for homemaking services, as appropriate.
- Do not include the homemaking recommendation within your reports (i.e., do not include it in the "Services to be Provided" section of the report).
    - You may document such a recommendation separately in the "Additional Information" section of the report under "Comments", stating for example: "Homemaking assistance is recommended for this injured worker as a result of the compensable injury –the WorkSafeBC officer has been advised."

If a WorkSafeBC officer requests that you provide homemaking services for an injured worker, please reach out to Health Care Programs regarding the exception and to receive billing instructions.

Independence and Home Maintenance Allowance (IHMA)
The WorkSafeBC officer may consider the injured worker for an Independence and Home Maintenance Allowance (IHMA) if the injured worker meets certain eligibility criteria based on Law & Policy.

This benefit may be paid to injured workers whose compensable injury severely impacts their mobility or function (either temporarily or permanently). In the cases where IADL assistance is required and approved, it is paid directly to the injured worker as a monthly allowance (e.g., the IHMA or the PCA). It is then the responsibility of the injured worker to arrange and pay directly for any related services, should they choose to do so.

Additional services
If an injured worker requests additional services that are excluded under the Home Care Services Agreement, such as personal care assistance for a non-compensable condition (Parkinson's, etc.), or homemaking services, you are not prohibited from providing such additional services and receiving fees from an injured worker; however, you may not actively solicit additional services from an injured worker.

You may contact the WorkSafeBC officer to discuss and confirm whether any services offered to an injured worker constitute additional services that are excluded from the Home Care Services Agreement.

If you do provide additional services to an injured worker, please note that:
- any such arrangement is solely between you and the injured worker, even if the injured worker pays you for the additional services using funds received from WorkSafeBC (e.g., the IHMA);
- the additional services must be delivered to the injured worker distinctly from the other care services that are approved to take place under the Home Care Services Agreement (by using distinct scheduling or separate staff, etc.);
- the injured worker must be made aware of the distinction between the services delivered under Home Care Services Agreement and the additional services you are providing; and,
- you should include the additional services in the "formal supports" section of your reports.

Training/supervision

You are responsible for ensuring (under your business expense) that personnel performing the services meet the requirements set out in the Home Care Services Agreement, including having all required professional qualifications and licensing and are properly instructed and trained prior to performing services.

On-going nursing supervision is required to ensure that personnel have the knowledge, skills, and experience necessary to perform the client-specific care tasks required, and to identify any skill deficits where additional training may be required.

Orientation, training, and supervision are not billable to WorkSafeBC.

Training exceptions

In exceptional cases and with the appropriate rationale, a training exception *may* be approved for a complex, severely injured worker. If you believe that a training exception is warranted, please contact the clinical specialist nurse (CSN) to discuss and receive approval. Any such approved exceptions must be clearly detailed in an updated progress report.

- You may wish to consider a "train the trainer" format, where your nurse is trained for the special skills required and it is their responsibility to train other personnel.

Any approved training exceptions are a shared cost between you and WorkSafeBC, so are to be billed at 50% of the caregiver's regular hourly rate. The hours shall be billed as the actual time (length) of the training on the DOS that it took place, under the exception fee code provided by the CSN (up to the maximum number of hours approved per caregiver, and up to the total number of caregivers approved to be trained). For example:

- If 3 HCAs were approved for 6 hours of training and this took place across 2 different DOS (i.e., all 3 HCAs attended for 3 hours each on 2 different DOS), it would be billed as:
    - 9 hours of total HCA Services on each DOS, at 50% of the current HCA rate provided in Schedule B, under the exception fee code provided by the CSN.

Travel – personnel

Travel guidelines – general

Best efforts should be made to arrange appointments with injured workers located in the same area to maximize efficiency and minimize cost where possible. Travel may be allocated equally among injured workers located in the same area and seen on the same day, where applicable.

Here are the general rules associated with when and how travel is billable (referring to both travel time and mileage):

- Travel is billable only **within the contracted location code** in which the injured worker resides. See the travel across location codes section below for more information and exceptions for nursing staff and extenuating referrals.
- Travel is billable **between clients** only. Travel associated with your staff getting to or from work is not payable, so travel is not billable to first client of the day, or from the last client of the day, unless it is for a long-distance out-of-town visit or an extenuating referral.
- Travel is only billable **one-way**, from the previous client *to* the injured worker (non-WorkSafeBC clients included), unless it is for a long-distance out-of-town visit or an extenuating referral. (Travel to the next client, injured workers included, would be billed to that client.)
- Travel is billable from the previous client, or your business location (office), whichever is closer. As such, the **maximum** amount of travel billable is the time/distance it takes to travel (one-way) from your business location to the injured worker.
    - If you do not have a business location within the location code that the injured worker resides, then travel is billable from the previous client, or next closest large municipality within that location code. The **maximum** amount of travel billable in this case is the time/distance it takes to travel (one-way) from the border of the location code to the injured worker.
- Travel on statutory holidays is compensable at the regular rate (i.e., there is no statutory uplift for travel time or mileage).

Travel time
Travel time is considered as the time spent travelling between clients' homes and is billable to the nearest ¼ hour (15 minute increment) using the applicable fee code and rate provided in Schedule B according to the designation of staff travelling. Travel time is billable concurrently with mileage.

Travel time is separate from the time spent performing the service; therefore, travel time cannot be invoiced concurrently with the service under the personnel's regular hourly rate (HCA, RN/LPN, LPN, foot care, etc.).

- Note: if an HCA is travelling by taxi between a hospital and an injured worker's home, this is considered HCA service time, not HCA travel time.

All the general travel guidelines above apply to travel time.

Mileage
Mileage is considered the actual distance travelled between clients' homes and is billable to the nearest kilometer. The mileage rate is the same for all designations of staff. Mileage is billable concurrently with travel time.

- Note: If there is more than one visit to an injured worker in one DOS, combine the mileage and bill the total for the whole day (e.g., 10 km for an LPN visit and 15 km for an HCA visit on the same DOS would be billed as 25 km mileage for that DOS for that injured worker).

If you are approved to transport an injured worker in your vehicle, mileage may be billed concurrently with the service time.

All the general travel guidelines above apply to mileage.

Long-distance out-of-town travel

An injured worker may live in a rural area or smaller municipality where you do not have local staff and so your staff would be travelling from a larger municipality nearby. In these cases, return travel (travel time and mileage) is billable, from the previous client or your staff's home (the first/last client of the day rule does not apply), whichever is closer, up to the maximum distance of your closest business location.

- **HCAs:** It is presumed that you will have local HCA staff within the major municipalities within your contracted location code, and as such, the maximum long-distance out-of-town travel would be expected to be from/to what Google Maps deems the centre point for the closest major municipality within that location code (if there is one), unless you have a business location that is closer.
    - Example: if you are contracted for location code M, you may not have local staff in the municipality of Cache Creek or Merritt, but you would be expected to have staff in Kamloops, so the centre of the city of Kamloops would be the expected maximum distance of the travel in this case.
- **Nurses:** We understand that nursing resources (RNs, RPNs and LPNs) are more limited and that you may not have nursing staff in each major municipality within your contracted location code. As such, the long-distance out-of-town travel would be expected to be billed from/to the next closest major municipality within that location code (if there is one), up to the maximum distance of your closest business location, or if you do not have a business location in that location code, then up to the border of that location code, unless the nurse exception for travel across location codes applies.
    - Example: if you are contracted for location code B, you may not have nurses in both Richmond and Delta, so it is understandable for return travel to be billed if your nurse travels from a client in Delta to an injured worker in Richmond (or vice versa), unless you

have a business location in Delta, in which case that would be the maximum time/distance billable.

Local staff should be sourced and used wherever possible to maximize efficiency and minimize cost. Due to the additional expenses involved with long-distance out-of-town travel, be sure to discuss the expected travel costs with the WorkSafeBC officer. If long-distance out-of-town travel is authorized, document this within the applicable section of the initial assessment form.

Since municipalities differ in size, it is difficult to set a specific time/distance for which long-distance out-of-town travel applies; however, as a rule of thumb, the injured worker should live approximately 20 minutes or more outside of the municipality's limits for long-distance out-of-town travel to be billable.

Long-distance out-of-town travel does not apply, and thus return travel is not billable, for the following location codes: A, B, F, G, H, I, J & K.

For more specific travel guidelines for your contracted area(s), please refer to Appendix D – List of Home Care Service Regions, Location Codes and Travel Guidelines.

Injured worker relocation
Should an injured worker move during the course of services, causing long-distance out-of-town travel to now apply, seek approval from the WorkSafeBC officer at that time and, if approved, document this within the applicable section of the progress report.

- Note: if the injured worker moves to a different location code, services may be transferred to a contractor within that new location code (since travel is not billable across location codes). If you are contracted for, and/or have staff within the new location code that the injured worker resides, you can discuss the continuity of care with the WorkSafeBC officer and bill travel according to the guidelines and geography of the new location code.

Travel across location codes
As noted above, travel is only billable within the contracted location code in which the injured worker resides. If staff are travelling from outside of that location code (whether staff are borrowed from another area or are travelling from a client in another area), we are not responsible for the additional associated travel costs.
In such cases, travel is only billable up to the maximum distance of your business location, or if you do not have a business location in that location code, then up to the border of that location code.

Nurse exception for travel across location codes
The allowable exception to the above is that: If your nurse is conducting assessments or providing care services for two or more injured workers on the same day, you may invoice us for the nurses' travel across location codes, up to a daily maximum of 100 km (mileage) and two hours (travel time) per DOS.

- Note: this is a daily total maximum for all injured workers visited that day (i.e., not up to 100km and 2 hours *per* injured worker).

Such travel may be allocated equally among the injured workers seen on that day, where applicable.

- Example 1: Your nurse travels from her home in Vancouver to Langley (45 minutes and 50 km) to provide foot care for an injured worker, then travels to Delta to conduct a re-assessment (progress report) for an injured worker (30 minutes and 25 km) and then travels back to Vancouver to conduct a re-assessment for another injured worker (45 minutes and 30 km) before returning home (10 minutes and 7 km). The nurse exception applies, since your nurse visited 3 injured

workers in one day, and in this case the maximum amount of 2 hours and 100 km would be billable.
*Note: If your nurse travels from her home in Vancouver to provide services for only 1 injured worker who lives in Delta, and it is not an extenuating referral, then travel is only billable from the border of location code B (i.e., from the bridge connecting Vancouver to Richmond), unless you have a business location in Delta, in which case that would be the maximum time/distance billable.

This scenario mostly applies where multiple contracted location codes are close together (i.e., the lower mainland), or where municipalities in bordering location codes are close together, since for more remote areas, long-distance out-of-town travel within the location code likely already exceeds the daily maximum for travel across location codes.

Travel for extenuating referrals
If you accept an extenuating referral, with approval from the WorkSafeBC officer you may bill return travel (time and mileage) from your closest contracted location code.

In these cases, travel is billable from the previous client, or your staff's home (the no billing to/from the first/last client of the day rule does not apply), whichever is closer, up to the maximum distance of your business location, or if you do not have a business location within that closest contracted location code, then the maximum amount of travel would be expected to be from the centre of the closest major municipality within that location code.

- Example: if you are contracted for location code W and accept an extenuating referral in location code X for an injured worker living in Duncan, return travel would be billable from the centre of Victoria to Duncan and back, unless your staff's home, previous client, or your business location is closer, in which case travel would be billed from that lesser point.

Travel billing examples

- Location Code Q: You are providing HCA services to an injured worker who resides in Summerland and you have a business location (office) in Penticton. Travel (time and mileage) shall be billed as follows based on the HCA's starting point:
  - HCA is travelling from your business location: travel is billable for the time/distance it takes to travel from your business location in Penticton to the injured worker's home in Summerland.
    **Note: Long-distance out-of-town travel would not apply to this scenario since Summerland is less than 20 minutes from Penticton.*
  - HCA is travelling from a previous client in Summerland: travel is billable for the time/distance it takes to travel from the previous client's address in Summerland to the injured worker's address in Summerland.
  - HCA is travelling from a previous client in Oliver: travel time/mileage is billable for the time/distance it takes to travel from your business location in Penticton to the injured worker's address in Summerland, as this the lesser distance compared to travel from Oliver.
  - HCA is travelling from their home in Oliver: travel time/mileage is not payable since it is the first client of the day. Long-distance out-of-town travel would not apply to this scenario since your business location is in Penticton.
    **Note: If the injured worker lived in Oliver and the HCA lived in Penticton, then long-distance out-of-town travel would apply.*

    - HCA is travelling from Kelowna: travel is billable for the time/distance it takes to travel from your business location in Penticton to the injured worker's home in Summerland, as this is the lesser distance compared to travel from Kelowna.
      **Note: if you did not have a business location in Penticton and borrowed staff from Kelowna to provide services to this injured worker, travel would only be billable from the border of Summerland, since that is the border of the location code.*
- Location Code A: Your HCA drives 8 km from a client in Vancouver to an injured worker who also lives in Vancouver, which takes 10 minutes. The HCA provides care for the injured from 10:00 am – 2:00 pm, including personal care and transporting the injured worker to and from a medical appointment at 12:00 (using the HCAs vehicle). The distance to and from the medical appointment was 15 km each way. The HCA then drives 15 km to their next client, which takes 20 minutes.
    - This would be billed as: 4 hours of HCA services (10:00 am – 2:00 pm), 0.25 hours (15 minutes) of HCA travel time (for the 10 minute drive *to* the injured worker, one way), and 38 km of mileage (8 km for the mileage *to* the injured worker, one-way, plus the 30 km for transporting the worker in their vehicle, to and from the appointment).
      **Note: The travel to the next client should be billed to that client (injured worker or not).*
- Location Code C: Your LPN travels from home to a non-WorkSafeBC client in Vancouver, then to an injured worker who lives in North Vancouver to provide wound care. The LPN then travels to another non-WorkSafeBC client in Vancouver before returning to their home.
    - LPN travel time is billable from the border of location code C only (i.e., the time/distance from the Lions Gate bridge to the injured worker's home), since travel across location codes is not applicable in this case (only 1 injured worker was seen by this nurse).

