Saskatchewan Workers' Compensation Board

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Chiropractor practice standards for WCB service providers

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Intent

This document sets out the accreditation standards, and service provider guidelines for chiropractors providing services to WCB customers.

Introduction

The Chiropractors' Association of Saskatchewan (CAS) and the Workers' Compensation Board (WCB) developed and agreed to this document. The CAS or WCB can dissolve this agreement with appropriate notice.

Professional affiliation and WCB accreditation requirements

All chiropractors providing services to WCB customers will be members in good standing of the CAS. Chiropractors will comply with:

- Chiropractor practice standards for WCB service providers which may be amended with input of the CAS during the term of this agreement.
- Primary chiropractic and physical therapy soft tissue treatment guidelines.
- Service fees and fee codes for Saskatchewan Workers' Compensation Board primary chiropractic service providers.
- The ethical requirements of the CAS.
- *The Workers' Compensation Act, 2013*.
- *The Chiropractic Act, 1994*, and
- CAS bylaws.

All members of the CAS are accredited by the WCB and will get a billing number from the Ministry of Health.

By providing care to WCB customers, chiropractors intuitively indicate their:

- Understanding of this agreement,
- Willingness to comply with this agreement, and
- Intent to maintain WCB accreditation.

The WCB will revoke a chiropractor's accreditation and delete their billing number if the chiropractor:

- Does not want to provide services to WCB customers (these chiropractors should tell the WCB immediately).
- Does not comply with chiropractor practice standards for WCB service providers and/or the primary chiropractic and physical therapy soft tissue treatment guidelines.

If the WCB revokes a chiropractor's accreditation, the WCB will give the chiropractor and the CAS notice within 30 days.

CAS members that are not accredited by the WCB (by choice or WCB decision) will redirect WCB customers to accredited providers.

If a chiropractor is non-compliant with these standards and guidelines, or is providing care that is not helpful in returning a WCB customer to work, medical and health-care services may:

- Make the chiropractor aware of the issues.
- Identify how those issues will be resolved and measured, and
- Set a timeline for a resolution.

Chiropractors not willing to address issues identified by the chiropractic consultant may have their WCB accreditation discontinued on a temporary or permanent basis.

To maintain independence and objectivity, chiropractors must not advocate on behalf of any worker or employer for other WCB benefits (for example, earnings loss, vocational rehabilitation).

Chiropractors that enter into agreements with employers for the treatment of workers for work-related injuries or have received employer-based referral or employer funded work assignment within the past year will ensure the worker's written consents to treatment acknowledges both that relationship and that the worker is aware he or she may choose another provider.

Chiropractors that contravene this agreement may be subject to disciplinary actions initiated by the:

- CAS, or
- WCB.

Disciplinary actions, related to abnormal billing or quality assurance reviews, and maintaining a CAS member's WCB accreditation will be at the discretion of the WCB.

If the CAS terminates or suspends a member's licence, or if a member's licence becomes conditional due to professional misconduct or incompetence, the CAS must tell the WCB within seven days.

Practice standards

Assessment guidelines

Chiropractic assessments of injured workers should include:

- Thorough reviews of case history.
- Reviews of past medical history specific to the area of injury.
- Physical examinations.

- Diagnoses.
- Appropriate investigations.
- Detailed management and treatment of the injury.
- Identification of risk factors for chronic disability.

Chiropractors will provide enough time to ensure work-related injuries are efficiently and effectively managed in accordance with the primary chiropractic and physical therapy soft tissue treatment guidelines.

Management guidelines

Visit service means all examinations and treatments provided for the injured worker during each calendar day. Unless specifically identified as an additional service with an additional payment in the fee schedule, the WCB will pay for one treatment visit per day.

a. Initial visit:

The following usually constitutes an initial visit:

- A detailed customer history including documenting past medical history to the area or region of injury.
- Physical examination.
- Ordering and recommending appropriate radiological and laboratory tests to confirm diagnosis.
- Diagnosis.
- Developing and implementing a management and treatment plan.
- Prognosis and timeline for treatment.
- Identifying potential risks for chronic disability.
- Complete record of the visit, including any reasons for deviation from this standard.

