Workers Compensation Board of Manitoba

WCB Service Code Manual

Updated: July 28, 2025

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WCB Workers Compensation Board of Manitoba

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Workers Compensation Board of Manitoba

1. Contact information

The services provided for treating injured workers are valued and it is the goal of the Workers Compensation Board of Manitoba (WCB) to ensure that you are paid for those services as quickly and accurately as possible.

For your convenience, we have detailed the requirements for reporting and invoicing the WCB for your services.

You can **download** a brief booklet detailing the process and information required for billing the WCB for your services.

Please keep in mind that in some instances, treatment and services must be pre-approved before billing.

Pre-approval for treatment and services applies to physiotherapy, chiropractic treatments, pain management injections, surgery and optometry.

For telephone inquiries regarding invoices already submitted, call:

- Winnipeg: 204-954-4321
- Toll-Free within Canada and the United States: 1-855-954-4321

For inquiries concerning service codes and fees:

Supervisor of Medical Aid
Workers Compensation Board of Manitoba
Phone: 204-954-4507
Toll Free: 1-855-954-4321Fax: 204-954-4999
Email: **kroy@wcb.mb.ca**

2. Claims submissions and payment processing

Submitting invoices and billing forms to the WCB

All vendors and service providers need a WCB account to invoice the WCB. If you don't have one, complete the WCB **provider registration/change form** and submit it by email or fax (see form for details). If you practice out of multiple locations, you'll need a separate WCB account for each one.

The **provider registration/change form** can be found on the WCB website under *Resources and forms*.

To ensure your payment is processed quickly, your invoices or the WCB billing form **must include the following**:

1) Invoice date
2) Service provider/clinic information (WCB account number, account name, physical address and phone and fax number)
3) Patient information (claim number, date of birth, name, PHIN, personal mailing address, telephone number, date of incident and area of injury)
4) Date of service (initial and subsequent visits)
5) WCB tariff/service code and description of service
6) Quantity (unit of treatment)
7) Dollar amount of tariff/service code
8) Treating healthcare provider's name (first name and last name)
9) Treating healthcare provider's registration number

If any of the information listed above is missing from your invoice or WCB billing form, additional follow-up may be required. This may delay payment for the services provided.

Processing and payment

The WCB processes payments in the order they are received. Payments and remittance statements are issued on or about the 15th and 30th of the month and mailed out the next business day.

If you receive your payment by direct deposit, a detailed remittance statement will be mailed when your deposit has been processed.

The WCB makes every effort to pay invoices within 45 business days from when the invoices were received at the WCB office. If you have not received payment for an invoice that you've submitted, please wait at least 45 days from the date you submitted the invoice to the WCB before resending the invoice.

If you resend an invoice, please write "re-submission" on the invoice.

Payment dates

Goods and services payments are processed on the 15th and second last business day of the month. If the 15th falls on a weekend or statutory holiday, the payment is processed on the business day before the 15th.

Payments issued by direct deposit are generally deposited into the designated bank account two business days after the payment is processed, except at the end of December, where the funds are deposited on the third business day after the payment is processed.

Payment Processing Date	Direct Deposit Date	Cheque and Remittance Mail Date
January 15, 2025	January 17, 2025	January 16, 2025
January 30, 2025	February 3, 2025	January 31, 2025
February 14, 2025	February 18, 2025	February 18, 2025
February 27, 2025	March 3, 2025	February 28, 2025
March 14, 2025	March 18, 2025	March 17, 2025
March 28, 2025	April 1, 2025	March 31, 2025
April 15, 2025	April 17, 2025	April 16, 2025
April 29, 2025	May 1, 2025	April 30, 2025

Payment Processing Date	Direct Deposit Date	Cheque and Remittance Mail Date
May 15, 2025	May 20, 2025	May 16, 2025
May 29, 2025	June 2, 2025	May 30, 2025
June 13, 2025	June 17, 2025	June 16, 2025
June 27, 2025	July 2, 2025	June 30, 2025
July 15, 2025	July 17, 2025	July 16, 2025
July 30, 2025	August 1, 2025	July 31, 2025
August 15, 2025	August 19, 2025	August 18, 2025
August 28, 2025	September 2, 2025	August 29, 2025
September 15, 2025	September 17, 2025	September 16, 2025
September 26, 2025	October 1, 2025	September 29, 2025
October 15, 2025	October 17, 2025	October 16, 2025
October 30, 2025	November 3, 2025	October 31, 2025
November 14, 2025	November 18, 2025	November 17, 2025
November 27, 2025	December 1, 2025	November 28, 2025
December 15, 2025	December 17, 2025	December 16, 2025
December 29, 2025	January 2, 2026	December 30, 2025

No-shows and cancelled appointments

The WCB is not responsible for the failure of an injured worker to adhere to a cancellation policy or any associated costs related to, but not limited to, fees associated with no-shows, missed appointments, or late charges for an injured worker to attend for the services.

Submitting invoices beyond 12 months

In accordance with subsection 27(7) of *The Workers Compensation Act*, an invoice for medical aid or medical report(s) must be submitted within 12 months from when the goods or services were provided to the worker or the medical report was provided to the WCB. Any invoices submitted after the 12-month period are not eligible for payment.

Submitting claims to Manitoba Health after costs have been paid

If you provided services to an injured worker whose claim status is later changed or modified, the WCB may attempt to recover some or all of the payments made and instruct you to recover the costs from Manitoba Health or another non-WCB payer. Service providers referring these costs back to Manitoba Health can find information for submitting beyond the six-month claim submissions deadline on the **Manitoba Health website**.

Out-of-province service providers

In order to ensure out-of-province workers are not disadvantaged and continue to receive the level of care they require, the WCB will pay fees that are reasonable, most often at the rate paid by the workers compensation board in the province in which the services were provided.

Out-of-country service provider

Fees may be negotiated and settled on a case-by-case basis at an amount different than was originally billed.

3. Manitoba Health tariff codes

Fees for medical aid are set under the WCB's legislative authority. Each service provided to an injured worker and billed to the WCB has an associated tariff or service code. Certain codes and fees mirror those set out by Manitoba Health, while others are specific to the WCB.