Travel – summary

To recap and summarize the travel details above:

- Travel is billable within the location code where the injured worker resides only, unless it is an extenuating referral or for a nurse who meets the requirements for travel across location codes.
- If the injured worker lives in a major municipality, travel is billable one-way (to the injured worker), as long as it isn't the first client of the day. Travel is billable from the lesser of (a) the actual time/distance travelled (from the previous client), (b) the time/distance from your business location/office, or if you do not have a business location within that location code, then the maximum time/distance billable is (c) from the boundary of the location code.
- If the injured worker lives outside of a major municipality (i.e., a rural area), and long-distance out-of-town travel has been approved by the WorkSafeBC officer, travel is billable both ways (to and from the injured worker), from the lesser of (a) the actual time/distance travelled (between the adjacent client(s) or caregiver's home), (b) the time/distance from your business location/office, or if you do not have a business location within that location code, then from (c) the centre of the closest major municipality (HCAs), with the maximum time/distance billable being (d) from the boundary of the location code (nurses).

Pre-Authorized travel expenses

In unique circumstances, you may incur additional travel expenses in the course of providing the approved services. In such cases, the WorkSafeBC officer must pre-approve the travel expense(s).

Here are a few sample scenarios for where additional travel expenses may be approved:

- Your nurse is required to take a ferry to an injured worker who resides in the Gulf Islands to conduct the initial assessment.

- An HCA must park at a hospital, or in the city where there is no option for free parking.
- An HCA is required to accompany an injured worker on a flight and stay overnight with them in a hotel and per diems were approved by the WorkSafeBC officer.

Note: Airfare and hotel rooms are most often arranged (and paid for directly) by WorkSafeBC for your staff, so it should be rare for you to be out of pocket for this type of approved travel expense. Meals are generally only approved if an overnight stay is required.

Taxi expenses for Medical Escorts
If your staff are required to meet an injured worker at a medical facility and accompany them home and your staff requires a taxi to/from their vehicle before or afterwards, the one-way taxi expense is reimbursable with pre-approval from the WorkSafeBC officer.

The recommended process is for your staff to park their vehicle at the worker's residence (or other location of the service, such as the hotel) and take a taxi to the medical facility to avoid parking expenses at the facility. The injured worker will be provided with a taxi voucher (from WorkSafeBC) for the trip home to their residence, so your staff will be travelling with the injured worker (using their voucher) for that leg of the trip.

Note: your staff should **not pay for any of the injured worker's expenses whilst travelling with them – should the injured worker be out of pocket for a travelling expense, they must submit the expense themselves to WorkSafeBC for reimbursement.*

Invoicing for Pre-Authorized travel expenses
If your staff travel with an injured worker, refer to Schedule B for the associated guidelines for travel expenses, including the maximum amounts billable for each type of expense.

Approved travel expenses are reimbursable upon submission of a copy of the original receipt(s), which must be attached to the Provider Portal invoice, and by using the applicable fee code provided in Schedule B.

When invoicing, use separate line items for separate travel expenses, with the total amounts per DOS (e.g., one line for a ferry expense, one line for the meal total for the day, etc.).

Gratuities are not billable to WorkSafeBC, so must not be included in the invoiced amount (for taxis, meals, etc.).

Transporting an injured worker

If your staff are required to accompany an injured worker outside of their residence (to a medical appointment, hospital, or surgical centre, etc.), travel must be by taxi service or other means of public transportation (bus, sky train, etc.). Your staff are not authorized to transport an injured worker, except with the prior authorization of a WorkSafeBC officer.

If a WorkSafeBC officer approves your staff to transport an injured Worker, you must ensure that:
- Where the vehicle is owned by the injured worker, or their spouse or family member:
  - the driver of the vehicle holds the appropriate class of license under the *Motor Vehicle Act*; and,
  - the vehicle is road-worthy and in good repair and is insured with the appropriate class of insurance for its use.
- Where the vehicle is owned by you, your staff or anyone other than the injured worker (including their spouse or family member):
  - the driver of the vehicle holds the appropriate class of license under the *Motor Vehicle Act*, and an appropriate amount of third-party legal liability insurance which must be no less than $5 million per occurrence; and,

- the vehicle is road-worthy and in good repair and is insured with the appropriate class of insurance for its use.

Travel with an injured worker

If the injured worker has travel plans that require your staff to accompany them, you are responsible for providing the appropriate number of staff to ensure adequate scheduling of the care services (including appropriate breaks, etc.) in the most cost-effective manner possible.

If the travel is of a long duration and/or if transport assistance is not required (e.g., a caregiver is not required to attend to the injured worker on a flight), WorkSafeBC may arrange for a local agency to provide the services at the injured worker's destination. In these cases, your staff may be asked to accompany the injured worker to a certain point (e.g., to the airport) before services are transferred to the other agency.

Any travel-related care services must be provided within the already approved services and care plan. If the travel plans disrupt or change the services or care plan in any way (more care hours being required, etc.), the WorkSafeBC officer must be contacted for pre-approval. If any changes are approved, submit an updated Progress Report to reflect the changes.

Travel for claim-related purposes
If an injured worker is travelling for claim-related purposes (e.g., a surgery related to their compensable injury), WorkSafeBC will arrange and pay for the travel costs for the injured worker and your staff.

See the pre-authorized travel expenses section above for more information on related travel costs.

Travel for personal reasons
If an injured worker plans to travel for personal reasons (e.g., for a vacation) and, in accordance with their care plan, will continue to require care services whilst they are away, contact the WorkSafeBC officer to discuss and to receive approval to travel with the injured worker.

If approved, please note that WorkSafeBC will continue to cover the costs of the care services (which, per above, must be provided within the already approved services and care plan, unless a change is approved by the WorkSafeBC officer), but any travel expenses incurred (flights, hotel, meals, etc.) are the injured worker's responsibility and are not billable to WorkSafeBC.

Other important details

Medical supplies and equipment

Durable medical equipment
Durable medical equipment (wheelchairs, walkers, transfer equipment, hospital beds, etc.) must be purchased or rented by WorkSafeBC directly, so do not purchase any such equipment for an injured worker.

If you identify the need for durable medical equipment during an assessment, or at any time during the provision of services, communicate this recommendation to the WorkSafeBC officer, who can then follow-up with our approved vendors to provide such equipment.

Disposable medical supplies
Disposable medical supplies must be clinically related to the compensable injury and are divided into two timeframes, short term and long term, as follows:

- If an injured worker requires **short term** (6 weeks or less) disposable medical supplies, the process for supplying these (in priority order) after obtaining WorkSafeBC officer approval, is as follows:
    - Order through a local supplier (e.g., pharmacy, medical supply company) who will bill us directly;
    - You may purchase the supplies directly and submit an invoice with a copy of the original receipt(s) attached, using the fee code provided in Schedule B; or,
    - The injured worker may purchase the supplies and submit the receipts to us for reimbursement.
- If an injured worker requires **long term** (greater than 6 weeks) disposable medical supplies, contact the WorkSafeBC officer who will make alternate arrangements for the provision of the supplies using the Product Distribution Centre (PDC). In these circumstances, you are responsible for identifying:
    - the specific products needed, and
    - the quantities required for a one-month supply.
- Where a PDC account has been set up, the injured worker (or a family member/representative) is responsible for re-ordering supplies; however, your staff should let the injured worker know when supplies are low and need to be re-ordered.

WorkSafeBC does not pay for subsidiary supplies provided to an injured worker, or your staff (educational or training material, administrative supplies, etc.).

Personal protective equipment (PPE)
WorkSafeBC does not pay for PPE, such as masks or disposable gloves, for your staff; it remains an employer responsibility to ensure staff safety.

WorkSafeBC does not provide general PPE for injured workers either; however, we do provide necessary disposable medical supplies to support their care needs (PPE if they are self-catheterizing, etc).

Chronic Wound Care - 3M NPWT order process
You are authorized to order Negative Pressure Wound Therapy (NPWT) supplies, where indicated and prescribed for an injured worker with an accepted claim, to expedite the acquirement of time sensitive wound supplies.

- Note: You must have received authorization from the WorkSafeBC officer prior to placing the order with 3M (KCI Medical).

Here are the steps that are required for this ordering process:

- Your nurse receives a prescription for Vacuum Assisted Closure (VAC) or Negative Pressure Wound Therapy (NPWT) from the discharging hospital, physician or nurse practitioner, or our Chronic Wound Care provider (Access Community Therapists);
- Contact the WorkSafeBC officer to get approval (please remind them to entitle this service, if approved);
- Complete the order form (more information below) and fax it to the number at the bottom of the form;
- Submit a copy of the order form and prescription to us via the WorkSafeBC Provider Portal. The pages should be uploaded as a PDF document (the same way as a receipt) and using the following form ID: CORRMED (Medical Correspondence).

In summary, you:
Receive a prescription → contact the WorkSafeBC officer for approval → fax the order form to the supplier (3M) → send a copy of the order form and prescription to us

For an electronic a copy of the 3M order form, please contact Heath Care Programs. For a sample of this form, please refer to Appendix G – Sample 3M Order Form.

Please ensure that you include your contact details in the "Nursing Agency" section of the order form. 3M is required to accept or decline your referral (order form) within one business day of receipt and will advise you by telephone. 3M is required to deliver the NPWT device and any accompanying supplies to the injured worker within 5 business days.

- **Important:** To avoid unnecessary costs to WorkSafeBC, please be sure to notify 3M as soon as you become aware that the NPWT device is no longer needed.

Note: WorkSafeBC has not formalized an ordering process for other NPWT suppliers (e.g., Smith and Nephew - Renasys).

Service quality and performance management

If we have any concerns related to the provision of your services under the Home Care Services Agreement (issues/complaints, invoicing enquiries, etc.), we will reach out to your Contractor Representative to discuss them, who shall act as the main point of contact with respect to the matter.

The Contractor representative must acknowledge receipt of a service issue/complaint that we send you within one business day and shall take appropriate steps to investigate and resolve the complaint to our satisfaction within five business days, which may require the development of a corrective action plan that sets out how you will address the performance issues identified and a date by which you commit to meeting the required performance standards.

Where a service quality review reveals an overbilling, we may correct the overpayment by deducting (crediting) the amount of the overbilling against future amounts owed to you.

Additional resources

Our website (www.worksafebc.com) provides links to various health and safety information and is an excellent resource for numerous publications that can be downloaded. You can use the search function to search key words on the topic you are looking for.

Here are some examples of related resources that may be useful:

- Home and Community Health Worker Handbook
- Handle With Care: Patient Handling and the Application of Ergonomics (MSI) Requirements
- Patient Handling in Small Facilities: A Companion Guide to Handle with Care
- Moving and Handling People: Reducing the Risks
- Dealing with "Latex Allergies" at Work
- Controlling Exposure: Protecting Workers from Infectious Disease
- Preventing Violence in Health Care: Five steps to an effective program
- Be Sure...Be Safe: Safety in the Health Care Workplace (Discussion Guide)

Appendices

If you have a question:
Appendix A: Important contact information
Appendix B: Important links

If you have a question about regions and location codes:
Appendix C: Map of Home Care Service Regions and Location Codes
Appendix D: List of Home Care Service Regions, Location Codes and Travel Rules

If you'd like help writing reports for us:
Appendix E: Reports and forms for Home Care Services
Appendix F: Guidelines for using Schedule B
Appendix G: Sample 3M VAC Order Form
Appendix H: "Restrictions" vs. "considerations"

If you offer telehealth services/hybrid program delivery:
Appendix I: Telehealth treatment guidelines

If you're curious about our other programs:
Appendix J: Summary of related health care programs

Appendix A: Important contact information

We want to make sure you have all the information you need to work with us as a health care service provider. Contact information for key departments is listed below. (You can find contact information for more departments and services on worksafebc.com.)