The WCB requires the use of functional outcome measures by:

- Including a field for functional outcome measure scores on WCB reporting forms, and
- Chiropractors are welcome to include other functional outcome measures in the comments section of the report, however the WCB requires that an outcome measure relative to the area(s) of injury shall be completed from the options provided by the WCB.

b. Subsequent visit:

A chiropractic visit will include necessary injury management and advice to facilitate a timely recovery and return to work. Management, advice and treatments/interventions will promote the normal progression of the stages of soft tissue healing. This may include:

- Advising the injured worker on early activity and an active lifestyle,

- Home and work injury management advice,
- Home rehabilitative exercises and activities and
- A progressive transitional return to work plan during the recovery period.

Four weeks post injury: the chiropractor may add clinic supervised:

- conditioning

If transitional return to work is not expected to help the worker progress to full work duties regional conditioning may be considered as an intervention. Other interventions after the initial four weeks (for example, supervised conditioning) code 410 can be billed appropriately as deemed necessary. Education shall be provided to all injured workers as part of their initial or subsequent visits.

The WCB will only fund one subsequent visit per day.

If the worker sustained a soft tissue injury, the chiropractor will adhere to the primary chiropractic and physical therapy soft tissue treatment guidelines.

Adjunctive physical procedures include the following and are included in the office visit fee:

- Therapeutic ultrasound.
- Muscle stimulation.
- Interferential current therapy.
- Short wave diathermy.
- Transcutaneous electrical nerve stimulation (TENS).
- Microelectrical neuromuscular stimulation (MENS).
- Exercise and nutritional advice.
- Support procedures (for example, orthotics).
- First aid advice and emergency procedures.
- Consultation and indicated referral, and
- Complete record of visit.
- Acupuncture, where the Chiropractor meets the minimum requirements of the CAS to administer this procedure.
- Low level laser.
- Low energy extra corporeal therapy.

Modalities will not be billed independent of other therapeutic interventions and will be suitable to the stage of tissue healing specific to the worker. The WCB supports a functional model of care and chiropractic management of the worker should incorporate an active approach to treatment. A single modality treatment for injured workers will not be funded. A treatment may be a separate

entity or may be included in the consultative process. When a treatment is a separate entity, as in a subsequent visit, it must also include a:

- Review of subjective symptoms.
- Re-evaluation of objective signs and
- Recording of the customer's assessment and progress.

c. Identifying the need for re-assessment:

Chiropractors will reassess:

- New conditions after four to six weeks of treatment and
- Chronic conditions after six to eight weeks of concentrated treatment.

The WCB may revise the assessment/treatment and reporting forms protocol during the term of this contract. If this happens, the WCB will notify the CAS.

Chiropractors will ask for a WCB multidisciplinary assessment team review if recovery becomes prolonged.

WCB complex case

In general terms, a complex case is one in which the injuries will require more intensive and frequent management by the practitioner and will require more monitoring by the administrative staff at WCB.

A complex case would be considered if an injured worker has multiple areas of substantive injury and each area is requiring significant time for management. Multiple areas are defined as more than two regions that may comprise the back (including the neck) and two or more of the upper extremity and/or the lower extremity also meeting the definition of type II or type III[1].

Given that there are multiple areas of injury, when providing the CHI and CHP reports, there should be a corresponding functional measure using the appropriate measure required by the WCB for that region for each area of injury.

The treating practitioner will provide sufficient physical examination and injury description in the initial assessment report as to why the case should be so defined and how the case meets the criteria for a complex case.

The additional management time for a complex case would be equal to a normal subsequent visit. Billing for this additional time will be funded at the subsequent visit rate but using fee code 429.