The WCB utilizes the Manitoba Health tariff codes for services that would have been covered by Manitoba Health had it not been for the injury. Please see the **Manitoba Health Physicians Manual** for a list of tariff codes and applicable rates.

For all other cases, service codes are assigned and rates are set by the WCB. See section four of this manual.

Athletic Therapy

Service code	Description	Fee schedule (1 January 2025)	Fee schedule (1 January 2024)	Notes
0180	Initial visit	$77.08	$76.01	AT.1
0213	Initial visit, Northern Manitoba	$78.33	$77.25	AT.1, AT.2
0181	Follow up visit	$55.99	$55.21	AT.3, AT.4
0214	Follow up visit, Northern Manitoba	$57.24	$56.45	AT.2, AT.3, AT.4
0165	Acupuncture tray fee	$19.26	$18.99	AT.5
0182	Multi-site visit	$47.93	$47.26	AT.6
0204	Initial report fee	$47.19	$46.54	AT.1, AT.7
0205	Progress/discharge report fee	$47.19	$46.54	AT.8
0218	Narrative report fee	$150.48	$148.40	AT.9
8116	Request for additional treatment	$47.19	$46.54	AT.10
0052	Photocopy charge (up to first five pages)	$18.21	$17.95	AT.11
0053	Photocopy charge (over five pages)	$3.64	$3.59	AT.12
N/A	Sundry items	As billed	As billed	AT.13
0075	Telephone consultation with WCB	$219.26	$216.24	AT.14

Notes

AT.1 A "guaranteed" expense that will be paid regardless of if the claim is unadjudicated, accepted or disallowed.

AT.2 Any athletic therapy clinic north of Swan River receives a location allowance based on the service codes for the northern clinics.

AT.3 Eighteen treatments before extension are required.

AT.4 Follow up visits will not be paid for by the WCB on disallowed claims.

AT.5 Acupuncture tray fee (service code 0165) with the initial athletic treatment (service code 0180) or the follow-up visit (service code 0181) can be billed on the same day.

AT.6 Multi-site visit requires pre-approval.

AT.7 Billable if a completed initial report (WCB form) is submitted.

AT.8 Progress or subsequent reports are not required for every follow-up/subsequent visit. Progress reports should be submitted upon the request of the WCB or when there is a notable change in the worker's recovery.

Billable if a completed progress report (WCB form) is submitted.

AT.9 Fee per page. The first page will be paid as a full page; all subsequent pages will be pro-rated based on the length of the letter and paid at the rate of a half page or full page.

A typed or written detailed letter from an Athletic Therapist addressed to the WCB in response to a request for a narrative report from the WCB. Left and right margins should be no greater than one inch. The header should be no greater than three inches, and the text should be no greater than 12-point font, single-spaced.

AT.10 Not to be combined with progress/discharge report fee.

AT.11 Administrative fee to print/photocopy test results, chart notes, diagnostic imaging, etc. upon the request of the WCB.

AT.12 Fee per each additional page over five pages.

AT.13 Sundry items (i.e., Medical Supplies). Item description is required for billing. GST exempt.

Once therapy has been approved, the clinic may invoice and receive payment from the WCB without approval for a one time supply of:

- Ice packs Max of $35
- Crutches Max of $45
- Slings Max of $35
- Taping supplies Max of $20
- Tubing Max of $15
- TheraBand Max of $30
- Hand Putty Max of $20

If the above items are required more than one time in an accepted claim, those items are subject to approval by the WCB.

If the sundry items supplied is not listed above, it is subject to approval by the WCB.

AT.14 The fee listed is an hourly rate and is paid in five-minute increments. Billable for telephone communications with the WCB regarding a WCB claim. The communication must be initiated by the WCB or, with prior approval of the WCB, initiated by the billing athletic therapist. Communications may include returning missed calls. Billable for each full five-minute period and each additional five-minute period or major portion thereof. A major portion thereof equals more than half of the five minutes or more than two and a half minutes.

Additional information

Athletic therapists in the northern region are entitled to a northern allowance.

One initial assessment and 18 follow up treatments are initially approved. Pre-approval is required beyond the 18 treatments.

Audiological Goods and Services*

Service code	Description	Fee schedule (1 May 2025)	Fee schedule (1 May 2024)	Notes
0134	Full audiological assessment	$145.09	$143.51	**AU.1**
0055	Partial audiological assessment	$72.58	$71.79	**AU.2**
0133	Batteries	$1.69	$1.67	**AU.3**
0054	Cleaning fee	$22.36	$22.12	**AU.4**
0143	Ear molds	$112.67	$111.44	**AU.5**
0135	Fitting/dispensing fee	$601.44	$594.90	**AU.6**
0131	Hearing aids**	As billed	As billed	**AU.7**
0141	Miscellaneous	As billed	As billed	**AU.8**
0140	Repair fee	$153.48	$151.81	**AU.9**
0142	Service fee	$44.71	$44.22	**AU.10**

* Please see the **Audiological Goods & Services Guidelines for Service Providers**

** Please see the **Hearing Aid Approved Product List**

Notes

AU.1 Billable for assessment conducted by a certified audiologist. Comprehensive evaluation includes:

- History of hearing problems
- Otoscopic evaluation
- Pure-tone air conduction testing and masking when indicated, to include the following frequencies: 250, 500, 1000, 2000, 3000, 4000, 6000 and 8000 Hz
- Pure-tone bone conduction testing to include the above-noted frequencies and masking when indicated (Please note that the WCB requires all frequencies, including 3000 Hz, for determining a worker's degree of permanent impairment)
- Speech audiometry, including speech reception threshold testing, determination of uncomfortable levels, most comfortable levels and determination of uncomfortable levels, most comfortable levels and speech discrimination testing level
- Assessment of the function of the middle ear system or impedance audiometry
- Depending on the results of the impedance testing, referral for additional testing may be required

AU.2 Billable for assessment conducted by a hearing instrument specialist.

AU.3 Maximum rate per cell, billable upon request by worker or WCB. The product shall have an appropriate shelf life based on anticipated use and volume of supply.