If an injured worker threatens anyone, including a WorkSafeBC employee or property, call the police immediately, followed by the people listed on page 16.

WorkSafeBC department	How to contact	Reason to contact
Health Care Programs	604.232.7787 (Lower Mainland) 1.866.244.6404 (toll-free) homecareservices@worksafebc.com	You need to discuss: • Your contract and fee schedule • Contracted clinical services • Updating your contacts (or contact details) for our Home Care Services email distribution list or contract representative
Payment Services	604.276.3085 (Lower Mainland) 1.888.422.2228 (toll-free)	You need to discuss: • A specific invoice or billing rejection • General information about our billing process
Procurement Services	604.276.3344 (Lower Mainland) 1.844.276.3344 (toll-free) purchase@worksafebc.com	You need to: • Update your general contact information • Inquire about the status of your contract
Claims Call Centre	604.231.8888 (Lower Mainland) 1.888.967.5377 (toll-free)	You need basic information about a claim. • For detailed questions about a specific claim, contact the claim owner. If you don't have the claim owner's contact information or are not hearing back, contact our Claims Call Centre.
Provider Referrals	604.231.8887 (Lower Mainland) 1.866.481.8887 (toll-free) Fax: 604.233.9777 Toll-free fax: 1.888.922.8807	Provider Referrals may initiate contact with you if they are attempting to issue a referral. They will also contact you to advise if a referral they are sending you is an extenuating referral.
Freedom of Information and Protection of Privacy Office	604.279.8171 (Lower Mainland) 1.866.266.9405 (toll-free) fipp@worksafebc.com	You have questions about privacy legislation (e.g., the Freedom of Information and Protection of Privacy Act)

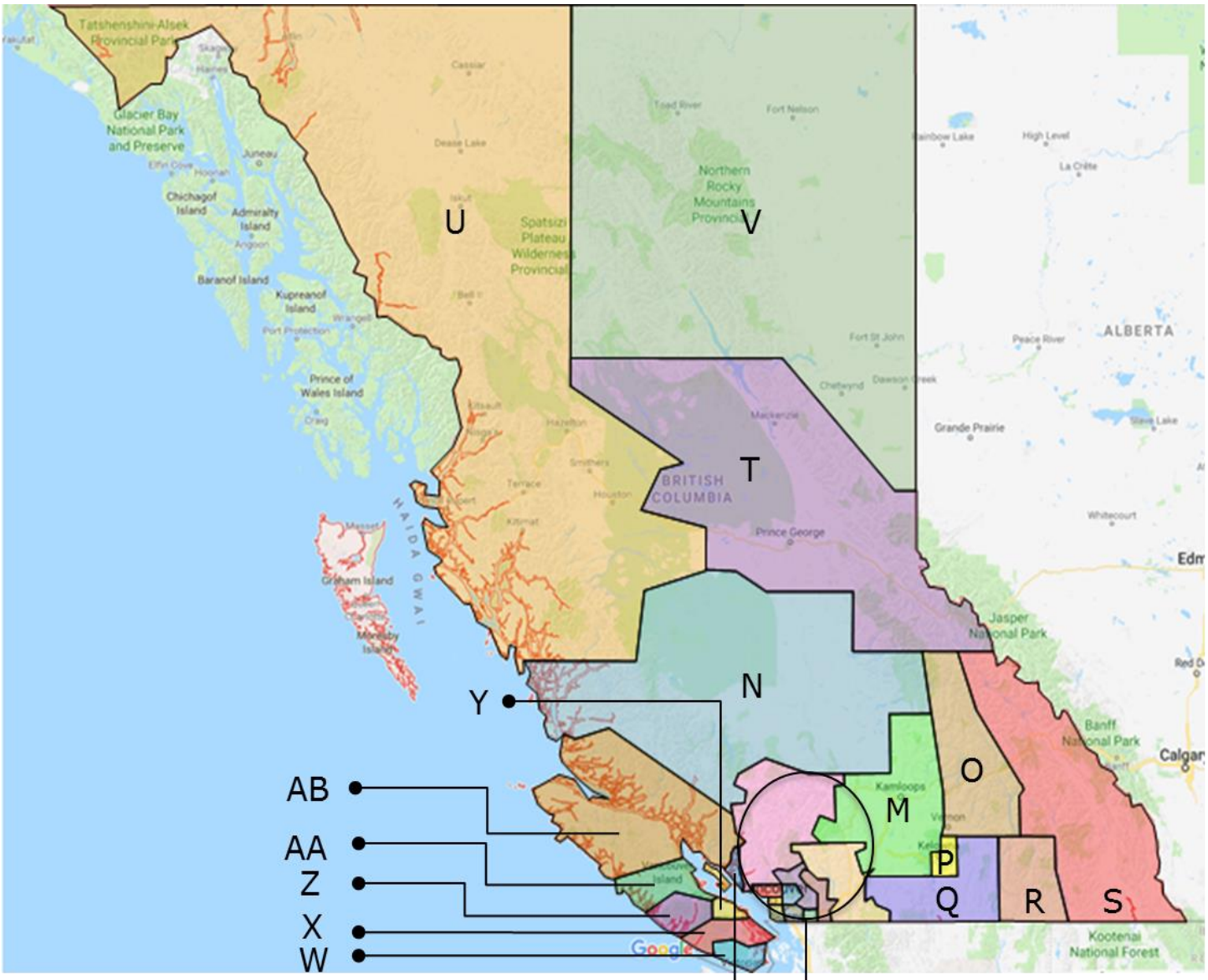
Questions about the WorkSafeBC Provider Portal?

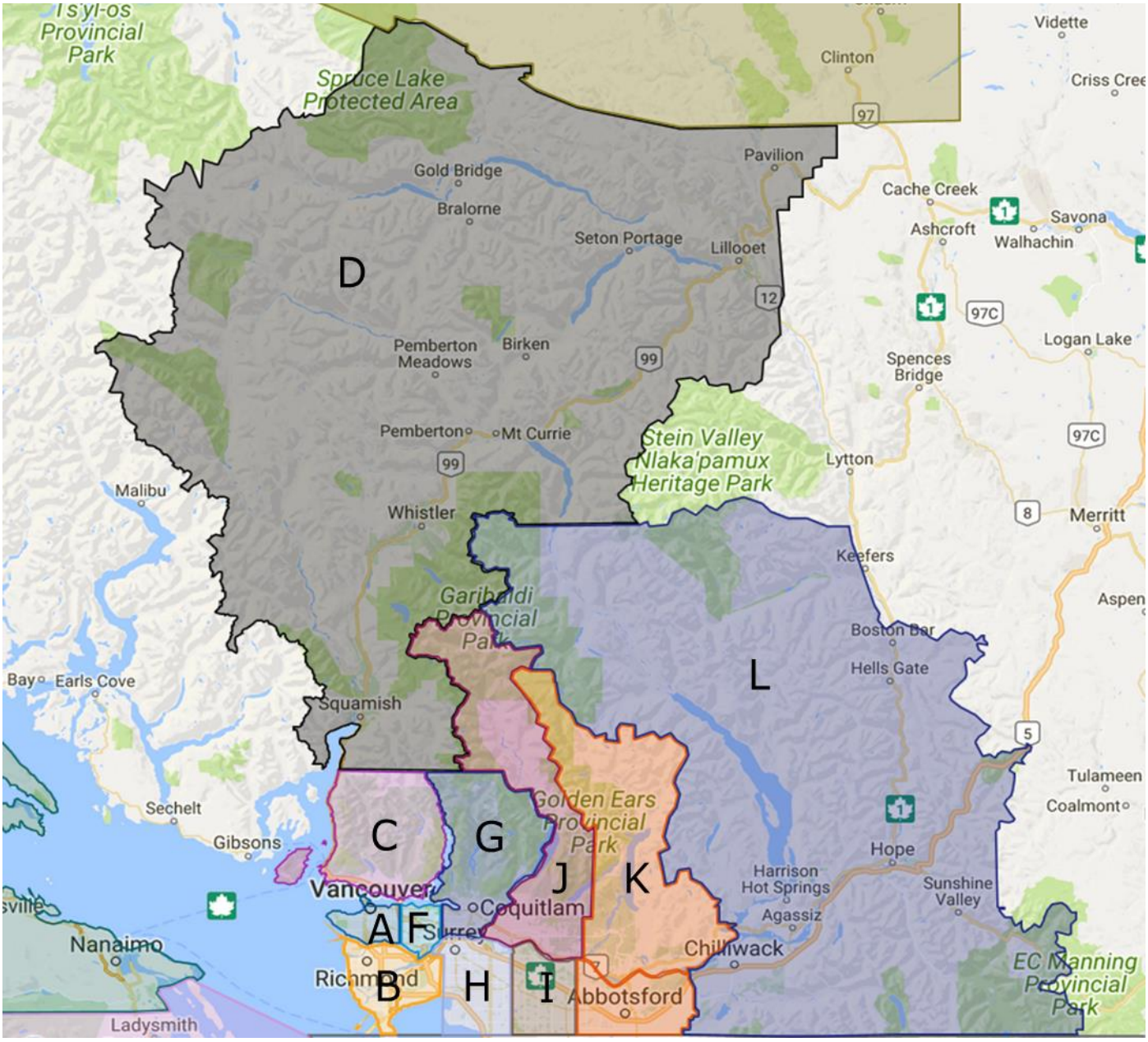
Call Telus Health Solutions for 24/7 support: 1.855.284.5900. Ask for a ticket number for reference. If you'd like to add or remove Provider Portal access for any staff member, email provider.mgmt5@telus.com.

Appendix B: Important links

Essential for working with us (worksafebc.com webpages)	What you'll find
For health care providers	Information for all health care providers we work with
Home Care Services - WorkSafeBC	Information, reporting forms, Reference Manual, and bulletins specific to Home Care Services
Forms & Resources	Important WorkSafeBC forms, documents, videos, and more (see Appendix E for links to specific forms you'll need to download)
WorkSafeBC Provider Portal	The online portal where you'll receive and respond to referrals, submit reports and invoices, and more
Provider Portal Quick Reference Guide	Basic instructions for using the Provider Portal
Provider Portal video training	In-depth training on using the Provider Portal
Accessing disclosures online	Instructions on how to access medical and other information in an injured worker's claim file within the Provider Portal
Essential for working with us (external webpages)	**What you'll find**
bceid.ca	The site where you and your staff can get a unique BCeID (you'll need this to log in to the WorkSafeBC Provider Portal)
Workers' Advisers Office on gov.bc.ca	A resource to point injured workers to if they'd like independent advice and assistance on their claim
Important background info on worksafebc.com	**What you'll find**
Your role in the claims process	Where you fit into an injured worker's claim with WorkSafeBC
Who we are	An overview of what WorkSafeBC does
Provider types	Information on other health care providers we work with
Interpretation, translation & sign language services	An overview of tools we provide to help you communicate with injured workers
How recovery at work helps	The overall health benefits of a safe, timely return to work for injured workers

Appendix C: Map of Home Care Service regions and location codes




Tsyl-os Provincial Park
Spruce Lake Protected Area
Clinton
Vidette
Criss Cree
97
Pavilion
Gold Bridge
Bralorne
Cache Creek
Ashcroft
Savona
Walhachin
Seton Portage
Lillooet
D
12
97C
Logan Lake
Pemberton Meadows
Birken
99
Spences Bridge
Pemberton
Mt Currie
99
Stein Valley Nlaka'pamux Heritage Park
Lytton
97C
Malibu
Whistler
8
Merritt
Keefers
Aspen
Garibaldi Provincial Park
Boston Bar
Hells Gate
L
Bay
Earls Cove
Squamish
5
Tulameen
Coalmont
Golden Ears Provincial Park
Sechelt
Gibsons
C
G
Hope
J
K
Harrison Hot Springs
Sunshine Valley
Vancouver
Coquitlam
A
F
Surrey
Agassiz
Nanaimo
Chilliwack
EC Manning Provincial Park
Richmond
B
H
I
Abbotsford
Ladysmith