Definition of a complex case[1]

Auto injuries can be classified as type I, type II and type III, which can be used in the definition of a complex case.

Type I injuries have a favorable natural history. These injuries improve in a short period of time with no significant injury and an expectation of recovery in a few days to a few months. There is typically no significant loss of anatomical alignment, or structural integrity. Typically, the impact of treatment interventions is modest (short term) and is usually limited to a reduction in symptom intensity and an increase in function.

There is no evidence that higher dose intensity, more frequent or longer provision of treatment/interventions, or multiple providers will improve function.

Type II injuries involve a substantial loss of anatomical alignment, structural integrity, psychological, cognitive and/or physiological functioning. The majority of patients with such injuries will require (in addition to natural healing) a significant amount of medical, surgical, rehabilitation, and/or psychiatric/psychological intervention to ensure an optimal recovery.

Type III injuries are a subset of Type II injuries, and fall into the framework of catastrophic impairments, with injuries such as amputation, spinal cord injuries and severe brain injuries.

[1] Adopted from the Ontario Protocol for Traffic Injury Management (OPTIMa) Collaboration (Côté P, Shearer H, Ameis A, Carroll L, Mior S, Nordin M, and the Ontario Protocol for Traffic Injury Management Collaboration. *Enabling Recovery from Common Traffic Injuries: A Focus on the Injured Person*. Toronto, Ontario: UOIT-CMCC Centre for Disability Prevention and Rehabilitation, 2015).

Criteria for defining a claim being a complex case

- Severity of injury equivalent to the definition of type II and type III injuries.
- Worker is off work.
- Multiple areas of substantive injury and each area is requiring significant time for management. Multiple areas are defined as two or more regions that may comprise the back (including the neck) and/or one or more of the upper extremities and/or the lower extremity. Treating practitioner provides sufficient physical examination and injury description as to why the case should be so defined and how the case meets the criteria for a complex case.

Treatment limits

- If the case is defined as complex, an additional treatment time per day using code 429 would be allowed with each of the initial and subsequent visits.
- The practitioner should identify in the initial assessment report sufficient physical examination and injury description as to why the case should be so defined and how the case meets the criteria for a complex case.
- If the worker is still off work after the first month of treatments, or at work in a reduced capacity still requiring a complex status of treatment, the file shall be referred to the

chiropractic/physical therapy consultant to determine if the frequency of treatment can continue for another four weeks, or the worker should be referred for a multidisciplinary assessment (MDA).

Approval process for complex case

- Treating practitioner shall provide sufficient physical examination and injury description as to why the case should be defined as complex.
- The chiropractic consultant will review those complex cases, either by direct referral from the case manager or auto routed by cost to determine if primary treatment frequency should remain, be reduced, or should go on to an MDA.

Facility

The chiropractic treatment facility must abide by the CAS clinical office space standards and have adequate space, facilities, and equipment to fulfill the needs required to manage WCB customers.

Continuing education

All chiropractors must obtain the recommended continuing education hours for licensure by the CAS. Chiropractors will also be encouraged to participate in continuing education programs sponsored by the CAS and the WCB.

Record keeping and reporting

In-clinic chart:

Each clinic will keep written records for each customer. Written and electronic records will include the:

- Date.
- Subjective symptoms.
- Objective findings, both positive and negative.
- Areas to be (or not to be) treated or manipulated.
- Recommendations for future care (management plan).
- Missed or cancelled appointments.
- Telephone calls.
- Copies of all letters, x-ray and diagnostic reports.

Where an injured worker requests a copy of the customer chart, the chiropractor will provide those reports and clinic notes which he or she generated. Reports from other care providers or the WCB are not provided and the injured worker is advised that these remaining reports should be requested from the source, i.e. the care provider and/or the WCB.

