

# Engaging with the WSIB / Insurance Systems - Part 1

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Workplace Safety and Insurance Board (WSIB)

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# Faculty/Presenter Disclosure

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  - No conflict of interest to declare

# Mitigating Potential Bias

- The information presented in this program is based on recent information that is explicitly “evidence-based”.
- This Program and its material is peer reviewed and all the recommendations involving clinical medicine are based on evidence that is accepted within the profession; and all scientific research referred to, reported, or used in this CME/CPD activity in support or justification of patient care recommendations conforms to the generally accepted standards

# Learning Objectives

By the end of this session, participants will be able to:

1. Explain what the WSIB is and how it functions
2. Describe the role of health care providers in the workers' compensation system
3. Effectively complete Form 8s and other insurance forms for your patients

# The WSIA and the WSIB



In Canada, most workers are covered by workplace insurance – also called workers' compensation – a system of disability insurance administered by twelve agencies across the country.



In Ontario, the agency is the Workplace Safety and Insurance Board, or WSIB.



The WSIB was established in 1914 by the Ontario government based on the work of Sir William Meredith, who was the provincial Chief Justice at the time. Meredith proposed an insurance system based on a 'historic compromise'.



# Basis for Workers' Compensation: the **historic compromise**

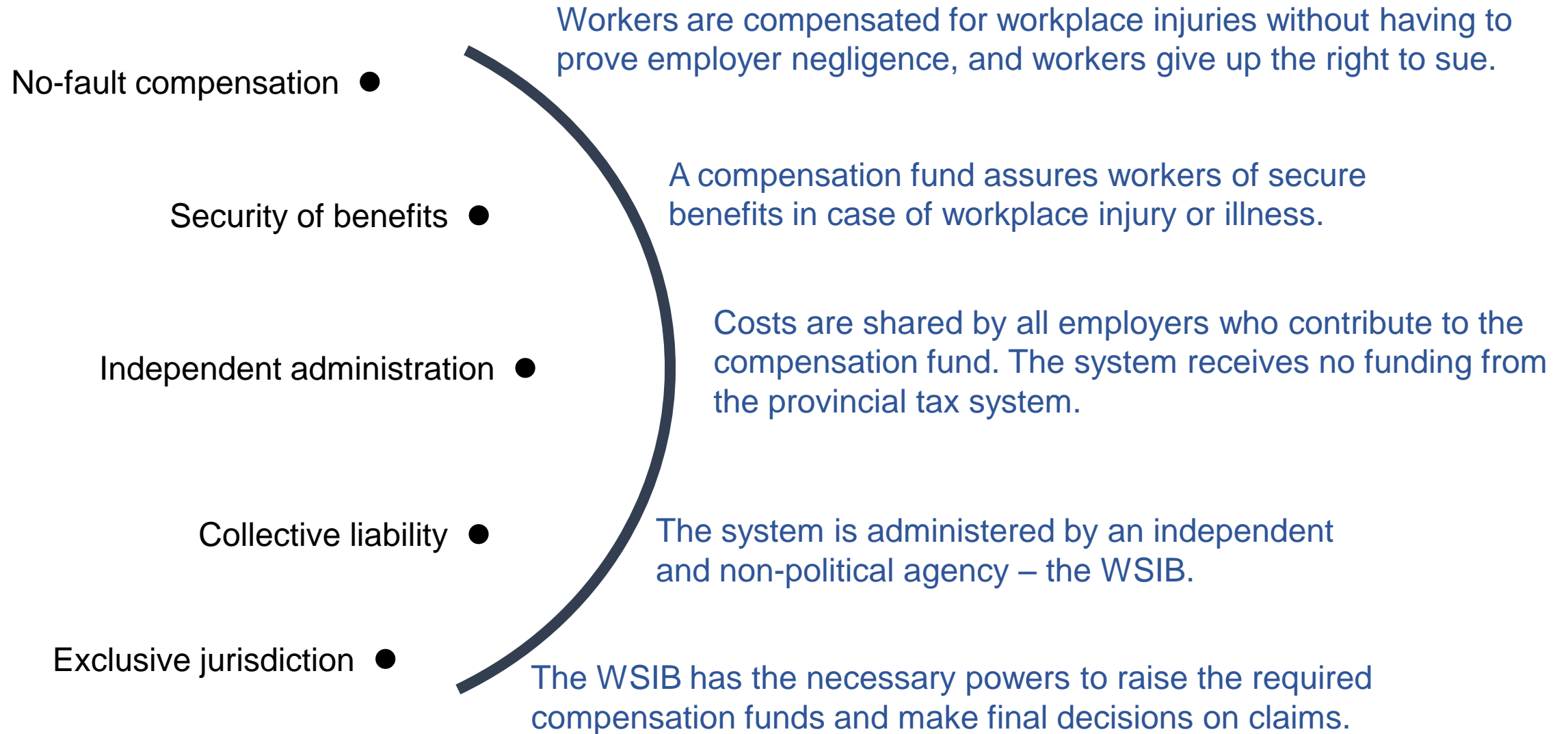


People with work-related injuries or illnesses waived the right to sue their employers in exchange for compensation that was prompt and dependable.



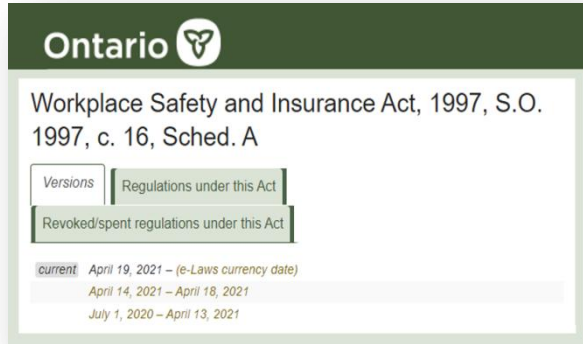
Employers agreed to pay into a shared insurance fund in exchange for protection from lawsuits and a more predictable cost of doing business.

# Meredith Principles



# Workplace Safety and Insurance Act (WSIA)

## Workplace Safety and Insurance Board (WSIB)



Meredith's 5 principles for workers compensation serve as the foundation of Ontario's workplace insurance law – the Workplace Safety and Insurance Act or WSIA.



Workplace Safety and Insurance Board (WSIB) is Ontario's Workers' compensation board. It is an agency of the Ontario Government. WSIB is one of the largest compensation boards in North America and is responsible for administering and enforcing the Workplace Safety and Insurance Act (WSIA).

# Role of the WSIB



1. Promote health and safety in workplaces to prevent and reduce the number of workplace injuries and occupational diseases



2. Facilitate return to work and recovery of patients who sustain personal injury or who suffer from an occupational disease