Appendix D: List of Home Care Service regions, location codes and travel rules

SERVICE REGION	LOCATION CODE	SERVICE AREA	TRAVEL RULES* **excluding extenuating referrals and the nurse exception for travel across location codes*
VANCOUVER COASTAL	**A**	VANCOUVER	Long-distance out-of-town travel does not apply; only one-way travel is billable.
	B	RICHMOND & DELTA	Long-distance out-of-town travel does not apply; only one-way travel is billable, even if Richmond staff are borrowed to service Delta, or vice versa.
	C	NORTH VANCOUVER, WEST VANCOUVER & NORTH TO FURRY CREEK	Only one-way travel is billable for North Vancouver and West Vancouver, even if staff from one is borrowed to service the other. Long-distance out-of-town travel would only apply for areas north of Horseshoe Bay (e.g., Lions Bay, Furry Creek)
	D	SQUAMISH, WHISTLER, PEMBERTON & NORTH TO LILLOET	Only one-way travel is billable for Squamish. Long-distance out-of-town travel would apply for areas outside of this municipality (e.g., Whistler, Pemberton, Lillooet).
	E	SUNSHINE COAST: GIBSONS, SECHELT & POWELL RIVER	Only one-way travel is billable within the municipalities listed; however, long-distance out-of-town travel would apply for areas outside of these municipalities, or if staff must travel from one to another (e.g., Gibsons to Sechelt).
FRASER	**F**	NEW WESTMINSTER & BURNABY	Long-distance out-of-town travel does not apply; only one-way travel is billable, even if New Westminster staff are borrowed to service Burnaby, or vice versa.
	G	COQUITLAM, PORT COQUITLAM & PORT MOODY	Only one-way travel is billable for the cities listed, even if Port Moody staff are borrowed to service Coquitlam, etc. Long-distance out-of-town travel would only apply to Belcarra.
	H	SURREY WEST OF HWY 15 & WHITE ROCK	Long-distance out-of-town travel does not apply; only one-way travel is billable, even if Surrey staff are borrowed to service White Rock, or vice versa.
	I	LANGLEY EAST OF HWY 15 & ALDERGROVE	Long-distance out-of-town travel does not apply; only one-way travel is billable, even if Langley staff are borrowed to service Aldergrove, or vice versa.
	J	PITT MEADOWS & MAPLE RIDGE	Long-distance out-of-town travel does not apply; only one-way travel is billable, even if Maple Ridge staff are borrowed to service Pitt Meadows, or vice versa.
	K	ABBOTSFORD & MISSION	Long-distance out-of-town travel does not apply; only one-way travel is billable, even if Abbotsford staff are borrowed to service Mission, or vice versa.
	L	CHILLIWACK, AGASSIZ, HOPE & BOSTON BAR	Only one-way travel is billable for Chilliwack and Hope. Long-distance out-of-town travel would apply for areas outside of these municipalities (e.g., Agassiz, Harrison Hot Springs, Laidlaw, Boston Bar).

INTERIOR & EASTERN BC	**M**	KAMLOOPS, NORTH TO CLEARWATER, EAST TO CHASE, SOUTH TO MERRITT & WEST TO CACHE CREEK	Only one-way travel is billable for Kamloops. Long-distance out-of-town travel would apply for areas outside of this municipality.
	N	WILLIAMS LAKE, NORTH TO QUESNEL, EAST TO HORSEFLY, SOUTH INCLUDING 100 MILE HOUSE TO CLINTON & WEST TO BELLA COOLA	Only one-way travel is billable within Williams Lake and Quesnel; however, long-distance out-of-town travel would apply for areas outside of these municipalities, or if staff must travel from one to another (e.g., Williams Lake to Quesnel).
	O	VERNON, NORTH TO SALMON ARM & EAST TO REVELSTOKE & NAKUSP	Only one-way travel is billable within Vernon and Salmon Arm; however, long-distance out-of-town travel would apply for areas outside of these municipalities, or if staff must travel from Vernon to Salmon Arm.
	P	KELOWNA, WESTBANK, NORTH TO LAKE COUNTRY & SOUTH TO PEACHLAND	Only one-way travel is billable for Kelowna and Westbank. Long-distance out-of-town travel would apply for areas outside of these municipalities.
	Q	PENTICTON, NORTH TO SUMMERLAND, EAST TO BEAVERDELL & GRAND FORKS, SOUTH TO OSOYOOS & WEST TO PRINCETON	Only one-way travel is billable within Penticton and Osoyoos; however, long-distance out-of-town travel would apply for areas outside of these municipalities, or if staff must travel from Penticton to Osoyoos.
	R	NELSON, NORTH TO MEADOW CREEK, EAST TO CRESTON & WEST TO CHRISTINA LAKE	Only one-way travel is billable for Nelson. Long-distance out-of-town travel would apply for areas outside of this municipality.
	S	KIMBERLEY, CRANBROOK, NORTH TO GOLDEN, EAST TO FERNIE & ALBERTA BORDER, SOUTH TO U.S. BORDER & WEST TO YAHK	Only one-way travel is billable within Cranbrook, Kimberley and Fernie; however, long-distance out-of-town travel would apply for areas outside of these municipalities, or if staff must travel from Cranbrook to Kimberley or Fernie.
NORTHERN	**T**	PRINCE GEORGE, NORTH TO CHETWYND, EAST TO VALEMOUNT, SOUTH TO HIXON & WEST TO BURNS LAKE	Only one-way travel is billable for Prince George. Long-distance out-of-town travel would apply for areas outside of this municipality.
	U	TERRACE, NORTH TO DEASE LAKE, EAST TO HOUSTON, SOUTH TO KITIMAT & WEST TO PRINCE RUPERT	Only one-way travel is billable within Terrace and Prince Rupert; however, long-distance out-of-town travel would apply for areas outside of these municipalities, or if staff must travel from one to another (e.g., Terrace to Prince Rupert).
	V	FORT ST. JOHN, NORTH TO FORT NELSON & SOUTH TO DAWSON CREEK	Only one-way travel is billable within Fort St. John and Dawson Creek; however, long-distance out-of-town travel would apply for areas outside of these municipalities, or if staff must travel from one to another (e.g., Fort St. John to Dawson Creek).
VANCOUVER ISLAND	**W**	VICTORIA, NORTH TO SIDNEY & MALAHAT & WEST TO PORT RENFREW	Only one-way travel is billable within Victoria and Sidney; however, long-distance out-of-town travel would apply for areas outside of these municipalities, or if staff must travel from Victoria to Sidney.
	X	DUNCAN, NORTH TO LADYSMITH, SOUTH TO MILL BAY, WEST TO COWICHAN LAKE & SOUTHERN GULF ISLANDS	Only one-way travel is billable for Duncan. Long-distance out-of-town travel would apply for areas outside of this municipality.

	Y	NANAIMO, NORTH TO QUALICUM BEACH, SOUTH TO CASSIDY & NORTHERN GULF ISLANDS	Only one-way travel is billable within Nanaimo, Qualicum and Parksville; however, long-distance out-of-town travel would apply for areas outside of these municipalities, or if staff must travel from Nanaimo to Parksville or Qualicum. Long-distance out-of-town travel does not apply for travel between Parksville and Qualicum (and vice versa).
	Z	PORT ALBERNI, WEST TO TOFINO & UCLUELET	Only one-way travel is billable for Port Alberni, Tofino and Ucluelet. Long-distance out-of-town travel would apply for areas outside of these municipalities, or if staff must travel from Tofino to Ucluelet (or vice versa).
	AA	COURTENAY/COMOX, NORTH TO BLACK CREEK & SOUTH TO BOWSER	Only one-way travel is billable for Courtenay and Comox, even if Comox staff are borrowed to service Courtenay, or vice versa. Long-distance out-of-town travel would apply for areas outside of these municipalities (e.g. Black Creek and Fanny Bay).
	AB	CAMPBELL RIVER, NORTH TO PORT HARDY & BELLA BELLA, EAST TO QUADRA ISLAND, SOUTH TO SARATOGA BEACH & WEST TO GOLD RIVER	Only one-way travel is billable for Campbell River. Long-distance out-of-town travel would apply for areas outside of this municipality.

Appendix E: Reports and forms for Home Care Services and how to complete them

All forms can be found on the Forms & Resources page on worksafebc.com.

Use these forms to complete your assessments and care plans:

- Home Care Services Referral and Services Confirmation (83M377)
  Here are instructions on how to complete this form.

  83M377 - Home Care Services Referral Conf
- Home Care Services Initial Assessment (83M378)
  Here are instructions on how to complete this form.

  83M378- Home Care Services Initial Assessı
- Home Care Services Care Plan (83M375)
  Here are instructions on how to complete this form.

  83M375 - Home Care Services Care Plan - S
- Home Care Services Progress Report (83M379)
  Here are instructions on how to complete this form.

  83M379 - Home Care Services Progress Rep
- Home Care Services Discharge Report (83M376)
  Here are instructions on how to complete this form.

  83M376- Home Care Services Discharge Re

Complete this form within one business day of the incident or event:

- Health Care Programs - Incident Report (form 83M380)

Appendix F: Guidelines for using Schedule B

Note: this document explains how to bill each fee code and includes some examples. For the applicable rules and eligibility to invoice each fee code, please refer to Schedule B of the Home Care Services Agreement.

Fee Code	Service Description	Billing Guidelines
1136640	Referral Fee	To bill the Referral Fee, enter 1 in the '# of Units' column and the flat rate will auto-populate (as per Schedule B) as the 'Unit Price'.
1136645	Initial Assessment and Care Plan	To bill the Initial Home Care Assessment and Care Plan fee, enter '1' in the '# of Units' column and the flat rate will auto-populate (as per Schedule B) as the 'Unit Price'. Both the Initial Assessment (83M378) and Care Plan (83M375) forms must be received to be paid, and the Date of Service (DOS) of the billing must match the DOS on the reports (i.e., the date the assessment took place). If the reports are submitted within the required timelines, payment will include a timely completion bonus (as per Schedule B). Example: • You receive a new referral on October 31. Your nurse conducts the in-person assessment with the injured worker on November 1 and submits the reports on November 5. The Contractor shall enter: • November 1 in the 'Date of Service' column, 1 in the '# of Units' column, select 1136645 in the 'Fee Code' column and the corresponding rate for the Initial Home Care Assessment and Care Plan (as per Schedule B) will auto-populate in the 'Unit Price' column.

1170432 (RN/RPN)
 	
1211904 (LPN)
	Concurrent Nursing Services – RN, RPN or LPN	To bill for Concurrent RN/RPN or LPN Services (i.e., nursing services that take place on the same DOS as an assessment visit), enter the fractional number of hours, to the nearest ¼ hr (15 min) increment, in the '# of Units' column along with the hourly rate (as per Schedule B) in the 'Unit Price' column.
		
		Example 1:
		• You receive a referral for an injured worker that requires wound care – an RN visits the injured worker for the initial assessment and whilst there, also provides the first wound care treatment, which takes the RN 25 minutes. In this case you invoice:
		  • the Initial Home Care Assessment and Care Plan fee (as above); and
		  • 0.5 (30 min) in the '# of Units' column, select 1170432 in the 'Fee Code' column and enter the corresponding

		hourly rate for Concurrent Nursing Services – RN/RPN (as per Schedule B) in the 'Unit Price' column.
		
		Example 2:
		• An LPN visits an injured worker for the monthly Progress visit and whilst there, also provides a dressing change, which takes the LPN 10 minutes. In this case you invoice:
		  • the Progress Report – LPN – With Visit fee (as below); and
		  • 0.25 units (15 min) in the '# of Units' column, select 1211904 in the 'Fee Code' column and enter the corresponding hourly rate for Concurrent Nursing Services - LPN (as per Schedule B) in the 'Unit Price' column.

1136641 (RN/RPN)
 	
1136642 (LPN)
	Nursing Services – RN, RPN or LPN	To bill for Nursing Services, enter the fractional number of hours provided, to the nearest ¼ hr (15 min) increment, in the '# of Units' column along with the appropriate hourly rate (as per Schedule B) for either RN/RPN or LPN, depending on the designation of the nurse attending, in the 'Unit Price' column.
		
		Example 1:
		• An RN provided 2 hours and 10 minutes of complex wound care. In this case you invoice:
		  • 2.25 units (2 hrs & 15 min) in the '# of Units' column, select 1136641 in the 'Fee Code' column and enter the corresponding hourly rate for Nursing Services – RN/RPN (as per Schedule B) in the 'Unit Price' column.
		
		Example 2:
		• An LPN provided 40 minutes of would care. In this case you invoice:
		  • 2 units (the 2 hr minimum) in the '# of Units' column, select 1136642 in the 'Fee Code' column and enter the corresponding hourly rate for Nursing Services - LPN (as per Schedule B) in the 'Unit Price' column.

1136643	Care Services – HCA	To bill for HCA Services, enter the fractional number of hours provided, to the nearest ¼ hr (15 min) increment, in the '# of Units' column and the hourly rate (as per Schedule B) in the 'Unit Price' column. Example 1: • An HCA provided 1 hour and 40 minutes of care. In this case you invoice: • 2 units (the 2 hr minimum) in the '# of Units' column, select 1136643 in the 'Fee Code' column and enter the

		corresponding hourly rate for Care Services – HCA (as per Schedule B) in the 'Unit Price' column.
		