Duty to report work injury

Section 55 of *The Workers Compensation Act, 2013* states:

> Any health care professional who attends to or is consulted with respect to an injury to a worker shall:
>
> (a) Furnish the board with any reports respect to the examination or treatment of the worker that are relevant to the injury for which compensation is claimed.
>
> (b) Give all reasonable and necessary information, advice and assistance to the injured worker or the worker's dependants in making an application for compensation; and furnish any certificates and proofs that the board may require.

Chiropractors will report injuries by sending chiropractor's initial report (CHI) forms to the WCB. Chiropractors will tell WCB customers to report their injuries:

- By telephone (1-800-787-9288)
- Online at wcbsask.com, or
- By completing a workers' report of injury form (this form can be attached to the chiropractor's reports).

WCB reporting forms

a. Chiropractor's Initial Report (CHI) form:

Chiropractors will send CHI forms to the WCB within three business days of the initial assessment. The WCB will pay for the:

- Intake assessment,
- Initial report and

Subsequent treatment to the date of the WCB letter advising of non-coverage to a maximum of six treatments/interventions.

Until the WCB advises of non-coverage, other insurers and/or the worker will not be billed for any treatment or portion of treatment.

b. Chiropractor's Progress/Discharge Report (CHP) form:

Chiropractors will send the CHP forms to the WCB:

- After the first six treatments/interventions.
- Following each subsequent block of six subsequent treatments/interventions.

CHP forms will include:

- Present complaints related to the work injury where a worker has not received treatment from the provider for more than 30 days (the chiropractor should re-submit the above forms to confirm funding).
- Impact of pre-existing and non-compensable factors delaying recovery, including areas of treatment.
- Subjective and objective physical findings (especially positive neurological finding that confirms the chiropractor's diagnosis).
- Diagnostic reports and findings.
- Management program.
- Duration and timeline for further treatment.
- Transitional work.
- Factors that may delay recovery.
- Functional outcome scores.
- Suggestion regarding referral to assessment team (for example, secondary, tertiary) where appropriate and
- Comments.

In all cases, the chiropractor will provide full and accurate information regarding the customer's progress towards recovery and the impact of non-compensable factors.

The chiropractor must submit another CHP form if continued care is required after the first six treatments/interventions. The chiropractor can continue care, unless otherwise directed by the WCB. The WCB may refuse to fund the additional treatments if the subsequent CHP form is not sent to the WCB.

Chiropractors shall report online

When a WCB customer requests further treatment but has not attended treatment for more than 30 days, or has received secondary or tertiary treatment for the work injury for which treatment is sought the WCB will fund an initial assessment and initial assessment report. WCB will develop a specific Initial Assessment form for this recurrent treatment scenario. Chiropractors will then await approval for further treatment once this form has been submitted.

c. Discharge report (CHP) form:

Chiropractors will send discharge summaries within three business days of discharge.

The CAS will support electronic communication initiatives for reporting and invoicing.

Confidentiality requirements

All health-related and personal information received during treatment of a WCB customer will be treated in a confidential manner and no information will be revealed to any person or party other than those persons to whom reports are to be made or to such other persons as may, from time to time, be designated by the WCB. Information pertaining to functional ability may be provided to the employer for the purposes of establishing a return to work arrangement.

Fees for service

Section 103(1) of *The Workers' Compensation Act, 2013* states:

> Every worker who is entitled to compensation or who is disabled only on the day of the injury is entitled without charge to:
>
> (a) any medical aid that may be necessary as a result of the injury.
>
> (b) any other treatment by a health care professional.

Chiropractors will direct bill the WCB for services unless the WCB provides written notification that funding will not be provided.

Where a flat rate fee is indicated, the fee is intended to represent the average time required to treat a WCB customer. Where a prorated fee is indicated, the provider will bill using the major portion thereof method. (More than half of the minimum time stated in the code must have elapsed for the additional unit to be billed. For example., six minutes for a 10-minute intervention.)

Fee code 400 – initial visit

See above under management guidelines

Fee code 401 – subsequent visit

See above under management guidelines.

Fee code 429 – complex case – additional time

See above under complex case.