The type and quantity of cells provided shall be clearly outlined on the invoice.

Batteries: Size 13, 312 and 675, a max of 60 batteries per aid shall be funded per year.

Batteries: Size 10, a maximum of 100 batteries per aid shall be funded per year.

For rechargeable hearing aids, the cost of chargers and batteries per year shall not exceed the cost of the current yearly allotment of batteries.

AU.4 For cleaning of aids only. Must be a separate visit and cannot be combined with service fee or repair fee.

Limited to two visits per aid per year.

Cleaning fees only applicable one year from date of initial fitting/dispensing.

AU.5 The ear molds fee applies to ear molds provided beginning one year from the date of initial fitting/dispensing. Ear molds provided at time of initial fitting/dispensing (standard, custom, power) will be paid at the manufacturer cost, and in addition to the initial fitting/dispensing fee. Manufacture's invoice must be submitted with billing.

Fee includes impression and ear mold. This applies to BTE/RIC/RITE models. Maximum of one per ear every two years. Pre-approval is required.

AU.6 Billable for each hearing aid supplied. Service to include:

- Selection of appropriate hearing aid device
- Ear mold impression
- Programming of the hearing aid device
- Real Ear Measurements (REM) for fitting verification
- Verification of audibility, comfort, and tolerance
- Speech mapping, if available
- Quality control checks (electro-acoustic checks)
- Appropriate training and counselling regarding the usage of hearing aid devices, battery cells and accessories (includes care & maintenance)
- Counseling worker regarding the realistic expectations of benefits during and after an adjustment period
- Follow up with the worker within the hearing aid manufacturer's noted trial period (follow-up visit to include adjustments, counselling, repair, and re-programming if necessary)
- Provide all product manuals & warranty information and

- Any warranty work required.
- Cros/Bi-Cros device fittings may be invoiced at the same rate as a binaural fitting.

AU.7 The WCB will pay for the cost of a hearing aid device if the device is identified by an audiologist and is chosen from the WCB's hearing aid approved product list at the time of fitting. If a hearing aid device is required but has not been pre-approved, the request will be reviewed by the WCB on a case-by-case basis.

Service providers must obtain written authorization from the WCB for the replacement of hearing aid devices.

AU.8 Accessories require pre-approval from the WCB.

AU.9 Repair fees require pre-approval from the WCB. A copy of the manufacturer invoice with the repair description is required. Manufacturer's invoice must be included when billing for a repair fee.

The fee is billable once per transaction with the manufacturer (not per aid) and is not to be combined with the service fee or cleaning fee.

AU.10 Service to include minor in-house repairs, performance checks, reprogramming, adjustments, and cleaning. Fee includes all incidental parts and products required for regular maintenance of aids including domes, tubes etc.

Limit two visits per aid per year.

Service fees are billable one year from the initial fitting/dispensing.

Applicable if service is provided by an audiologist or hearing instrument specialist.

Not to be combined with repair fee or cleaning fee.

Miscellaneous includes:

- Domes/wax guards: a maximum of 12 of each per aid shall be funded per calendar year.
- Dry-Aid Kits, and other items not considered to be accessories will be considered for funding on a case-by-case basis.
- In-house receiver replacements must receive pre-approval and can be billed with a service fee.

Chiropractic

Service code	Description	Fee schedule (1 March 2025)	Fee schedule (1 January 2025)	Fee schedule (1 March 2024)	Notes
0222	Initial visit	$78.80	$76.88	$76.88	C.1, C.2
0220	Follow up visit	$52.53	$51.25	$51.25	C.1, C.3, C.4, C.5
3095	Multi-site visit	$39.30	$38.34	$38.34	C.1, C.4, C.5, C.6
0224	Acupuncture treatment	$56.18	$54.81	$54.81	C.5, C.7
0225	Acupuncture tray fee	$20.37	$19.88	$19.88	C.5, C.7
3019	Initial report fee	$56.73	$55.35	$55.35	C.2
0226	Active Release Technique (ART)	See note	See note	See note	C.6, C.8
0208	Progress/discharge (Regular) report fee	$56.73	$55.35	$55.35	C.9
3017	Narrative report fee	$158.22	$154.36	$154.36	C.10
3028	Chart note report	$15.79	$15.79	$15.57	C.11
0223	Emergency house call visit	$36.92	$36.02	$36.02	C.12
0019	Exercise tariff	$66.77	$65.14	$65.14	C.13
3056	Postage/courier	As billed	As billed	As billed	C.14
3040	Sundry items	As billed	As billed	As billed	C.15
0059	Telephone consultation with WCB	$284.76	$277.82	$277.82	C.16

Notes

C.1 Treatment is approved by weeks. Maximum frequency of treatment billable to the WCB:

- First week - daily treatment
- Two to fourteen weeks – three treatments per week

For services performed prior to September 1, 2025 the start of a billing week is based on the day of the initial assessment (e.g., the initial assessment occurred on Wednesday, a week is then Wednesday to Tuesday).

Effective Monday, September 1, 2025, each billing week begins on Monday and ends Sunday, regardless of when the initial assessment occurred.

C.2 A "guaranteed" expense that will be paid regardless of if the claim is unadjudicated, accepted or disallowed.

C.3 Initial treatment (service code 0222) and follow-up treatment (service code 0220) can be billed on the same day.

C.4 Multi-site treatment (service code 3095) is applicable where two or more distinct and separate areas of injury require dedicated treatment. Conjoined spinal areas will be considered one area.

In addition to the follow-up treatment fee (service code 0220), a multi-site treatment may be billed with pre-approval from the WCB.

Multi-site treatment (service code 3095) and follow-up treatment (service code 0220) must be billed on the same day.

C.5 A follow-up visit fee (service code 0220) cannot be charged on the same day with acupuncture treatment (0224) or acupuncture fee (service code 0225)

C.6 Multi-site visit (service code 3095) cannot be billed with Active Release Technique (ART) (service code 0226).

C.7 Funding for up to five visits is automatically approved; acupuncture beyond five visits needs pre-approval from the WCB.