		Example 2:
		• An HCA provided 2 hours and 18 minutes of care. In this case you invoice:
		  • 2.25 units (2 hrs & 15 min) in the '# of Units' column, select 1136643 in the 'Fee Code' column and enter the corresponding hourly rate for Care Services – HCA (as per Schedule B) in the 'Unit Price' column.
		Example 3:
		• An HCA provided vigilant, 24 hour care. In this case you invoice:
		  • 24 units in the '# of Units' column, select 1136643 in the 'Fee Code' column and enter the corresponding hourly rate for Care Services – HCA in the 'Unit Price' column.
		  **Reminder: Be sure to bill the hours on the correct DOS, based on a 24 hour clock, to reflect the hours worked within 00h00 and 24h00 (i.e., midnight to midnight) of that particular DOS.*

1212161 (RN/RPN) 1212162 (LPN)	Progress Report Fee – RN, RPN or LPN – With Visit	To bill for a Progress Report Fee where an in-person re-assessment visit took place, enter 1 in the '# of Units' column and the flat rate for either an RN/RPN or LPN (based on the designation of the nurse conducting the assessment and as per Schedule B) in the 'Unit Price' column. A Progress Report (83M379) form must be received to be paid, and the DOS of the billing must match the DOS on the report (i.e., the date the assessment took place). Example: • An LPN visits an injured worker for a progress visit/re-assessment on September 7. The LPN completes and submits the report on September 10. In this case you invoice: • September 7 in the 'Date of Service' column, 1 in the '# of Units' column, select 1212162 in the 'Fee Code' column and enter the corresponding flat rate for Progress Report – LPN (as per Schedule B) in the 'Unit Price' column.

1236225	Progress Report Fee – RN, RPN or LPN – Without Visit	To bill for a Progress Report Fee where an in-person re-assessment visit did not take place (i.e., a telehealth visit), enter 1 in the '# of Units' column and the flat rate (as per Schedule B) in the 'Price' column.
		
		A Progress Report (83M379) form must be received to be paid, and the DOS of the billing must match the DOS on the report (i.e., the date the assessment took place).
		
		Example:
		• An RPN conducts a re-assessment via Telehealth on November 10. The RPN completes and submits a Progress report on November 13. In this case you invoice:
		  • November 10 in the 'Date of Service' column, 1 in the '# of Units' column, select 1236225 in the 'Fee Code' column and the flat rate for the Progress Report Fee – RN/RPN or LPN – Without Visit (as per Schedule B) in the 'Unit Price' column; and
		  • The applicable units of the Telehealth Services – RN/RPN, for the video call (as below).

1236480 (RN/RPN)
 	
1236481 (LPN)
	Telehealth Services – RN, RPN or LPN	To bill for Telehealth Services (i.e., nursing services through the use of video technology), enter the fractional number of hours provided, to the nearest ¼ hr (15 min) increment, in the '# of Units' column along with the appropriate hourly rate (as per Schedule B) for either RN/RPN or LPN, based on the designation of the nurse that conducted the video call, in the 'Unit Price' column.
		
		Example:
		• An RPN conducted a re-assessment via Telehealth and was on the video call with the injured worker for 43 minutes. In this case you invoice:
		  • 0.75 units (45 min) in the '# of Units' column, select 1236480 in the 'Fee Code' column and enter the corresponding hourly rate for Telehealth Nursing Services – RN/RPN (as per Schedule B) in the 'Unit Price' column; and
		  • The Progress Report Fee – RN/RPN – Without Visit, for the report (as above).

1271040	Care Services – Telephone – HCA	To bill for HCA Telephone Services, enter the fractional number of hours provided, to the nearest ¼ hr (15 min) increment, in the '# of Units' column along with the appropriate hourly rate (as per Schedule B) in the 'Unit Price' column. Example:

		• An HCA called an injured worker to remind them to take their medications. The call lasted 5 minutes. In this case you invoice: • 0.25 units (15 min) in the '# of Units' column, select 1271040 in the 'Fee Code' column and enter the corresponding hourly rate for Care Services – Telephone – HCA (as per Schedule B) in the 'Unit Price' column.

1212416 (RN/RPN)
 	
1212672 (LPN)
	Indirect Time – RN, RPN or LPN	To bill for Indirect Time, enter the number of minutes, to the nearest 5 minute increment, in the '# of Units' column and the per minute rate (as per Schedule B) in the 'Unit Price' column.
		
		Example 1:
		• An RN speaks with a hospital nurse for 18 minutes in regard to discharge planning for an injured worker. In this case you invoice:
		  • 20 (20 min) in the '# of Units' column, select 1212416 in the 'Fee Code' column and enter the corresponding per minute rate for Indirect Time – RN (as per Schedule B) in the 'Unit Price' column.
		
		Example 2:
		• An LPN speaks with a WorkSafeBC Clinical Specialist Nurse for 16 minutes regarding a clinical issue that has arisen for an injured worker. In this case you invoice:
		  • 15 (15 min) in the '# of Units' column, select 1212672 in the 'Fee Code' column and enter the corresponding per minute rate for Indirect Time – LPN (as per Schedule B) in the 'Unit Price' column.

1212673	Foot Care – RN, RPN, or LPN	To bill for a Foot Care visit, by either an RN, RPN, or an LPN, enter 1 in the '# of Units' column and the flat rate (as per Schedule B) in the 'Unit Price' column.
		
		Note: this flat fee may be billed concurrently with other Nursing Services and/or assessment visits, as appropriate.
		
		Example 1:
		• A new referral is received for foot care only. The RN, who is a specially trained foot care nurse, conducts the initial assessment and whilst there, also provides the first foot care treatment, which takes 40 minutes. In this case you invoice:
		  • the Initial Home Care Assessment and Care Plan fee (1136645); and
		  • 1 in the '# of Units' column, select 1212673 in the 'Fee Code' column and enter the corresponding flat rate for

		Foot Care – RN, RPN or LPN (as per Schedule B) in the 'Unit Price' column.
		
		Example 2:
		• An injured worker requires daily wound care from an LPN and foot care every 8 weeks. The LPNs providing the wound care are not trained to provide foot care and so a specially trained foot care nurse is sent separately on the days foot care is performed. The foot care takes 35 minutes and the wound care takes 45 minutes. In this case you invoice:
		  • 2 hours (minimum service visit) of Nursing Services – LPN (1136642); and
		  • The Foot Care – RN, RPN or LPN fee (as above).
		
		Example 3:
		• An injured worker requires wound care from an RN every other day and foot care every 6 weeks. The RN providing the wound care is also a specially trained foot care nurse and so provides both services on the same DOS. The wound care takes 50 minutes and the foot care takes 25 minutes. In this case you invoice:
		  • 0.75 units (45 mins) of Nursing Services – RN (1136641); and
		  • The Foot Care – RN, RPN or LPN fee (as above).
		  **Reminder: the 2 hour minimum does not apply to the nursing services in this case due to the flat rate foot care fee being billed by the same nurse during the same visit.*
		
		Example 4:
		• An injured worker requires wound care and foot care on the same DOS as an assessment/re-assessment. In this case you invoice:
		  • the appropriate assessment report fee code; and,
		  • the appropriate units of the applicable Concurrent Nursing Services fee code (for the wound care); and
		  • the Foot Care – RN, RPN or LPN fee (as above).

1212931 (RN/RPN) 1212674 (LPN)	Discharge Report Fee – RN, RPN or LPN – With Visit	To bill for a Discharge Report fee where an in-person re-assessment visit took place, enter 1 in the '# of Units' column and the flat rate for either an RN/RPN or LPN as appropriate (as per Schedule B) in the 'Unit Price' column. A Discharge Report (83M376) form must be received to be paid, and the DOS of the billing must match the DOS on the report (i.e., the date the assessment took place). Example: • An RPN visits an injured worker for a progress visit/re-assessment on August 15 and determines that the injured

		worker no longer requires Services. The RPN completes and submits a Discharge report on August 20. In this case you invoice: • August 15 in the 'Date of Service' column, 1 in the '# of Units' column, select 1212931 in the 'Fee Code' column and enter the corresponding flat rate for the Discharge Report Fee – RN/RPN – With Visit (as per Schedule B) in the 'Unit Price' column.
1211650	Discharge Report Fee – RN, RPN or LPN - Without Visit	To bill for a Discharge Report fee where an in-person re-assessment visit did not take place, enter 1 in the '# of Units' column and the flat rate (as per Schedule B) in the 'Unit Price' column. A Discharge Report (83M376) form must be received to be paid, and the DOS of the billing must match the DOS on the report (i.e., the date the assessment took place). Example: • A Clinical Specialist Nurse calls your LPN on November 13 advising that the injured worker is to be discharged from Services and that you shall continue to provide Services only through to the end of the week (Friday, November 16). The LPN completes and submits a Discharge report on November 15. In this case you invoice: • November 13 in the 'Date of Service' column, 1 in the '# of Units' column, select 1211650 in the 'Fee Code' column and the flat rate for the Discharge Report Fee – RN, RPN or LPN – Without Visit (as per Schedule B) in the 'Unit Price' column. **Note: the DOS/date of assessment in this case would be the date the decision was made to discharge the worker (i.e., the date of the call from the CSN).*
1211651 (RN/RPN) 1212928 (LPN)	Injured Worker Not Available Fee – RN, RPN, LPN and HCA	To bill for a visit where the injured worker was not available , enter the applicable fractional number of hours for the scheduled visit, to the nearest ¼ hr (15 min) increment (up to a maximum of 2 hours as per Schedule B), in the '# of Units' column, along with the appropriate hourly rate (as per Schedule B) for either RN/RPN, LPN, or HCA, depending on the level of care that was required, in the 'Unit Price' column. Example 1: • An LPN was scheduled to provide a dressing change for an injured worker on December 7 from 11:00-12:00. The appointment time was confirmed with the injured worker in advance; however, when the LPN arrived, the injured

1212929 (HCA)		worker was not home. The LPN waited the required 30 minutes, and the injured worker did not arrive. In this case you invoice: • December 7 in the 'Date of Service' column, 1 unit (1 hr) in the '# of Units' column, select 1212928 in the 'Fee Code' column and enter the corresponding hourly rate for the Injured Worker Not Available Fee - LPN (as per Schedule B) in the 'Unit Price' column. • Example 2: An HCA was scheduled to provide 2.5 hours of morning care for an injured worker on December 14 from 8:00-10:30 am. The injured worker called your office at 6:00pm on December 13 to cancel their home care visit for the following day. You tried but were unable to find replacement work for the HCA on such short notice. In this case you invoice: • December 14 in the 'Date of Service' column, 2 units (2 hr maximum) in the '# of Units' column, select 1212929 in the 'Fee Code' column and enter the corresponding hourly rate for the Injured Worker Not Available Fee – HCA (as per Schedule B) in the 'Unit Price' column.
1258496	Injured Worker Not Available Fee – Foot Care – RN, RPN, or LPN	To bill for a Foot Care visit where the injured worker was not available, enter 1 in the '# of Units' column and the flat rate (as per Schedule B) in the 'Unit Price' column. Example: • An RN was scheduled to provide foot care on March 15 at 10:00 am; however, the injured worker called your office at 1:00pm on March 14 and advised that they wished to cancel and re-schedule their visit to a later date. You tried but were unable to find replacement work for the RN. In this case you invoice: • March 15 in the 'Date of Service' column, 1 unit in the '# of Units' column, select 1258496 in the 'Fee Code' column and enter the corresponding rate for the Injured Worker Not Available Fee – Foot Care – RN, RPN or LPN (as per Schedule B) in the 'Unit Price' column.
1136647 (RN/RPN)	Travel Time	To bill for Travel Time, enter the fractional number of hours travelled, to the nearest ¼ hr (15 min) increment, in the '# of Units' column along with the appropriate hourly rate (as per Schedule B) for either RN/RPN, LPN, or HCA, depending on the personnel travelling, in the 'Unit Price' column.

1136648 (LPN)
 	
1136649 (HCA)
		Example 1:
		• An HCA drove 25 minutes from a previous client on one end of the city to an injured worker who lived on the opposite side of the city. Your closest business location is 35 minutes away from the injured worker, so the full travel time is billable since the previous client was closer. The HCA's next client was a 15 minute drive away. In this case you invoice:
		  • 0.5 units (30 min) in the '# of Units' column, select 1136649 in the 'Fee Code' column and enter the corresponding rate for Travel Time - HCA (as per Schedule B) in the 'Unit Price' column.
		  **Since the travel is within the city, only one-way travel time is billable for this injured worker (from the previous client to the injured worker). If the HCA's next client was also an injured worker, the next 15 minutes of travel time would be billed to that injured worker's claim.*
		
		Example 2:
		• An LPN drove for 58 minutes from a previous client in a small town to an injured worker who lived rurally, outside of the town. You have received approval from the WorkSafeBC officer to bill for long-distance out-of-town travel for this injured worker and thus, return travel time is billable. The LPN's next client was 1.5 hours away from the injured worker; however, your closest business location is 1 hour and 10 minutes from the injured worker, which is the maximum distance billable. In this case you invoice:
		  • 2.25 units (1 hr + 1 hr and 15 min) in the '# of Units' column, select 1136648 in the 'Fee Code' column and enter the corresponding rate for Travel Time - LPN (as per Schedule B) in the 'Unit Price' column.