Fee code 402 – emergency visit

The emergency intervention service is one that is initiated by the injured worker and which occurs at any locale between 7:00 p.m. and 7:00 a.m. on the chiropractor's normal working day outside the normal working hours, or at any locale on weekends or statutory holidays outside the normal working hours. An emergency visit is considered when the injured worker's injury is acute and the practitioner has to assess or treat the worker out of normal working hours. The visit should be documented as an emergency in their clinic notes.

Fee code 403 – initial report with functional outcome information (CHI)

The CHI shall include physical examination findings, with appropriate functional outcome measure as identified in the Standards of Care Document. The report shall include one or more of the following: Roland Morris, Quick Dash (with QD Work Module if required) Neck Disability Index, Lower Extremity Function Sort. Other functional measure information is welcome, but the form shall contain one of the prescribed functional outcome measures. If functional outcome measure is unavailable, chiropractor to enter 0 in the field and must include in the report rationale for why this was not available to be reported on (such as learning visit was related to a WCB claim after the initial visit had already occurred.)

- Due within 3 business days of initial visit.

This report is also required if the worker is still covered by WCB following a treatment hiatus for management of a flare in symptoms accompanied by a diminution of function. In this case the *Recurrent Condition* box should be checked off.

Fee code 404 – Progress/Discharge Report with functional outcome information (CHP)

- Electronic report of progress (CHP) shall include appropriate functional outcome measure as identified in the standards of care document. The report should include one or more of the following: Roland Morris, quick dash (with QD work module if required) Neck disability index, lower extremity function sort. Other functional measure information is welcome, but the form shall contain one of the prescribed functional assessment perception instruments.
- The examination section should contain enough information to identify change in examination findings.
- Due within three business days of every sixth intervention
- Rarely a report is required, and the practitioner has not had the opportunity to have the injured worker complete the appropriate functional outcome measure. In this case the report may be provided with the most recent clinical information, the chiropractor to enter zero in the measurement field and the rationale for why the outcome measure was not available.

Fee code 412 – conferencing

Conferencing may be via telephone, video or in person. A conference code can be billed when there is formal interprofessional communication between health care providers involved in the management of the injured worker's care. Code 412 is based on a 10-minute session. It is expected that this code is used when there is a formal meeting, discussion between professions. "Water cooler" chats would not be considered appropriate meetings to bill this code.

It is expected in a normal file there would only be a maximum of four conference units used per claim.

Partners included in conferencing could include any of physician, nurse practitioner, physical therapist, kinesiologist, occupational therapist, massage therapist, mental health provider, WCB consultant or WCB case management staff. See fee code 407 for communication with a worker's employer regarding return to work planning.

Each conference session should be documented in the workers file including duration.

A conference session can be billed for the following but not limited to the following:

- Changes to the management plan.
- Concerns of safety.
- Clarification for timelines to recovery and discharge.
- RTW planning and responsibilities.
- Management responsibilities.
- Imaging requests and other diagnostics testing.
- Psychosocial concerns.
- Exercise and functional programming.
- Record of same in file.

Fee code 406 – research fee

This code is to be used if the WCB requests a written report from the practitioner describing patient history, prior history, treatment prior to the work injury or other historical chart review. The reasonable charge per 10-minute segments represents the amount of time used to review, collate, and interpret clinic notes and any other chart information as required.

Fee Code 407 – Return to Work Plan Development and Monitoring

The chiropractor may bill this code when he/she requires time to develop and document a return to work schedule for the injured worker. Time spent communicating with employers for return to work development is included in this code. The code reflects a 10-minute unit in which it takes to develop, document and arrange the return to work plan. For example, an return to work time of 40 minutes would reflect billing code 407 times four. There shall be a record in the file and a copy of the plan shall be forwarded to the WCB electronic file. If a workplace return to work form (not a WCB form), including functional abilities and time at work, is required and completed the 407 code may be used.