C.8 Chiropractic treatment that includes Active Release Technique (ART) captures all parts of the treatment. ART (service code 0226) cannot be combined with regular chiropractic treatment (follow up visit, service code 0220). ART has to be pre-approved by the WCB. ART will only be approved when provided by currently credentialed providers.

Invoices will be reviewed for reasonable charges. The maximum coverage is $60.

C.9 Progress or subsequent reports are not required for every follow-up/subsequent visit. Progress reports should be submitted upon the request of the WCB or when there is a notable change in the worker's recovery.

Billable if a completed progress report (WCB form) is submitted.

C.10 Fee per page. The first page will be paid as a full page; all subsequent pages will be pro-rated based on the length of the letter and paid at the rate of a half page or full page.

A typed or written detailed letter from a chiropractor addressed to the WCB in response to a request for a narrative report from the WCB. Left and right margins should be no greater than one inch. The header should be no greater than three inches, and the text should be no greater than 12-point font, single-spaced.

C.11 Flat rate fee.

C.12 This fee can be paid in addition to an initial and/or follow-up visit and report fees (service codes 0222, 0220, 3019 and 0208).

C.13 Payable only one time per claim.

Funding for this fee will be approved if the following criteria have been met:

- Under clinic instruction and/or demonstration by a chiropractor and/or practice by the WCB claimant with ongoing correction and coaching
- Exercise program will be progressed or regressed as appropriate on subsequent encounters or form
- Exercise program is supported by current best practices such as the Canadian Chiropractic Guidelines exercise module or equivalent
- Encourage the use of supplementary materials (e.g., video, online, print)
- Documentation of the program is to be included in the reporting

C.14 Billable when x-ray films are delivered via Canada Post to be read.

The WCB will pay for the cost of delivering the original x-ray films back to the treating chiropractic office based on the most cost-effective method.

C.15 Sundry items (i.e., medical supplies). The item description is required for billing. GST is exempt.

Accessories such as pillows, braces, belts, etc. require WCB's approval.

Once therapy has been approved, the clinic may invoice and receive payment from the WCB without approval for a one-time supply of:

- Ice packs Max of $35
- Crutches Max of $45
- Slings Max of $35
- Taping supplies Max of $20
- Tubing Max of $15
- TheraBand Max of $30
- Hand Putty Max of $20

If the above items are required more than one time in an accepted claim, those items are subject to approval by the WCB.

If the sundry items supplied are not listed above, it is subject to approval by the WCB.

C.16 The fee listed is an hourly rate and is paid in five-minute increments. Billable for telephone communications with the WCB regarding a WCB claim. The communication must be initiated by the WCB or, with prior approval of the WCB, initiated by the billing chiropractor. Communications may include returning missed calls. Billable for each full five-minute period and each additional five-minute period or major portion thereof. A major portion thereof equals more than half of the five minutes or more than two and a half minutes.

Additional information

X-Rays - Tech fees are paid to the person taking the x-ray (chiropractor) and billed according to the Manitoba Health fee guides.

Only the certified radiologist can be billed for the pro fee.

Dental

Service code	Description	Fee schedule	Notes
0227	Dental Treatment	See note	D.1

Notes

D.1 A dental claim form must be submitted. Where applicable, a copy of the lab report must be provided with the invoice.

Additional information

The WCB follows the Manitoba Dental Association fee guide or the Denturist Association fee guide.

The WCB requires a dental claim form for preauthorization.

The WCB will only pay the fee(s) for the procedure code(s) that have been approved by the WCB.

Fees will be paid when services are provided and upon receipt of the invoice.

Hospital

Service code	Description	Fee schedule (1 April 2025)	Fee schedule (1 January 2025)	Fee schedule (1 April 2024)	Notes
0239	Standard outpatient visit	$462.00	$440.00	$440.00	H.1, H.2, H.3, H.4
1060	Day surgery - low	$1,402.00	$1,335.00	$1,335.00	H.3, H.5, H.6
1062	Day surgery - medium	$5,103.00	$4,860.00	$4,860.00	H.3, H.5, H.6
1063	Day surgery - high	$15,692.00	$14,945.00	$14,945.00	H.3, H.5, H.6
3054	Hospital in-patient per diem	See note	See note	See note	H.7
1058	CT scan	$806.00	$768.00	$768.00	H.3
3040	Medical supplies	See note	See note	See note	H.8
1059	MRI	$731.00	$696.00	$696.00	H.3
0921	Release of patient information	$60.19	$60.19	$59.35	H.9

Notes

H.1 Rates include physician compensation paid directly by the hospital, and therefore cannot be billed with Manitoba Health tariff code 8509, 8529, 8540, nor 8644.

H.2 Standard outpatient visit, including select discrete high-cost diagnostic imaging procedures. Excludes specific services identified within other service codes.

H.3 When two or more outpatient activities (service code 0239, 1058, 1059, 1060, 1062 or 1063) are provided to the same patient on the same day at the same hospital, regardless of whether the patient was discharged and/or re-admitted to the same hospital on the same day, only one outpatient activity can be billed by the hospital (i.e., the one activity with the highest rate).

H.4 An outpatient charge can be billed on the same day as an inpatient admission or discharge from the same hospital if the patient is not a registered inpatient at the hospital at the time of services.

If a patient receives outpatient services while admitted as an inpatient, the hospital cannot bill for the outpatient services. In these instances, the cost of the outpatient services is included in the inpatient according to diem rates.

If a patient is registered at a hospital as an outpatient and leaves before being seen by a physician or receiving treatment, service code 0239 may be billed.

An outpatient is an individual who has been officially accepted by a hospital and receives one or more health services without being admitted as an inpatient, and the individual's identifiable data is recorded in the registration or information system of the organization and to whom a unique identifier is assigned to record and track services.

H.5 Follow interprovincial billing rules. CCI codes must be provided.

H.6 A day-surgery patient is one who has received emergency services or has been pre-booked to receive non-emergent services in a hospital (e.g. an operating room, an endoscopy suite, a cardiac catheterization lab).