1212930	Travel Mileage	To bill for Mileage, for any caregiver type, enter the actual number of kilometers travelled in the '# of Units' column along with the mileage rate (as per Schedule B) in the 'Unit Price' column. Using the same examples as above in Travel Time, but calculating for distance instead of time: Example 1: • An HCA drove for 20 km from a previous client on one end of the city to an injured worker who lived on the opposite side of the city. Your closest business location is 30 km away from the injured worker, so the full mileage is billable since the previous client was closer. The HCA's

		next client was a 25 km drive away. In this case you invoice: • 20 (20 km) in the '# of Units' column, select 1212930 in the 'Fee Code' column and enter the corresponding rate for Travel Mileage (as per Schedule B) in the 'Unit Price' column. **Since the travel is within the city, only one-way mileage is billable for this injured worker (from the previous client to the injured worker). If the HCA's next client was also an injured worker, the next 25 km would be billed to that injured worker's claim.* Example 2: • An LPN drove for 65 km from a previous client in a small town to an injured worker who lived rurally, outside of the town. You have received approval from the WorkSafeBC officer to bill for long-distance out-of-town travel for this injured worker and thus, return mileage is billable. The LPN's next client was 105 km away from the injured worker; however, your closest business location is only a 75 km drive from the injured worker, which is the maximum distance billable. In this case you invoice: • 140 km (65 km + 75 km) in the '# of Units' column, select 1212930 in the 'Fee Code' column and enter the corresponding rate in the 'Unit Price' column.
1137152 (RN/RPN) 1137153 (LPN)	Stat Holiday Uplift	To bill for the Stat Holiday Uplift, enter the fractional number of hours provided, to the nearest ¼ hr (15 min) increment, in the '# of Units' column and the appropriate hourly rate (as per Schedule B) for the type of personnel providing the service in the 'Unit Price' column. Note: The Stat Holiday Uplift is billable concurrently with the caregiver's regular hourly rate; therefore, the number of units billed for the stat uplift portion should match the number of units billed for the Service. Example 1: • An HCA provides 2 hours of care on Labour Day. In this case you invoice:

1137154 (HCA)		• 2 units of 1136643; and • 2 in the '# of Units' column, select 1137154 in the 'Fee Code' column and enter the corresponding rate for Stat Holiday Uplift - HCA (as per Schedule B) in the 'Unit Price' column. Example 2: • An HCA provided vigilant, 24 hour care on Christmas Day. In this case you invoice: • 24 units of 1136643; and • 24 units of 1137154 (as above). Example 3: • An LPN provided 1 hour of wound care on Boxing Day. In this case you invoice: • 1 unit of 1136642; and • 1 unit of 1137153 (as above)
1213185	Disposable Medical Supplies	To invoice for reimbursement of Disposable Medical Supplies, enter 1 in the '# of Units' column and the sub-total dollar amount for the item in the 'Unit Price' column. Any applicable taxes must be entered separately in the corresponding 'PST' and/or 'GST/HST' columns. A copy of the receipt(s) must be attached to the invoice as proof of purchase to be reimbursed. The DOS of the billing must match the date on the receipt. Example: • An LPN was set to visit an injured worker for a dressing change, but they had run out of supplies. The LPN purchased the disposable medical supplies that were required to tend to the wound, which totalled $24.76 (before tax). In this case you invoice: • 1 in the '# of Units' Column, select fee code 1213185 in the 'Fee Code' column, the sub-total of $24.76 in the 'Unit Price' column and the applicable taxes in the 'PST' and/or 'GST/HST' columns.

1271041	Pre-Authorized Travel Expenses	To invoice for reimbursement of Pre-Authorized Travel Expenses, enter 1 in the '# of Units' column and the sub-total dollar amount for the item in the 'Unit Price' column. Any applicable taxes must be entered separately in the corresponding 'PST' and/or 'GST/HST' columns.
		**Note: this fee code can also be billed in reverse, i.e., with the sub-total dollar amount for the item in the '# of Units' column and $1 in the 'Unit Price' column.*
		
		A copy of the receipt(s) must be attached to the invoice as proof of purchase to be reimbursed. The DOS of the billing must match the date on the receipt.
		
		Invoice the total amount for the same type of expense on the same DOS (e.g., one line for the meal total for the day, etc.). Invoice separate line items for separate types of travel expenses.
		
		Example 1:
		• An HCA was approved to accompany an injured worker on an overnight trip from Terrace to Vancouver. WorkSafeBC arranged the flight and hotel for the HCA (and paid for that directly). The WorkSafeBC officer approved meal expenses during the travel, which meant lunch and dinner on day 1 and breakfast and lunch on day 2. The HCA spent the following (including meals and beverages):
		  • Day 1 lunch: $19.54 excluding tax and a $3.00 tip
		  • Day 1 dinner: $27.86 excluding tax and a $5.00 tip
		  • Day 2 breakfast: $16.36 excluding tax and a $2.00 tip
		  • Day 2 lunch: $12.11 excluding tax (purchased - no tip)
		• In this case you invoice:
		  • Day 1: enter 1 in the '# of Units' column, select fee code 1271041 in the 'Fee Code' column, the total billable amount of $44.36 ($16.50, per the maximum amount for lunch + $27.86, since the total for dinner does not exceed the maximum amount of $29.00) in the 'Unit Price' column, and enter the applicable taxes in the 'PST' and/or 'GST/HST' columns.
		  **Note: the gratuities of $8 are not reimbursable.*
		  • Day 2: enter 1 in the '# of Units' column, select fee code 1271041 in the 'Fee Code' column, the total billable amount of $26.61 ($14.50, per the maximum amount for breakfast + $12.11, since the total for lunch does not exceed the maximum amount of $16.50) in the 'Unit Price' column, and enter the applicable taxes in the 'PST' and/or 'GST/HST' columns.
		  **Note: the gratuity of $2 is not reimbursable.*

		Example 2: • An LPN takes a ferry from Nanaimo to Gabriola Island to visit an injured worker for a Progress visit/re-assessment. The LPN returned the same day and the ferry was $25 each way, excluding tax. In this case you invoice: • 1 in the '# of Units' column, select fee code 1271041 in the 'Fee Code' column, the sub-total of $50 ($25 + $25) in the 'Unit Price' column and the applicable taxes in the 'PST' and/or 'GST/HST' columns.
1136651	Photocopies (first 5 pages)	To bill for the first 5 pages for Photocopies, enter 1 in the '# of Units' column and the flat rate (as per Schedule B) in the 'Unit Price' column.

1136652	Photocopies (every page over 5 pages)	To bill for additional pages (after the first 5 pages) for Photocopies, enter the additional number of pages photocopied in the '# of Units' column and the per page rate (as per Schedule B) in the 'Unit Price' column.
		
		Example:
		• WorkSafeBC requested copies of your chart notes for an injured worker. You photocopied 20 pages of chart notes to send WorkSafeBC. In this case you invoice:
		  • 1 unit of 1136651 (as per above); and
		  • 15 (20 pages minus the first 5 pages already invoiced above) in the '# of Units' column, select fee code 1136652 in the 'Fee Code' column, and the per page rate (as per Schedule B) in the 'Unit Price' column.

Appendix G: Sample 3M VAC order form

WORK SAFE BC

PO Number (Client Claim number):

New Order ☐ End of Order ☐ Renewal ☐	Order Date: Delivery Date:	Order Priority: Regular Order ☐ Urgent Order ☐ Other (Specify) ☐

3M's Account Executive:	Products	Daily VAC Rental	Approval Duration	Qty	Purchase Price
Billing Address:	VAC Therapy	Product codes		(cases)	
Account Number: 32509	Acti VAC rental (Portable-Home care setting)	☐ $90/day	fr: to:		
WorkSafeBC	VAC Ulta rental (Acute-Attach to bed or IV pole)	☐ $90/day	fr: to:		
	Small granufoam dressing 5 PACK	M8275051/5.S		☐	$365.98
	Small granufoam dressing 10 PACK	M8275051/10.S		☐	$580.34
	Medium granufoam dressing 5 PACK	M8275052/5.S		☐	$470.55
Mandatory WorkSafeBC approval	Medium granufoam dressing 10 PACK	M8275052/10.S		☐	$746.60
(This section MUST be completed prior to shipping)	Large granufoam dressing 5 PACK	M8275053/5.S		☐	$524.92
WorkSafeBC Case Manager's name:	Large granufoam dressing 10 PACK	M8275053/10.S		☐	$833.39
Telephone Number:	Small simplace EX dressing 5 PACK	M8275046/5.S		☐	$290.17
Fax number:	Medium simplace EX dressing 5 PACK	M8275045/5.S		☐	$373.30
Date approval received:	Bridge dressing case of 5	M8275042/5.S		☐	$499.82
Shipping Information	Bridge dressing case of 10	M8275042/10.S		☐	$796.79
Client's home ☐ Nursing agency ☐	Bridge XG Dressing Case of 5	M8275044/5.S		☐	$600.21
Address:	ACTIV.A.C. canister with gel 5/CASE	M8275058/5.S		☐	$375.39
	ACTIV.A.C. canister with gel 10/CASE	M8275058/10.S		☐	$596.02
	GranuFoam™ Silver Small Dressing Kit/10	M8275098/10.S		☐	$704.77
Telephone Number:	GranuFoam™ Silver Medium Dressing Kit/10	M8275096/10.S		☐	$881.49
Claim Number:	GranuFoam™ Silver Large Dressing Kit/10	M8275099/10.S		☐	$1,040.43
Contact Name:	TRAC Y-Connector/10	M6275066/10.S		☐	$124.43
	SensaTRAC® WhiteFoam 10 x 7.5 Dressing Kit/10	M8275068/10.S		☐	$606.48
Nursing Agency:	SensaTRAC® WhiteFoam 10 x 15 Dressing Kit/10	M8275067/10.S		☐	$784.24
Contact name:	WhiteFoam 10 x 7.5 Small Dressing Only/10	M6275033/10.S		☐	$309.51
Phone number:	Whitefoam 10 x 15 Large Dressing Only/10	M6275034/10.S		☐	$441.27
Email address:	Dermatac Drape case of 10 - Drape Only	DTAC10LDP.S		☐	$396.83
Fax number:	Prevena Peel and place: 7 Day Kit	PRE1001.S		☐	$577.39
Additional information:	VAC Via: 7 Day Kit	VIAKIT077D01/US.S		☐	$973.18

3M Customer Service #
1-800-668-5403

FAX 3M: 1-888-686-5672

Prices are subject to change without notice

Appendix H: "Restrictions" vs. "considerations"

Keep these definitions in mind when you're making recommendations and reporting to us.

Term	Definition
Medical restrictions (recommended by physicians or nurse practitioners and psychologists only)	Activities an injured worker **should not** perform because of risk of significant harm. A physician or nurse practitioner imposing restrictions on an injured worker should be able to describe the nature of the risk of harm. The test to use is this: If a patient begged you to let them perform the activity, would you still say no due to the risk of harm? For example, a patient with acute tib/fib fracture is prohibited from weight bearing; a patient with acute concussion is pulled off the playing field; and a patient with uncontrolled seizures is prohibited from driving. However, if a patient post–rotator-cuff repair begged you to let them return to typing, you would say that's okay. There's no need to restrict typing for someone with this injury, even if they complain they can't type.
Physical considerations	**Objective** • Are activities an injured worker cannot perform due to lack of physical capacity, not due to pain or fatigue. Examples of physical considerations include limited strength capacity or limited range of motion in a joint. **Subjective** • Are activities the injured worker reports having difficulty performing due to pain or fatigue. • Pain does not, by itself, lead to restrictions (as defined above). Only the medical pathology (if known) causing the pain can be the basis for imposing medical restrictions. Pain may lead to genuine physical considerations. These considerations can't be measured by medical means alone. • Work can be used as progressive exercise that builds capacity. An inappropriate prescription for decreased activity will decrease capacity. It is important that you frame considerations using abilities language and also offer mitigating strategies. For example: • **Consideration:** Worker has difficulty with sustained overhead reaching using their right (dominant) arm for periods of greater than two minutes. • **Ability language:** Worker is able to perform sustained or intermittent overhead reaching with their left arm and intermittent overhead reaching with their right (dominant) arm. • **Examples of some mitigating strategies:** Worker would benefit from using a stepladder ladder to minimize the degree of overhead reaching required; Alternating overhead reaching tasks with another job task is recommended to support pacing.

Remember to use an abilities framework whenever you can
It's your role as a home care provider to make considerations as appropriate during care services. The claim owner will adjudicate these considerations and decide whether to accept them or not. Considerations may be temporary or permanent. An injured worker may require certain care services that can be removed at the point of recovery (e.g., the injured worker no longer requires shower assistance). Considerations that are permanent in nature may require on-going care services and may have significant consequences to the individual's ability to return to their pre-injury job, find alternate employment, and maintain their income.