3. Facilitate work transition services for workers when required



4. Provide compensation and benefits to workers and to survivors of deceased workers

# Benefits for your patients

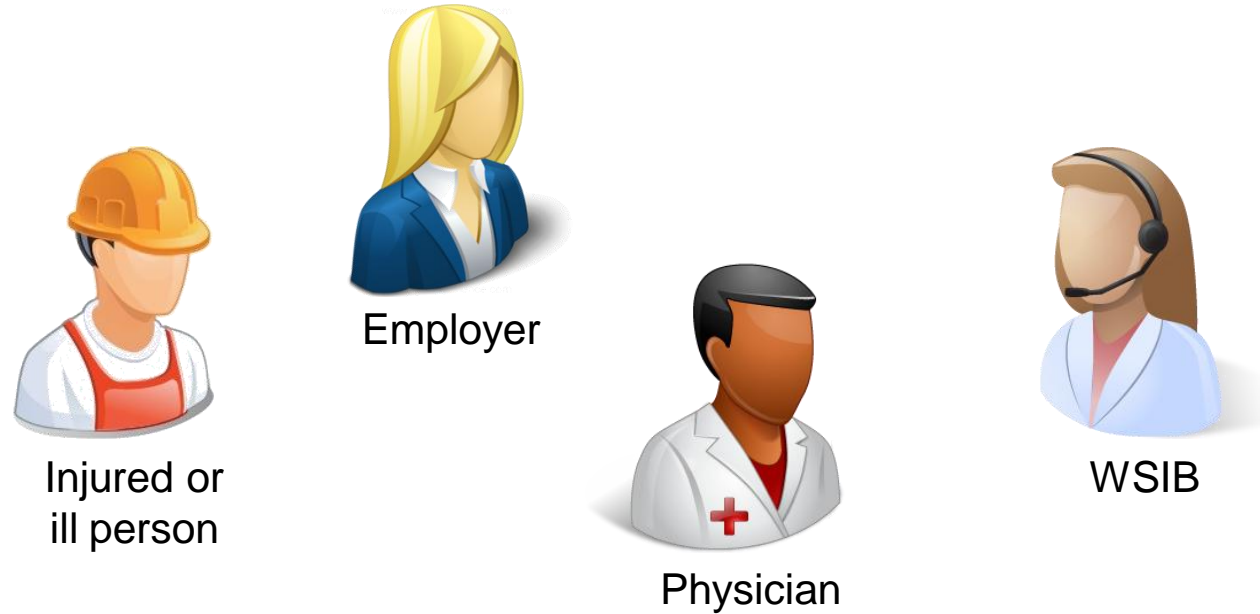
1. **Loss of earnings benefit** if there is time missed from work as a result of the work related injury or illness.
2. **Health care benefits** including hospitalization, surgery, or emergency care, prescription drugs, glasses and dental surgery.
3. **Non-economic Loss Benefits** for people who suffer a permanent impairment as a result of a workplace injury/illness.
4. **Return to work** and work transition services
5. **Loss of Retirement Income Benefits** that help to replace the money your patient would have saved for pension (only available to workers on continuous benefits for 12 months).
6. The Serious Injury and Occupational Disease programs offer **special services for severe and complex injury/illnesses**.



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# How does the WSIB claims process work?

# Claims process



There are many people involved in the claims process. It is helpful to understand the roles of each.

# Claims process



A person who suffers a work-related injury or illness should inform their employer.