H.7 The fee provides a fixed amount for an in-patient stay and covers all costs during the period of the hospital stay. In-patient per diem ward rates and ICU rates are unique to the facility and can be found in the interprovincial billing package from Manitoba Health. Billing must include the per diem rate and number of days. For a one-night hospital stay from March 31 to April 1, the WCB will pay the rate in effect on April 1.

H.8 The cost of medical/surgical supplies (e.g., gauze, syringes, bandages, sutures, etc.) is included in the ward rate (service code 3054) and/or day surgery rate (service code 1060, 1062 or 1063) and cannot be billed separately. Billable when the cost would have been charged to the injured worker directly (e.g., crutches, ice packs, wound care kits, etc.).

H.9 As requested by the WCB, this may include an emergency room report, patient summary report, ambulance report, etc. The rate is billable based on the date the request is fulfilled by the hospital.

Nurse Practitioner

Service / tariff code	Description	Fee schedule (1 January 2025)	Fee schedule (1 April 2024)	Fee schedule (1 January 2024)	Notes
8462	Age premium (65 - 69)	10%	10%	10%	NP.1
8463	Age premium (70+)	20%	20%	20%	NP.1
8540	Complete history & physical exam	$90.02	$90.02	$88.25	NP.2, NP.3
8529	Office visit - regional or subsequent	$39.43	$39.43	$38.66	NP.3, NP.4
8321	Virtual visit by telephone or video	$39.43	$39.43	$38.66	NP.3, NP.5
0209	Initial report fee	$47.88	$47.22	$47.22	NP.6, NP.7
0020	Initial report fee - opioid management	$67.78	$66.84	$66.84	NP.6, NP.8
0210	Progress/ discharge report fee	$47.88	$47.22	$47.22	NP.7, NP.9
0021	Progress report fee - opioid management	$48.26	$47.59	$47.59	NP.8
3026	Narrative report	$151.94	$149.84	$149.84	NP.10
3028	Chart note report	$15.79	$15.57	$15.57	NP.11
8561	Special calls made to patient's home	$52.93	$52.93	$51.89	NP.3, NP.12
0098	Telephone consultation with WCB	$162.21	$159.97	$159.97	NP.13

Notes

NP.1 Service codes 8462 and 8463, where applicable, can be billed with and as a percentage of Manitoba Health tariffs 8540, 8529, 8442 and 8321.

NP. 2 The time the nurse practitioner spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation.

NP.3 In addition to the amount set above, nurse practitioners will receive the following location allowance for office visits (tariff codes 8529 and 8540):

- Remote communities - 35%
- Northern Manitoba (north of the 53rd parallel) - 25%
- Rural Manitoba - 5%
- City of Brandon - 5%

NP.4 A service provided to a patient comprised of a history of the presenting complaints; an examination of the parts or systems related to the presenting complaint(s); a review of all pertinent investigations; a complete written record and advice to the patient.

NP.5 Virtual visit by telephone or video per patient per visit.

NP.6 A "guaranteed" expense that will be paid regardless of if the claim is unadjudicated, accepted or disallowed.

NP.7 Billable if it meets one of the following criteria:

- A completed initial/progress/discharge report (WCB form) or
- An incomplete initial/progress/discharge report and attached chart or clinic note(s) from the visit with the patient (chart and clinic notes must contain information like that requested in the initial report)

NP.8 Billable when a completed opioid management initial report or opioid management progress report is submitted.

NP.9 Progress or subsequent reports are not required for every follow-up/subsequent visit. Progress reports should be submitted upon the request of the WCB or when there is a notable change in the worker's recovery.

NP.10 Fee per page. The first page will be paid as a full page; all subsequent pages will be pro-rated based on the length of the letter and paid at the rate of a half page or full page.

A typed or written detailed letter from a specialist addressed to either the WCB or the referring health care provider in response to a referral to the specialist. Left and right margins should be no greater than one inch. Header should be no greater than three inches and text should be no greater than 12-point font, single spaced.

NP.11 Flat rate fee.

NP.12 Special calls made to a patient's home. The fee is billable per patient per visit.

NP.13 The fee listed is an hourly rate and is paid in 10-minute increments. Billable for telephone communications with the WCB in regard to a WCB claim. The communication must be initiated by the WCB or, with prior approval of the WCB, initiated by the billing nurse practitioner. Communications may include returning missed calls. Billable for each full 10-minute period and each additional 10-minute period or major portion thereof. A major portion thereof equals more than half of the 10 minutes, or more than five minutes.

Additional Information

For services not listed above, the WCB pays in accordance with the Manitoba Physicians Manual at a general practitioner rate.

Occupational Therapy

Service code	Description	Fee schedule (1 January 2025)	Fee schedule (1 January 2024)	Notes
0241	Initial visit	$86.30	$85.10	OT.1
0211	Initial visit, hand therapy	$122.19	$120.50	OT.1, OT.2
0240	Follow up visit	$65.77	$64.87	OT.3
0212	Follow up visit, hand therapy	$99.37	$97.99	OT.2
0165	Acupuncture tray fee	$19.26	$18.99	OT.4
0206	Initial report fee	$47.19	$46.54	OT.1, OT.5
0207	Progress/discharge report fee	$47.19	$46.54	OT.6
3012	Narrative report fee	$150.48	$148.40	OT.7
8116	Request for additional treatment	$47.19	$46.54	OT.8
0052	Photocopy charge (up to first five pages)	$18.21	$17.95	OT.9
0053	Photocopy charge (over five pages)	$3.64	$3.59	OT.10
N/A	Sundry items	As billed	As billed	OT.11
0097	Telephone consultation with WCB	$219.26	$216.24	OT.12

Notes

OT.1 A "guaranteed" expense that will be paid regardless of if the claim is unadjudicated, accepted or disallowed.

OT.2 Hand therapy can be authorized by the WCB if the injured worker has one of the following conditions:

- Burns: wound debridement
- Complex fractures (i.e., crush injuries)
- Elbow Surgery
- Elbow; following radial head replacement following contracture release
- Finger joint arthroplasty
- Finger joint capsulotomy
- Finger joint collateral ligament repair
- Nerve repairs; transfers, including brachial plexus
- Nerve transfers
- Physiotherapy post hand surgery
- Replantation/transplantation/re-attachment
- Tendon repairs
- Wrist fusions
- Wrist; ligament repairs

If the injured worker's condition does not fall within the above list but may benefit from hand therapy, the occupational therapist must inform the WCB via the initial report, progress report or discharge report for further consideration.