Appendix I: Telehealth treatment guidelines

Introduction

You'll notice this appendix is worded and structured more like the contract you signed with WorkSafeBC. As with the rest of this reference manual, read it closely and be sure you understand it.

Background

In these telehealth treatment guidelines (the "Guidelines"):

- "**Agreement**" means the Services Agreement between WorkSafeBC and a WorkSafeBC Health Care Provider.
- "**WorkSafeBC Health Care Provider(s)**" means the WorkSafeBC Health Care Provider authorized to deliver services under the Agreement and, where the context permits, office and other personnel supporting the services.
- "**Telehealth Services**" is defined as a health care provider–delivered health service provided to apatient via live image transmission to a receiving health care provider at another approved site, through the use of video technology.
- "**Injured Worker**" means a person who is entitled to compensation under the *Workers Compensation Act* and who receives services under the Agreement.

Telehealth Services have been increasingly employed by health care providers to increase accessibility of health care services, enhance quality of care, and decrease costs. In order to address barriers to accessing health care services, WorkSafeBC has agreed to the delivery of services (as defined in the Agreement) to injured workers using Telehealth Services. Telehealth Services allow WorkSafeBC Health Care Providers to meet face to face virtually with injured workers, book appointments, and share files necessary for sessions. The use of Telehealth Services is not mandatory or required by WorkSafeBC and is at the election and discretion of the WorkSafeBC Health Care Provider. WorkSafeBC Health Care Providers who wish to use Telehealth Services are responsible for their own arrangements with a Telehealth Services provider, are solely responsible for any and all costs related to the set-up and use of the telehealth services platform, and are also responsible for complying with the terms and conditions of that agreement.

Scope

These Guidelines apply to the provision of services by WorkSafeBC Health Care Providers to injured workers using Telehealth Services. They do not replace existing professional guidelines for the use of technology. These Guidelines have been adopted from already established guidelines from three main sources: The American Psychiatric Association and American Telemedicine Association ("APA/ATA") *Best Practices in Videoconferencing-Based Telemental Health* (2018); the Province of BC Health Authorities *Telehealth Clinical Guidelines* (Version 9, 2014); and the ATA *Practice Guidelines for Video-Based Online Mental Health Services* (2013).

In the event of any differences between these Guidelines and the Agreement or any agreement between the WorkSafeBC Health Care Provider and the telehealth service provider in the case of technical matters, those agreements will govern.

Professional considerations

The purpose of the Guidelines is to assist WorkSafeBC Health Care Providers in providing health care in a telehealth setting. These Guidelines are not a substitute for your independent professional judgment and obligations.

Each WorkSafeBC Health Care Provider is responsible for complying with the applicable standards of practice in regards to the services and the use of technology in their practice. For your convenience, some of those standards are included in the References section of these Guidelines.

Please note: If the WorkSafeBC Health Care Provider and/or injured worker will not be physically located in British Columbia during the telehealth encounter, then the provider should contact their provincial licensing body in B.C. and the other jurisdiction's licensing body to confirm whether there are any licensing requirements to use telehealth in the province where the injured worker resides.

The WorkSafeBC Health Care Provider is solely responsible for identifying and complying with all applicable standards and should not treat the References section as comprehensive or conclusive.

Clinical guidelines

Standards of care

The APA/ATA have recommended clinical practice guidelines for telehealth services in *Best Practices in Videoconferencing-Based Telemental Health* (April 2018) (the "*Best Practices*"). These *Best Practices* establish that delivery of health care services using video technology does not change professional or clinical standards:

> Health professionals **shall** be responsible for maintaining the same level of professional and ethical discipline and clinical practice principles and guidelines as in-person care in the delivery of care in [telehealth], as well as additional telehealth-related concerns, such as consent processes, patient autonomy, and privacy. (*Best Practices*, page 7)

When determining whether Telehealth Services are appropriate, the *Best Practices* indicate on page 6 that several factors should be considered, including the injured worker's "cognitive capacity, history regarding cooperativeness with treatment professionals, current and past difficulties with substance abuse, and history of violence or self-injurious behavior," as well as "geographic distance to the nearest emergency medical facility, efficacy of patient's support system, and current medical status."

In addition, WorkSafeBC Health Care Providers must ensure that in the discussion to obtain consent (as detailed below under Informed consent), the injured worker is made aware that Telehealth Services may be discontinued if the Injured Worker cannot be safely managed.

The Province of BC Health Authorities *Telehealth Clinical Guidelines* (Version 9, 2014) note on page 6 that health care professionals "must recognize when telehealth approaches are not appropriate for the client's needs and be aware of any ethical risks to clients. Backup plans and safeguards should be developed to reduce risk."

Injured worker privacy and confidentiality

WorkSafeBC Health Care Providers are required to comply with the *Freedom of Information and Protection of Privacy Act* ("FIPPA") in the delivery of services to injured workers. In addition to other requirements, FIPPA requires WorkSafeBC Health Care Providers to ensure there are reasonable security arrangements to protect the injured worker's personal information (as defined in FIPPA); only those persons with a direct need to access the personal information to deliver services have access to it; and the injured worker's personal information is accessed, used, disclosed, and stored in Canada only.

If you are uncertain as to whether or not the telehealth platform you are utilizing has the ability to delete stored information as required by FIPPA, then do not use the injured worker's full name when scheduling

appointments (only use initials), and do not use any open text boxes (if available). If you open a file when an injured worker shares a file, the usual professional and ethical standards regarding patient confidentiality apply, even if you don't download the file.

Please note: Secure messaging should not be utilized due to requirements under FIPPA.

Please refer to the Agreement for requirements with respect to injured worker personal information. These requirements apply to Telehealth Services.

The *Telehealth Clinical Guidelines* also note on page 7 that protecting privacy and confidentiality is of paramount concern and should be considered in all the following: privacy of personal communications, personal information, and consulting space.

Emergency management

The Guidelines recognize that the WorkSafeBC Health Care Provider should endeavour to ensure that a number of emergency-management considerations are in place at the start of each telehealth session, as set out in the *ATA Practice Guidelines for Video-Based Online Mental Health Services* (2013) (the "*Practice Guidelines*") on pages 12 to 14.

The WorkSafeBC Health Care Provider must acquire information regarding the emergency-management resources available in the vicinity of where the injured worker is attending the Telehealth Services session. Such information may include noting local emergency-personnel access (i.e., 911 access) and/or whether the injured worker is at a facility with access to professional care staff who may provide in-person assistance, or whether the injured worker has access to their own personal support system. Information should also be acquired regarding mobility and transportation services/access available in case of emergencies. The WorkSafeBC Health Care Provider will have to ascertain how to notify the aforementioned emergency personnel or professional staff and/or a combination of such assistive services prior to the start of the session. Additionally, the WorkSafeBC Health Care Provider should have emergency-management information in place should either or both the injured worker and/or their support system be uncooperative or unable to help in an emergency situation.

Please note: A medical certificate for involuntary admission (Form 4) can be completed by a physician or nurse practitioner on the basis of a Telehealth Services assessment. In these circumstances, it is important for the physician or other nurse practitioner to provide as much collateral information as they have to supplement their assessment.

Initiating Telehealth Services

Informed consent

At the start of each session, the WorkSafeBC Health Care Provider must obtain the injured worker's fully informed consent to the Telehealth Services. The ATA *Practice Guidelines* state the following regarding informed consent:

> The consent must include all information contained in the consent process for in-person care, including discussion of the structure and timing of services, record keeping, scheduling, privacy, potential risks, confidentiality, and mandatory reporting … In addition, the informed consent process must include information specific to the nature of video calling … in language that can be easily understood by the patient. This is particularly important when discussing technical issues like encryption or the potential for technical failure. (*Practice Guidelines*, page 11)

There are a number of elements the WorkSafeBC Health Care Provider must consider with regards to the consent process. These include being knowledgeable of confidentiality issues and the usual applicable

professional ethical conduct regarding electronic communications, issues related to documentation, and having plans in place for managing in-session emergencies or other types of session disruptions (injured worker distress, contacting/coordinating injured worker local support, technical issues, etc.). The WorkSafeBC Health Care Provider shall also have an established protocol in place regarding injured worker contact between telehealth sessions and have clearly outlined the conditions under which their provision of Telehealth Services may be terminated. (For further guidance, please refer to the ATA *Practice Guidelines*, page 11.)

Physical environment requirements

The APA/ATA *Best Practices* state:

> During a telehealth session, both locations shall be considered a patient examination room regardless of a room's intended use. Providers shall ensure privacy so clinical discussion cannot be overheard by others outside of the room where the service is provided. To the extent possible, the patient and provider cameras should be placed at the same elevation as the eyes with the face clearly visible to the other person. The features of the physical environment for both shall be adjusted so the physical space, to the degree possible, maximizes lighting, comfort, and ambiance. (*Best Practices*, page 6)

Session disruption

The WorkSafeBC Health Care Provider must have a backup plan in place should Telehealth Services sessions be disrupted due to technology failures and/or issues and routinely review that backup plan. The backup plan must be communicated to the injured worker before the start of the Telehealth Services session. If any technical issues arising during a Telehealth Services session cannot be resolved, the WorkSafeBC Health Care Provider may complete the session using a voice-based telecommunication system, or the WorkSafeBC Health Care Provider may choose to reschedule an in-person appointment if they determine that is more clinically appropriate.

Administrative guidelines

Documentation and record keeping

WorkSafeBC Health Care Providers must submit reports to WorkSafeBC for Telehealth Services following the same requirements for in-person services as set out in the Agreement, including timelines.

Telehealth Services sessions should be accurately documented as Telehealth Services and include dates, duration, and a description of service provided, in keeping with the existing documentation requirements of each specific program.

Billing

Use the billing fee codes for telehealth treatment found in the fee schedule (Schedule B) of the Agreement for the Telehealth Services being delivered to injured workers via a telehealth platform.

Technical information

WorkSafeBC Health Care Providers may deliver Telehealth Services to injured workers under the Agreement using a technology platform of the WorkSafeBC Health Care Provider's choice, which includes video calling and file sharing with the injured worker, provided that all obligations with respect to privacy and confidentiality set out in these Guidelines and the Agreement are complied with.

Please note: Secure messaging should not be utilized due to requirements under FIPPA.

Computer and mobile device requirements

WorkSafeBC Health Care Providers are responsible for ensuring that the personal computer and/or mobile device used for the Telehealth Services meets the telehealth platform's operating requirements as identified by the telehealth services platform provider.

Technical support

Please refer to your agreement with your telehealth provider for more information.

References

American Psychiatric Association and American Telemedicine Association (2018). *Best Practices in Videoconferencing-Based Telemental Health.* Retrieved from: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwiHnMCS8ZncAhUKFXwKHaOpBhAQFgg6MAA&url=https%3A%2F%2Fwww.psychiatry.org%2FFile%2520Library%2FPsychiatrists%2FPractice%2FTelepsychiatry%2FAPA-ATA-Best-Practices-in-Videoconferencing-Based-Telemental-Health.pdf&usg=AOvVaw0jNTBhvxF3B8lM7ZPiadxt

American Telemedicine Association (2013). *Practice Guidelines for Video-Based Online Mental Health Services.* Retrieved from: https://cdn2.hubspot.net/hubfs/5096139/Revised-Video-Based-Online-TMH-Guidelines.pdf

College of Physicians and Surgeons of British Columbia (2021). *Practice Standard — Virtual Care.* Retrieved from: https://www.cpsbc.ca/files/pdf/PSG-Telemedicine.pdf

Doctors of BC (2014). *Policy Statement — Telemedicine in Primary Care.* Retrieved from: https://www.doctorsofbc.ca/policy-statements/telemedicine-primary-care
(Please click on the full policy statement in this link.)

Appendix J: Summary of related health care programs

1. **Addiction Services:**
   - **Community Pain and Addiction Services (CPAS)** is an outpatient assessment program for injured workers with substance use disorder, concurrent disorders (pain and addiction), or complex medication regimens, as well as injured workers demonstrating aberrant behaviour. Physicians are certified by the American or Canadian Society of Addiction Medicine (ASAM/CSAM) or possess an American Board of Addiction Medicine (ABAM) addiction medicine fellowship or equivalent. Outpatient treatment may include medication management (e.g., opioid agonist therapy).
   - The **Intensive Outpatient Program** involves eight weeks of treatment, including psycho-educational group meetings, interpersonal process group meetings, individual counselling, and random drug and alcohol screening. It also includes up to 44 weeks of after-care (one group therapy session per week) and a family program. One-on-one supportive counselling may be offered in adjunct.
   - **Residential Addiction Services (RAS)** are medically supervised abstinence-based multidisciplinary inpatient programs that use a bio-psychosocial model to treat injured workers with alcohol and drug addictions. These programs provide medical and psychological treatment for drug effects, teach behavioural skills that promote lasting change, and provide long-term support to help clients live a drug-free lifestyle. Programs consist of peer and self-assessments, group and individual therapy, lectures, and conferences with family and referral sources.
   - **Support Recovery Services** provide a safe, supportive, and stable residential environment for injured workers in early remission to facilitate recovery and promote life skills. The structured and monitored environment fosters accountability to facilitate the transition to independent living in the community and long-term recovery. Services may include group therapy, lectures, individual counselling, structured activities, recreational programs, nutrition counselling, random drug screens, and conferences with family and referral sources. Programs provide 24-hour staffing by a house manager or addiction counsellor.