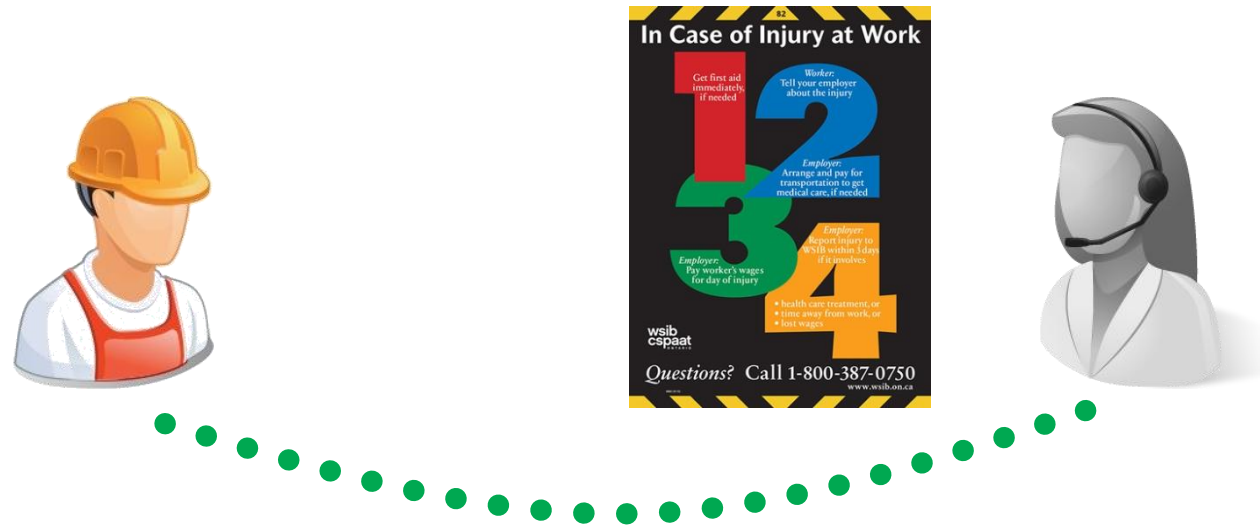


# Claims process



Employers must inform the WSIB of any cases they are aware of that involve health-care treatment, lost time, lost wages, or more than seven days of modified work.

# Claims process



The person must also inform the WSIB of any changes to their situation and co-operate in their recovery and return-to-work process.

# Claims process



A physician who cares for an injured worker claiming benefits has a duty to provide information to the WSIB regarding the person's clinical condition.

# Claims process



The WSIB reviews each claim and determines the eligibility for compensation.

What are my roles and obligations with respect to workers compensation?

# Health Care Worker's Role in Workers Compensation

1. Identify and treat work-related injuries and illnesses
2. Discuss with patients who have or may have a work related condition the importance of filing a workers compensation claim
3. Complete Form 8 for patients making a claim with WSIB (with consent)
4. Provide information to WSIB when requested (Waivers are not required, Section 37(1,2) WSIA)

# Insurance Forms - General

# Insurance Forms

## WSIB

Health Professional Form 8

Progress Report– Form 26

Functional Abilities Form (FAF) For Timely Return to Work

## Disability Forms and Other Insurance

Attending Physician's Statement

Physicals for pre-employment certification

Back to work note / Sick note

## Auto Insurance

Insurance Certificate OCF- 3 Disability Certificate

Insurance Certificate OCF-18 Treatment Plan

Insurance Certificate OCF-19 Catastrophic Impairment

Insurance Certificate OCF-23 Treatment Confirmation

## Government Forms

Revenue Canada, Federal Disability Tax Credit

Canada Pension Plan (CPP) Disability Medical Report Form

Canada Pension Plan (CPP) Narrative Medical Report

1. Medico-legal document - All information must be defensible
  - Objective medical findings
  - If subjective, state "Patient reports..."
2. Only requested information
3. Sufficient detail – some insurers will deny claims based of "insufficient medical"\*
4. For fitness / workability questions and forms:
  - Health Care Provider role: **restrictions** and **limitations**
  - Employer role: find modified work to accommodate to point of undue hardship (Human Rights Leg., WSIA)
  - Do not mix roles! Do not specify tasks, do not state cannot work (you have no way of knowing what accommodations might be possible!)

\*WSIB has burden of proof to collect all medical so will not deny claims based on insufficient medical, but some insurers for STD and LTD may.





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# How to Complete a Form 8

# Case



- 42 year old selector at grocery chain warehouse; lifts 10-15 lbs frequently, up to 25 lbs occasionally, uses MHE (pallet truck and sometimes drives lift truck).
- Acute onset low back pain initially right side predominant with some centralization over the course of 2 days (worker's weekend).
- Back dominant, pain worse flexion
- No red flags
- Physical examination normal SLR, power 5/5 MRC scale L4-S1, sensation normal, ROM mild limitation forward flexion and rotation secondary to reported stiffness and pain. Prone extension positive (PEP)
- Conclusion – Pattern 1 LBP
- Patient requests you complete a Form 8.

# Case



- **Restrictions**

- Should not use motorized equipment. Sudden onset pain with twist or aggravating movements could incapacitate (safety sensitive).
- Avoid heavy repetitive lifting / extreme twisting (could aggravate)

- **Limitations**

- Overhead work
- Bending

- **Abilities**

- lift / carry up to 5 lbs
- Sit / Stand / Walk at own pace (up to 20 min stand/5 min sit or up to 30 min sit/5 min stand)
- Full cognitive abilities

- Duration / Anticipated trajectory of recovery?