The following conditions and surgeries do not require specialized hand therapy and may be treated as part of the regular occupational therapy initial and subsequent visits:

- Sprains and strains
- Uncomplicated fractures
- Carpal tunnel release

- Trigger finger release

OT.3 Follow up visits will not be paid for by the WCB on disallowed claims.

OT.4 Acupuncture tray fee (service code 0165) with the initial occupational treatment (service code 0241) or the follow up visit (service code 0240) can be billed on the same day.

OT.5 Billable if a completed initial report (WCB form) is submitted.

OT.6 Progress or subsequent reports are not required for every follow-up/subsequent visit. Progress reports should be submitted upon the request of the WCB or when there is a notable change in the worker's recovery.

Billable if a completed progress report (WCB form) is submitted.

OT.7 Fee per page. The first page will be paid as a full page; all subsequent pages will be pro-rated based on the length of the letter and paid at the rate of a half page or full page.

A typed or written detailed letter from an occupational therapist addressed to the WCB in response to a request for a narrative report from the WCB. Left and right margins should be no greater than one inch. The header should be no greater than three inches, and the text should be no greater than 12-point font, single-spaced.

OT.8 Not to be combined with progress/discharge report fee

OT.9 Administrative fee to print/photocopy test results, chart notes, diagnostic imaging, etc., upon the request of the WCB.

OT.10 Fee per additional page over five pages

OT.11 Sundry items (i.e. medical supplies). The item description is required for billing. GST is exempt.

Once therapy has been approved, the clinic may invoice and receive payment from the WCB without approval for a one time supply of:

- Ice packs Max of $35
- Crutches Max of $45
- Slings Max of $35
- Taping supplies Max of $20
- Tubing Max of $15
- TheraBand Max of $30
- Hand Putty Max of $20

If the above items are required more than one time in an accepted claim, those items are subject to approval by the WCB.

If the sundry items supplied is not listed above, it is subject to approval by the WCB.

OT.12 The fee listed is an hourly rate and paid in five minute increments. Billable for telephone communications with the WCB in regard to a WCB claim. The communication must be initiated by the WCB or, with prior approval of the WCB, initiated by the billing occupational therapist. Communications may include returning missed calls. Billable for each full five-minute period and each additional five-minute period or major portion thereof. Major portion thereof equals more than half of the five minutes, or more than two and a half minutes.

Optometrists

Service/tariff code	Description	Fee schedule	Notes
8545	Complete eye examination	See note	**OP.1**
8546	Partial eye examination	See note	**OP.1**
9724	Full threshold visual fields	See note	**OP.1**
9726	Tonometry	See note	**OP.1**
9728	Dilated fundus exam	See note	**OP.1**
8556	Consultation, including refraction and other necessary tests	See note	**OP.1**, **OP.2**
0003	Tray fee	See note	**OP.1**
3024	Doctor's first report	See note	**OP.1**
3025	Doctor's progress report	See note	**OP.1**
3026	Narrative report	See note	**OP.1**

Notes

OP.1 Invoices will be reviewed for reasonable charges.

OP.2 Does not include patient-initiated office or telephone consultations.

Additional information

Services provided by an optometrist require pre-approval from the WCB.

Optometrists in the northern region are entitled to a northern allowance for service/tariff codes 8545, 8546, 9724, 9726 and 9728.

Physicians

Service code	Description	Fee schedule (1 February 2025)	Fee schedule (1 January 2025)	Fee schedule (1 January 2024)	Notes
8462	Age premium (65-69)	10%	10%	10%	P.1,
8463	Age premium (70+)	20%	20%	20%	P.1,
5515	Hospital care premium	15%	15%	15%	P.2
3024	Initial report fee	$73.41	$73.41	$71.27	P.3, P.4
8114	Initial report fee - opioid management	$103.89	$103.89	$100.86	P.4, P.5
3025	Progress/discharge report fee	$63.12	$63.12	$61.28	P.3, P.6
8115	Progress report fee - opioid management	$63.12	$63.12	$61.28	P.5
5562	Follow up visit admin fee	$17.02	$17.02	$16.52	P.7
3026	Narrative report	$169.54	$169.54	$164.60	P.8
0015	Photocopy charge (up to first five pages)	$19.10	$19.10	$18.54	P.9
0016	Photocopy charge (over five pages)	$3.82	$3.82	$3.71	P.10
0017	Chart note preparation fee	$84.24	$84.24	$81.79	P.11
3022	Pain management administrative fee	$169.54	$169.54	$164.60	P.12
0018	In-person consultation fee	$333.63	$333.63	$323.91	P.13
3010	Telephone consultation with WCB	$84.24	$84.24	$81.79	P.14
5559	Surgical admin fee ($100-$300)	$169.54	$169.54	$164.60	P.15
5560	Surgical admin fee (>$300)	$338.97	$338.97	$329.10	P.16
0025	Surgical assistant admin fee - non-expedited surgery	$158.16	$158.16	$153.55	P.17
0056	Expedited specialist consult that occurs within 15 or less business days from the time of referral	$300.00	n/a	n/a	P.18

0057	Expedited specialist consult that occurs between 16 and 30 business days from the time of referral	$250.00	n/a	n/a	**P.18**
0049	Expedited surgery - primary anesthetist	$450.00	n/a	n/a	**P.19**
0051	Expedited surgery multiplier - primary surgeon	Multiplier	n/a	n/a	**P.20**

Notes

P.1 Service codes 8462 and 8463, where applicable, can be billed with and as a percentage of Manitoba Health tariffs 8540, 8529, 8442, 8321, 8640 and 8350.