2. The **Amputee Multidisciplinary Program (AMP)** provides treatment for injured workers with major amputations to maximize function and return the injured worker to productive employment. The team includes the Visiting Specialist Clinic (VSC) or a community physiatrist, a physical therapist, an occupational therapist, and a psychologist. The team works closely with a community prosthetist to help the injured worker get an appropriate prosthesis.

3. **Activity-Related Soft Tissue Disorder (ASTD) Services** are designed for people who have an injury related to overuse of certain muscles, tendons, and/or ligaments at work. The services consist of an ASTD medical assessment and a multidisciplinary treatment program that's up to 12 weeks, with a focus on return to work.

4. **Chronic Wound-Care Services** provide early intervention and treatment for injured workers who have chronic wound-care issues. The goal is to enable return to work when appropriate and to provide long-term services to injured workers with permanent disabilities. The team includes an occupational therapist or physical therapist and an RN with wound-care specialization. Ongoing involvement by the attending physician, physical therapist, and a dietitian, as well as psychological counselling and education, are possible.

5. A **Cognitive Functional Capacity Evaluation (FCE)** determines an injured worker's overall cognitive and physical baseline abilities, considerations, and tolerances using standardized testing protocols and work simulation activities to determine the worker's employability in a specific job or general job category.

6. **Community Care Facility (CCF) Services** is a contracted network of CCF providers within B.C. that accommodates each worker's unique care needs. CCF Services are designed to assist workers with compensable injuries and/or illnesses:
   - To recover from surgery
   - By providing respite or palliative care
   - With long-term placements

   CCF Services support the injured worker with self-care and independence in activities of daily living.

7. **Driver Assessment and Rehabilitation Services (DARS)** aim to identify and address the functional factors that impact driving safely and independently (i.e., cognitive, physical, and/or psychological symptoms). Services include a comprehensive evaluation conducted by an occupational therapist or certified driving rehabilitation specialist and may involve a licensed driving instructor. Recommendations from the assessment may include on-road driver's rehabilitation, and/or training in use of adaptive driving equipment.

8. **Early Concussion Assessment and Treatment (ECAT)** provides early assessment, education, reassurance, and intervention (when indicated) for injured workers with confirmed or suspected concussions. The program supports recovery of function and aims to facilitate an early and durable return to work.

9. **Expedited Surgical Facilities Services (ESFS)** provide fully equipped surgical facility services (including, but not limited to, nursing and support staff, medications, supplies, equipment, and facilities) to any surgeon to perform expedited elective day-care surgical procedure(s) on injured workers.

10. A **Functional Capacity Evaluation (FCE)** determines an injured worker's overall physical abilities, considerations, and tolerances to determine whether they're employable in a specific job or general job category.

11. The **Hand Therapy Program** provides treatment and consultation for injured workers with acute traumatic or repetitive injuries of the arm below the shoulder. This includes injuries to the hands and wrists, such as open wounds, crush injuries, tendon repairs, and burns. Treatment is provided by certified hand therapists with specialized skills in assessing and treating these conditions.

12. The **Home Access and Modifications Program** allows WorkSafeBC to undertake modifications to a residence or workplace to lessen or remove factors impacting severely injured workers following a compensable injury. A WorkSafeBC officer will determine the modifications necessary based on the compensable injury and on recommendations from an occupational therapist assessment as required.

13. **Home Care Services** involve a contracted network of home care providers: community agencies that provide home support and nursing services to injured workers. Service is provided

in the injured worker's home and/or community setting and focuses on assisting with activities of daily living, personal care, and professional nursing services (e.g., wound care).

14. **Home IV Supply Services** are provided to injured workers at home by nurses from either our contracted home care network or the local health authority. Supplies, equipment, and medications for Home IV Supply Services are provided by Calea Pharmacy.

15. The **Medical and Return-to-Work Planning (MARP) Assessment Service** provides diagnostic clarification and helps establish appropriate treatment and return-to-work recommendations for the injured worker. The MARP Assessment consists of a psychosocial screen, subsequent visits, and a reassessment that factors in the injured worker's history and a physical examination.

16. **Medical Alarm Monitoring Services** provide a personal emergency-response system with two-way voice that gives injured workers help at the press of a button. This makes independent living possible for many injured workers.

17. **Mental Health Programs**:
    - **Psychology Assessments** are provided by a contracted network of qualified registered psychologists across the province. They provide psychological and neuropsychological assessment services as needed to injured workers who have mental health issues associated with a physical injury or related to workplace trauma.
    - **Mental Health Treatment** is provided by a contracted network of registered psychologists, registered clinical counsellors, and registered clinical social workers. Services include:
        - **Resiliency Support Service**, a short-term support that helps injured workers develop active coping strategies and/or access community supports and services so that they may either remain at or return to work. No DSM-5 diagnosis is required for this service.
        - **Recovery and Return-to-Work Standard Treatment**, which is targeted individual psychotherapy provided to injured workers with one or more accepted psychological conditions. Standard treatment aims to assist the injured worker to remain at or return to work and to promote a return to pre-injury psychological functioning.
        - **Transition Support Service (TSS)**, which helps injured workers maintain and apply strategies previously learned in standard treatment while participating in return-to-work activities. It's expected that the worker's compensable condition has stabilized or plateaued, but the worker needs continued clinical support to be successful in these activities.
        - **Supplemental Service**, a service available to injured workers with accepted psychological conditions who continue to experience severe psychological impairment after a plateau in recovery. Supplemental Service aims to reinforce the skills the injured worker needs to maintain their maximal level of psychological functioning and to promote independent functioning by establishing links to community supports for long-term support.
        - **Occupational Trauma Response (OTR) Intervention**, a short-term intervention designed to reduce the psychological and functional impact of trauma and to prevent the development or worsening of mental disorders and/or functional impairment. Providers assist injured workers by helping to normalize the trauma reaction, strengthen natural resiliencies, build supports, and provide the skills to manage triggers. Trauma-focused cognitive behavioural therapy (TF-CBT) is an important

component. Identified treatment targets are the foundation upon which any later interventions are built.

- **Trauma Recovery Services**, individual treatment services tailored to the injured worker using trauma-focused therapeutic interventions. Trauma Recovery Services are designed to help normalize the trauma reaction, strengthen natural resiliencies, build support, and provide the skills to prevent mental health issues from worsening. These services help the worker remain at or return to work, where possible.
- **Post-Traumatic Stress Disorder Interdisciplinary Programs**, comprehensive outpatient services for injured workers who have experienced psychological trauma and have developed a compensable trauma-related condition that interferes with their previous level of function and work. Different programs have different approaches (group-based vs. individualized) and service lengths, but generally run for approximately 8 to 12 weeks and have a return-to-work component.
- **Online CBT Education Program**, a tool to help injured workers mitigate stressors that may become disabling factors if not appropriately managed. The program helps injured workers recognize stressors and understand that in challenging situations, it is normal to experience worry, anxiety, and sadness — but these feelings do not need to become factors impacting resolution if managed appropriately. The program is designed to give injured workers a sense of control in improving their emotional and psychological response to stress. No psychological condition is required; any worker with an accepted claim can access this program.

18. **Mental Health and Addiction Programs**:
    - The **Concurrent Care Program** is an outpatient program for injured workers with co-occurring mental health, chronic pain, and substance use disorders. An interdisciplinary team (addiction physician, psychologist, physical therapist, and occupational therapist) addresses the worker's complex needs. The primary goal is to stabilize the worker's mental health and substance use disorder through a biopsychosocial treatment model. This model includes individual and group treatment sessions and may include cognitive behavioural therapy (CBT), dialectical behaviour therapy (DBT), mindfulness-based relapse prevention/stress reduction, family support, motivational enhancement therapy, and alternative therapies.
    - **Mental Health and Addictions Complex Transitional Care** is a step-down facility that provides a safe, monitored environment for workers with complex concurrent mental health, substance use, chronic pain, and medical conditions (e.g., brain injury) to support ongoing engagement in recovery or treatment. The facility includes 24-hour nursing staff and health care assistance. Residents access community physical, social, and recreational group activity programs; get random urine drug screens; and receive structured behaviour management and interventions. The facility supports safety and relapse-prevention planning and provides nutrition services.
    - **Residential Complex Mental Health and Addiction Services** are provided through a schedule 1 designated psychiatric facility under the Mental Health Act that provides observation, care, and treatment for patients experiencing mental health disorders. Referrals are based on symptom severity, level of functionality, chronicity and complexity, and significance of safety risk. Nine programs are available, including an assessment and stabilization unit, comprehensive psychiatric care, an integrated mood and anxiety program, and a program for traumatic stress recovery.
    - **Residential Mental Health and Addiction Services** are inpatient treatment services for workers with mental health disorders (e.g., mood disorder, anxiety disorder, or trauma-

related disorder) and/or substance-related disorder, with or without secondary diagnoses of chronic pain and personality disorders. The program is cohort-based, with each worker's treatment customized according to primary diagnosis. Treatment duration is six to nine weeks. The interdisciplinary team includes a psychiatrist, addiction psychiatrist, addiction physician, family physician, psychologist, social worker, and occupational therapist. Treatment may include medically supervised detox, cognitive processing therapy, CBT, DBT, mindfulness-based therapy, recreational therapy, art therapy, and horticultural therapy.

19. **Modified Vehicle Rental Services (MoVeRS)** allow WorkSafeBC to provide a worker who has significant injuries and impairments a wheelchair-accessible rental vehicle to improve community mobility, quality of life, and ease of access to medical services and appointments. A WorkSafeBC officer will determine the appropriateness of the rental based on the compensable injury, access to alternative modes of transportation, and the assessment and recommendations from an occupational therapist.

20. The **Occupational Rehabilitation 1 (OR1) Program** is a structured, active rehabilitation program offered by physical therapists supported by kinesiologists. OR1 is designed to assist injured workers with soft-tissue injuries, resolved surgery, or healed fractures to achieve a safe and durable return to work. Treatment may be provided at a rehabilitation clinic and/or the jobsite.

21. The **Occupational Rehabilitation 2 (OR2) Program** is a structured, active rehabilitation program focused on supported return to work through physical and functional conditioning and education. It is a multidisciplinary program offered by physical therapists, occupational therapists, psychologists, kinesiologists, and physicians. Treatment may be provided at a rehabilitation clinic and/or the jobsite.

22. **Occupational Therapy (OT) Services** help injured workers remain safe and gain, maintain, and/or improve skills in self-care and productivity, with the goal of return to work. The occupational therapist may provide services in the home and/or a community setting and assists the injured worker with adaptive skills required to return to a productive life. The three treatment streams are related to the primary compensable diagnoses and factor(s) impacting recovery:
    - OT — Physical Injury (OT-PI)
    - OT — Mental Health (OT-MH)
    - OT — Brain Injury (OT-BI)

23. The **Pain and Medication Management Program (PMMP)** is an outpatient multidisciplinary treatment program offered by physical therapists, occupational therapists, psychologists, physicians, and pharmacists for injured workers with complex pain issues, including complex regional pain syndrome. The PMMP can provide medication management for patients with chronic pain who may need modification to a medication regimen. If addiction becomes a co-occurring disorder, the injured worker should be referred to Addiction Services.

24. The **Post-Concussion Management Program (PCMP)** is an outpatient program designed for injured workers with ongoing post-concussion symptoms. The interdisciplinary treatment team includes physicians, neuropsychologists, psychologists, physical therapists, and occupational therapists working with the injured worker to achieve a comprehensive understanding of the factors that contribute to their current symptoms. The principles of treatment are self-

management and reduced reliance on passive methods of symptom management, such as medication and rest. Treatment may be provided at a clinic and/or the jobsite.

25. **Prosthetics** can be provided to injured workers by providers certified by the Canadian Board for Certification of Prosthetists & Orthotists.

26. **Return-to-Work Support Services (RTWSS)** are designed for the injured worker who does not require a structured treatment program but would benefit from a supported return to work. RTWSS may be performed by a physical therapist, an occupational therapist, or a kinesiologist experienced in return-to-work services and jobsite visits. RTWSS aim to return injured workers to their pre-injury duties at the workplace.

27. **Vehicle Modifications** to an existing vehicle, or a modified vehicle that is new to the injured worker, may be provided by WorkSafeBC to reduce or remove factors impacting severely injured workers following a compensable injury. A WorkSafeBC officer will determine the required modifications based on the compensable injury and on an occupational therapist's assessment and recommendations.

For more information on the programs and services offered by Health Care Programs, see our provider types and our rehabilitation programs & services on worksafebc.com.