**A. Patient and Employer Information - (Patient to complete Section A)**

Last Name		First Name		Init.	Sex
					<input type="checkbox"/> M <input type="checkbox"/> F
Address (no., street, apt.)		City/Town		Prov.	Postal Code
				ON	
Telephone	Social Insurance No.	Date of Birth	dd mm yyyy	Language	
				<input type="checkbox"/> Eng. <input type="checkbox"/> Fr. <input type="checkbox"/> Other	
Employer Name					
The Workplace Safety and Insurance Board (WSIB) collects your information to administer and enforce the Workplace Safety and Insurance Act. The Social Insurance Number may be used to identify workers and to issue income tax information statements as authorized by the Income Tax Act. Questions should be directed to the decision maker responsible for your file or toll free at 1-800-387-5540.					

**B. Incident Dates and Details Section****1. How did the injury/reinjury or illness occur at work?**

Acute new onset low back pain while stooped over moving (lifting and twisting) 35 lb box from a rack to a pallet at 10:30 am.

## Occupation

Warehouse Selector

Date of incident/or when  
did the symptoms start? dd mm yyyy  
16 01 2020**C. Clinical Information Section - (Please check all that apply)****1. Area of Injury/Illness**

<input type="checkbox"/> Brain	<input type="checkbox"/> Ears	<input type="checkbox"/> Upper back	Left	<input type="checkbox"/> Shoulder	Right	Left	<input type="checkbox"/> Wrist	Right	Left	<input type="checkbox"/> Hip	Right	Left	<input type="checkbox"/> Ankle	Right
<input type="checkbox"/> Head	<input type="checkbox"/> Teeth	<input checked="" type="checkbox"/> Lower back		<input type="checkbox"/> Arm			<input type="checkbox"/> Hand			<input type="checkbox"/> Thigh			<input type="checkbox"/> Foot	
<input type="checkbox"/> Face	<input type="checkbox"/> Neck	<input type="checkbox"/> Abdomen		<input type="checkbox"/> Elbow			<input type="checkbox"/> Fingers			<input type="checkbox"/> Knee			<input type="checkbox"/> Toes	
<input type="checkbox"/> Eyes	<input type="checkbox"/> Chest	<input type="checkbox"/> Pelvis		<input type="checkbox"/> Forearm						<input type="checkbox"/> Lower Leg				
<input type="checkbox"/> Other: _____														

**2. Description of Injury/Illness Physical Examination Findings**☐ Pain at rest/Night PainPain Rating Scale  
0 1 2 3 4 5 6 7 8 9 10

- ☐
- Abrasion
- 
- ☐
- Amputation
- 
- ☐
- Bite
- 
- ☐
- Burn
- 
- ☐
- Contusion/Hematoma/Swelling
- 
- ☐
- Crush Injury

- ☐
- Disc Herniation
- 
- ☐
- Dislocation
- 
- ☐
- Fall from Height
- 
- ☐
- Foreign Body
- 
- ☐
- Fracture
- 
- ☐
- Hernia
- 
- ☐
- Infection

- ☐
- Inflammation
- 
- ☐
- Internal Joint Derangement
- 
- ☐
- Joint Effusion
- 
- ☐
- Laceration
- 
- ☐
- Neurological Dysfunction
- 
- ☐
- Psychological
- 
- ☐
- Puncture (non-needlestick)

- ☐
- Repetitive Strain Injury
- 
- ☐
- Spinal Cord Injury
- 
- ☐
- Sprain/Strain
- 
- ☒
- Surgical Intervention
- 
- ☐
- Tendonitis/Tenosynovitis
- 
- ☐
- Range of Motion