P.2 Service code 5515, can be billed in addition to the following Manitoba Health tariff codes when services are provided in a hospital in-patient setting or an emergency department:

8409	8452	8477	8512	8551	8614	8622	8645	8662	8704
8410	8466	8490	8526	8554	8615	8623	8646	8663	8706
8411	8467	8504	8536	8596	8617	8624	8647	8664	8707
8413	8468	8508	8544	8599	8620	8625	8660	8667	8708

P.3 Billable if it meets one of the following criteria:

- A completed initial/progress/discharge report (WCB form)
- An incomplete initial/progress/discharge report and attached chart or clinic note(s) from the visit with the patient (chart and clinic notes must contain information similar to that requested in the initial report)
- Outpatient summary sheet generated by a healthcare facility

Service codes 0015 and 0016, where applicable, can be billed with an initial, progress or discharge report (3024 and 3025) when the initial/progress/discharge report is accompanied by a copy of test results, diagnostic imaging, etc. Service code 0017 cannot be billed when billing for an initial, progress or discharge report.

P.4 A "guaranteed" expense that will be paid regardless of if the claim is unadjudicated, accepted or disallowed.

P.5 Billable when a completed opioid management initial report or opioid management progress report is submitted.

P.6 Progress or subsequent reports are not required for every follow-up/subsequent visit. Progress reports should be submitted upon the request of the WCB or when there is a notable change in the worker's recovery.

P.7 WCB will pay physicians an administrative fee for second and subsequent visits in absence of a doctors progress/discharge report or opioid management progress report for the visit.

P.8 Fee per page. The first page will be paid as a full page; all subsequent pages will be pro-rated based on the length of the letter and paid at the rate of a half page or full page.

A typed or written detailed letter from a specialist addressed to either the WCB or the referring health care provider in response to a referral to the specialist. Left and right margins should be no greater than one inch. The header should be no greater than three inches, and the text should be no greater than 12-point font, single-spaced.

Service codes 0015 and 0016, where applicable, can be billed with a narrative report (service code 3026) when the narrative report is accompanied by copies of test results, diagnostic imaging, etc. Service code 0017 cannot be billed when billing for a narrative report.

P.9 Administrative fee to print/photocopy test results, chart notes, diagnostic imaging, etc., upon the request of the WCB. If the billing physician is required to be involved, service code 0017 is also billable.

P.10 Fee per each additional page over five pages.

P.11 Billable when physician time is required to produce chart notes upon the request of the WCB and must be billed together with 0015 and 0016, where 0016 is applicable. Eligible physician time includes, but is not limited to time related to retrieval, production, review, redaction, and summarization of medical information relevant to the WCB claim. Billable for each full 15-minute period and each additional 15-minute period or major portion thereof. A major portion thereof equals more than half of the 15 minutes or more than seven and a half minutes.

P.12 Administrative fee to a qualified physician who provides injections or surgical services on a WCB claimant for pain management.

P.13 Billable for in-person meetings with WCB Representatives at the request of the WCB. Minimum of one hour to be billed. Preparation time and direct travel time may be billed. A physician may bill a different hourly rate when mutually agreed prior to meeting with the WCB.

P.14 Billable for telephone communications with the WCB in regard to a WCB claim. The communication must be initiated by the WCB or, with prior approval of the WCB, initiated by the billing physician. Communications may include returning missed calls. Billable for each full fifteen minute period and each additional 15-minute period or major portion thereof. Major portion thereof equals more than half of the 15 minutes, or more than seven and a half minutes.

P.15 The surgical service must be either approved by the WCB or provided under an urgent/emergent basis. When the total cost of the surgical procedure(s) in the Manitoba Physicians Manual is more than $100.00 but less than $300.00, surgeons and anesthetist(s) (including general practitioners) involved in the treatment will receive an additional administrative fee.

The primary surgeon or anesthetist shall not bill an administration fee for expedited surgery in addition to an administration fee for non-expedited surgery.

P.16 The surgical service must be either approved by the WCB or provided on an urgent/emergent basis. When the total cost of the surgical procedure(s) in the Manitoba Physicians Manual is over $300.00, surgeons and anesthetist(s) (including general practitioners) involved in the treatment will receive an additional administrative fee.

If procedures are performed over 90 days apart on the same WCB claimant, a request for an additional administration fee can be billed. All surgical reports must be received within three weeks

of the surgery for the administrative fee to be paid. The WCB may consider reports received beyond that date on a case-by-case basis.

The primary surgeon or anesthetist shall not bill an administration fee for expedited surgery in addition to an administration fee for non-expedited surgery.

P.17 The surgical service must be either approved by the WCB or provided on an urgent/emergent basis. Billable in addition to surgical assistant services listed in the Manitoba Physicians Manual**.**

P.18 Billable only when the WCB initiates a request for expedited service.

Timeframes for expedited consultations by the primary surgeon shall count from the date the request is issued by WCB. Timeframes for expedited consultations by the primary anesthetist shall count from the date the primary surgeon consults the anesthetist. Note that anesthetists may only claim expedited consultation services for cases where the WCB has requested an expedited consultation from the surgeon.

P. 19 The anesthetist shall not bill an expedited surgery fee in addition to a non-expedited surgery fee. The surgeon must have received WCB approval for WCB expedited surgeries.

P.20 The primary surgeon shall bill the WCB for approved tariffs and apply a multiplier that results in a total surgery amount of 3x the tariff fees listed in the Manitoba Physicians Manual, when surgical services approved by the WCB are provided within:

- Thirty (30) business days of the expedited surgical consultation, or
- Thirty (30) business days following the day the decision is made to proceed with the surgery.

The multiplier is only applied to tariff fees in the Manitoba Physicians Manual that have been pre-approved by the WCB. The multiplier cannot be applied to WCB service codes.

The multiplier does not apply to fees billed by surgical assistants.

The primary surgeon or anesthetist shall not bill an administration fee for expedited surgery in addition to an administration fee for non-expedited surgery.