Fee code 424 – practitioner return to work form

Completion of the WCB's PRTW form with electronic submission to the WCB. The WCB requires the electronic submission in order to bill this code. This code is for the use of WCB's electronic submission PRTW form. WCB does not pay for any other form using this code.

Fee code 410 – Individual conditioning instruction

Individual conditioning management includes development of and provision or demonstration of a program to address injury specific strength and movement deficits relative to the work injury. This code is utilized to develop and teach an individualized regional/global program to be delivered in the clinic. Generally, programs are conducted at home in the early stages of tissue healing, and it is unlikely this code would be used in the first month post injury. The chiropractor must be present with the patient to bill for this fee code. Individual conditioning should be a one-on-one instruction in the office or gym and should be a minimum of 15 minutes. Conditioning is to be documented in chart notes including duration.

Fee code 415 – functional ability evaluation

A functional abilities evaluation (FAE) is an evaluation of the workers current physical and functional abilities using objective and measurable tests.

The FAE examination and testing takes into consideration the workers present abilities and how it can be applied to a transitional return to work with alternate duties specific to the work place, while functionally rehabilitating to the workers normal duties. Testing should only be up to the job demands. Record in patient file.

Fee code 31 – Appliances and supplies /orthotics

Payment for devices shall be the manufacturer's list price plus five per cent.

Fee code 427 – Response to the WCB request for PFI rating information

This is a flat fee including report provision which shall be on the patient file and in the WCB electronic file. The chiropractor will be provided with a form to complete. The form details specific information to be provided. The following information is required in order that the rating can be completed:

- Detailed physical examination including neurological exemption with specific note of upper and lower extremity nerve root reflex, sensation in dermatomal pattern. Stocking and glove sensation changes if present.
- Motor power should be rated out of 5 and detailed for upper and lower extremity nerve roots as appropriate with comparison for the opposite side.
- Measurement in cm/inches of variation in limb girth above and below elbow or knee as appropriate.
- Range of motion of the affected part or parts (i.e. if of the hand may require the ROM of each of the joints of the hand) in degrees, measured from neutral as outlined on the examination documents with comparative measurement of opposite side.

Fee code 425 – WCB RHCS4 form

Payment when RHCS4 form is completed and submitted to WCB.

Fee code 426 – WCB RHCS4 form: returned within five business days of WCB request date

Premium paid when RHCS4 form is submitted within five business days of the request.

Return to work

The main goal of the WCB is to return workers to appropriate work and health. The WCB believes and professional literature supports, that many workers benefit from an early return to work. A worker may be ready for some other form of work before they are ready for a return to work at the pre-injury job. This alternate work is referred to as “transitional work” and the return to these alternate duties is called “transitional return to work.” With recent legislation requiring the accommodation of workers with disabilities and injuries, the emphasis on transitional and alternate duties has accelerated. Many workplaces now have personnel who work specifically with workers needing to return to work in a gradual fashion. The WCB wishes to utilize these resources to support and encourage the recovery of workers.

Although several care providers may be treating the worker, the chiropractor will ensure that return to work planning occurs. If the chiropractor is not the primary care provider, the chiropractor may contact the primary care provider and arrange to manage the return to work process.

Chiropractors will advise the employer and the WCB of the worker’s current restrictions and abilities and the RTW plan, if any, within one or two treatments via the initial report and/or the practitioner return to work (PRTW) form

If the chiropractor is the primary care provider, the chiropractor must either manage the return to work process or delegate that responsibility to either a physical therapist or a physician who is co-treating the worker. To assist with the return to work process, chiropractors must provide comments on the worker’s functional ability in the initial and progress reports.

The chiropractor will notify the following of the worker’s ongoing restrictions and abilities until full return to work is achieved:

- worker
- employer and
- the WCB

If the worker is not making appropriate progress toward returning to work, the chiropractor or the WCB care manager will ask the WCB to arrange an assessment team review.

Information regarding this contact will be relayed to the WCB.