**Exposure/Illness**

- ☐
- Asthma
- 
- ☐
- Cancer
- 
- ☐
- Fumes - Inhalation
- 
- ☐
- Hand-arm Vibration
- 
- ☐
- Hearing Loss
- 
- ☐
- Infectious Disease
- 
- ☐
- Needle Stick
- 
- ☐
- Poisoning/Toxic Effects
- 
- ☐
- Skin Condition

**3. Are you aware of any pre-existing or other conditions/factors that may impact recovery?**☐ yes ☒ no

If yes, describe \_\_\_\_\_

**4. Diagnosis**

Lumbar strain / sprain

**D. Treatment Plan****1. What is the treatment plan (type of treatment, duration) including prescribed medications?**

Naproxen 250mg BID/home exercise program/advised keep activity modification to minimum.

**2. To be completed by physicians only.**

Work Injury/Illness Medications	Dose	Frequency	Duration	Work Injury/Illness Medications	Dose	Frequency	Duration
1. Naproxen	250 mg	BID	7 days	3.			
2.				4.			

**3. Investigations & Referrals:**

<input checked="" type="checkbox"/> None	<input type="checkbox"/> Labs	<input type="checkbox"/> Xrays	<input type="checkbox"/> CT Scan	<input type="checkbox"/> MRI	<input type="checkbox"/> EMG	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Other
<input type="checkbox"/> FP/GP	<input type="checkbox"/> Occupational Health Centre			<input type="checkbox"/> Physiotherapist		Would the patient benefit from the following referrals?	
<input type="checkbox"/> Specialist/	<input type="checkbox"/> Occupational Therapist			<input type="checkbox"/> Psychologist		<input type="checkbox"/> Specialty Clinic	
<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Other					<input type="checkbox"/> Regional Evaluation Centre (REC)	

Once completed, please ensure that a copy of this page only is provided to the worker.

Last Name	First Name	Init.	Birth Date	dd	mm	yyyy
Area(s) of Injury(ies)/Illness(es)						

Date of Incident	dd	mm	yyyy
	16	01	2020

**F. Return To Work Information - Must be completed by a Health Professional**

When work injury/illness occurs, focus on return to usual activity including return to safe and appropriate work is best practice. Most workers who experience soft tissue injury are able to remain at work.

**1. Have you discussed return to work with your patient?**☒ yes ☐ no

2. ☐ This worker can resume Regular duties. Start date 

dd	mm	yyyy

 If graduated hours required please specify \_\_\_\_\_

☒ This worker can begin Modified duties. Start date 

dd	mm	yyyy
16	01	2020

 If graduated hours required please specify \_\_\_\_\_

☐ This worker is not able to work because of the workplace injury/illness.

Please provide explanation \_\_\_\_\_

**3. Please indicate the worker's status and functional abilities in relation to the workplace injury and diagnosis.****A. Full Functional Abilities**☐**B. Worker Functional Abilities**

Bend/Twist  
Climb  
Kneel  
Lift

Able to	Not Able to
<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

Not Able to

Operate Heavy Equipment  
Operate a Motor Vehicle  
Push/Pull  
Sit

Able to	Not Able to
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

Not Able to

Stand  
Use of Public Transportation  
Use of Upper Extremities  
Walk

Able to	Not Able to
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>

Not Able to

**C. Other Limitations:** eg. Environmental Conditions, Medication, Use of Protective Equipment.

Please describe: No lift >5 lbs >3/hr, walk 20 min/5 min break, sit up to 30 min/5 min break

**4. From the date of this assessment, the above limitations will apply for approximately:**

☐ 1 - 2 days ☐ 3 - 7 days ☒ 8 - 14 days ☐ 14 + days

**5. Follow-up Appointment**

☐ None required ☐ As Needed

Date of next appointment

dd	mm	yyyy
30	01	2020

Health Professional's Name (Please print)

Dr. E. B. Practice

Address

# Discussion



More information:

<https://www.wsib.ca>

<https://www.wsib.ca/en/health-care-providers/resources/physician-learning-modules>