Billing Example

MB Health Tariff Code/ WCB Service Code	Description	Qty	Amount
MB Health tariff code 1037	Rotator Cuff Repair	1	$551.57
MB Health tariff code 1029	Sub Acromial Decompression	1	$340.10
WCB approved MB Health tariff total before multiplier	**Subtotal (x1)**		**$891.67**
WCB Service Code 0051	Expedited Multiplier (subtotal x 2)		$1,783.34
	Total for surgery (x3)		**$2,675.01**
WCB Service Code 0015	Photocopy charge (up to first five pages)	1	$19.10
	Total Invoice Amount		**$2,694.11**

Physiotherapy

Service code	Description	Fee schedule (1 January 2025)	Fee schedule (1 January 2024)	Notes
0176	Initial visit	$86.30	$85.10	**PT.1**
0136	Initial visit, hand therapy	$122.19	$120.50	**PT.1**, **PT.2**
3074	Initial visit, Northern Manitoba	$87.55	$86.34	**PT.1**, **PT.3**
0177	Follow up visit	$65.77	$64.87	**PT.4**, **PT.5**
0137	Follow up visit, hand therapy	$99.37	$97.99	**PT.2**, **PT.4**
3082	Follow up visit, Northern Manitoba	$67.03	$66.10	**PT.3**, **PT.4**, **PT.5**
0165	Acupuncture service fee	$19.26	$18.99	**PT.4, PT.6**
0179	Multi-site visit	$47.93	$47.26	**PT.7**
3029	Initial report fee	$47.19	$46.54	**PT.1**
0203	Progress/discharge report fee	$47.19	$46.54	**PT.8**
8116	Request for additional treatment	$47.19	$46.54	**PT.9**
3047	Functional capabilities evaluation (FCE)	See note	See note	**PT.10**
3012	Narrative report fee	$150.48	$148.40	**PT.11**
0052	Photocopy charge (up to first five pages)	$18.21	$17.95	**PT.12**
0053	Photocopy Charge (over five pages)	$3.64	$3.59	**PT.13**
N/A	Sundry items	As billed	As billed	**PT.14**
0064	Telephone consultation with WCB	$219.26	$216.24	**PT.15**

Notes

PT.1 A "guaranteed" expense that will be paid regardless of if the claim is unadjudicated, accepted or disallowed.

PT.2 Hand therapy can be authorized by the WCB if the injured worker has one of the following conditions:

- Burns: wound debridement
- Complex elbow surgery
- Complex fractures (i.e., crush injuries)
- Complex tendon and ligament repairs to the wrist and hand
- Elbow; following radial head replacement following contracture release
- Finger joint arthroplasty
- Finger joint capsulotomy
- Finger joint collateral ligament repair
- Nerve repairs; transfers including brachial plexus
- Nerve transfers
- Physiotherapy post hand surgery
- Replantation/transplantation/re-attachment
- Wrist fusions
- Wrist; ligament repairs

If the injured worker's condition does not fall within the above list but may benefit from hand therapy, the physiotherapist must inform the WCB via the Initial report, progress report or Discharge Report for further consideration.

The following conditions and surgeries do not require specialized hand therapy and may be treated as part of the regular physiotherapy therapy initial and subsequent visits:

- Sprains and strains
- Uncomplicated fractures
- Carpal tunnel release

- Trigger finger release

PT.3 Any physiotherapy clinic north of Swan River receives a location allowance based on the service codes for the northern clinics.

PT.4 Up to 18 follow-up and/or acupuncture treatments can be provided on an approved claim before an extension is required.

PT.5 If the service provider bills for a subsequent treatment when the claim is disallowed, treatment cannot be paid.

PT.6 Acupuncture service fee (service code 0165) with the initial physiotherapy treatment (service code 0176) or the follow-up visit (service code 0177) can be billed on the same day.

PT.7 Multi-site visit requires pre-approval**.**

PT.8 Progress or subsequent reports are not required for every follow-up/subsequent visit. Progress reports should be submitted upon the request of the WCB or when there is a notable change in the worker's recovery.

Billable if a completed progress report (WCB form) is submitted.

PT.9 Not to be combined with progress/discharge report fee.

PT.10 The WCB physiotherapy advisor must initiate the request for the FCE. The WCB physiotherapy advisor will advise the therapist on the amount that can be billed to the WCB.

PT.11 Fee per page. The first page will be paid as a full page; all subsequent pages will be pro-rated based on the length of the letter and paid at the rate of a half page or full page.

A typed or written detailed letter from a physiotherapist addressed to the WCB in response to a request for a narrative report from the WCB. Left and right margins should be no greater than one

inch. The header should be no greater than three inches, and the text should be no greater than 12-point font, single-spaced.

PT.12 Administrative fee to print/photocopy test results, chart notes, diagnostic imaging, etc. upon the request of the WCB.

PT.13 Fee per each additional page over five pages**.**

PT.14 Sundry Items (i.e., Medical Supplies). The item description is required for billing. GST exempt.

Once therapy has been approved, the clinic may invoice and receive payment from the WCB without approval for a one time supply of:

- Ice Packs Max of $35
- Crutches Max of $45
- Slings Max of $35
- Taping Supplies Max of $20
- Tubing Max of $15
- TheraBand Max of $30
- Hand Putty Max of $20

If the above items are required more than one time in an accepted claim, those items are subject to approval by the WCB.

If the sundry items supplied is not listed above, it is subject to approval by the WCB.

PT.15 The fee listed is an hourly rate and paid in five minute increments. Billable for telephone communications with the WCB in regard to a WCB claim. The communication must be initiated by the WCB or, with prior approval of the WCB, initiated by the billing physiotherapist. Communications may include returning missed calls. Billable for each full five-minute period and each additional five minute period or major portion thereof. Major portion thereof equals more than half of the five minutes, or more than two and a half minutes.

Psychology

Service code	Description	Fee schedule	Notes
3027	Psychological services	See note	PS.1
3026	Narrative report	See note	PS.1
0167	Telephone consultation with WCB	See note	PS.1, PS.2

Notes

PS.1 Invoice will be reviewed for reasonable charges.

PS.2 Billable for telephone communications with the WCB in regard to a WCB claim. The communication must be initiated by the WCB or, with prior approval of the WCB, initiated by the billing psychiatrist/psychologist. Communications may include returning missed calls. Billable for each full 10-minute period and each additional 10-minute period or major portion thereof. A major portion thereof equals more than half of the 10 minutes or more than five minutes.

Additional Information

Psychological treatment and/or counselling sessions require pre-approval from the WCB.