



*cutting through complexity™*

# **WSIB Adjudication & Claims Administration (ACA) Program Value for Money Audit Report**

# Table of Contents

<b>1. Engagement Overview.....</b>	<b>3</b>
1.1 Value for Money Audit Approach	4
1.2 ACA Program Background	5
1.3 ACA Program: Addressing the Challenges	9
1.4 Value for Money Audit Context	11
<b>2. Detailed Review: Five Decision Points.....</b>	<b>18</b>
2.1 ACA Program High Level End to End Overview	19
2.2 ACA Program Methodology	20
2.3 Eligibility	21
2.4 Recurrences	26
2.5 Second Injury Enhancement Fund	30
2.6 Non Economic Loss	34
2.7 Loss of Earnings Lock-In	39
<b>3. Value for Money Audit Opinion.....</b>	<b>44</b>
3.1 Overall Opinion	45
3.2 Observations, Conclusions & Recommendations	47
3.3 Management Responses	55
3.4 Recommendations: Impact	62
<b>Appendix A: Statistical Overview.....</b>	<b>64</b>
<b>Appendix B: Inter-jurisdictional Themes.....</b>	<b>67</b>
<b>Appendix C: Stakeholder Themes.....</b>	<b>72</b>

# 1.0 ENGAGEMENT OVERVIEW

# 1.1 Value for Money Audit Approach

KPMG LLP has conducted a value for money audit of the Adjudication & Claims Administration (ACA) Program at the Workplace Safety & Insurance Board (WSIB) of Ontario in accordance with the WSIB's request for proposal No. 2010-42-KH.

**SCOPE\*:** Provide an opinion as to whether current adjudication decision making and claims administration processes are being delivered in an efficient and effective manner. The audit focused on five key decision making functions, representing the highest impact areas of adjudication. They are:

- Initial Entitlement Decisions
- Non Economic Loss (NEL) Decisions
- Loss of Earnings (LOE) 72 month Lock-in Decisions
- Second Injury Enhancement Fund (SIEF) Decisions
- Recurrence Decisions

**ASSESS:** Assess a number of issues such as:

- Effectiveness of WSIB operational policies and guidelines in particular as to whether they provide adequate guidance to help ensure accurate, consistent and timely decisions are made in a financially responsible and accountable manner
- Administrative efficiencies of the adjudication and administration processes
- Adequacy of resources, information and systems to support cost effective and efficient decisions

Audit included inter-jurisdictional research related to workers' compensation boards in Canada that were similar in size. The research was focused on the five key decision making functions.

KPMG conducted the value for money audit in accordance with value for money audit standards recommended by the Canadian Comprehensive Auditing Foundation and accordingly included such tests and other procedures as we considered necessary. Due to relatively significant changes to the WSIB service delivery model, the focus of the audit will be on calendar years 2008-2010.

*\*Occupational disease and serious injuries are not included in the scope of this audit.*

## 1.2 ACA Program Background

### OVERALL

In 1914 Ontario passed the *Workmen's Compensation Act*, creating the Workmen's Compensation Board, later renamed the Workplace Safety and Insurance Board (WSIB) with the passing of the *Workplace Safety and Insurance Act (WSIA)* in 1998.

Ontario's Workplace Safety and Insurance Board plays a key role in the province's occupational health and safety system. WSIB administers no-fault workplace insurance for some 240,000 employers and covers some 4 million workers. It is committed to the prevention of workplace injuries and illnesses. WSIB provides disability benefits, manages the provision of quality health care and assists in early and safe return to work (RTW) for workers who are injured on the job or contract an occupational disease. WSIB also carries out and funds programs to help prevent workplace injuries. In 2010 a total of 242,371 claims were registered.

Adjudication is the process used to determine entitlement to benefits and services under the *WSIA*. A decision maker is the person who makes a determination regarding entitlement. Adjudicative decisions are made throughout the life of a case, and are guided and impacted by a number of factors including legislation, policy and decision support documents.

## 1.2 ACA Program Background *(Continued)*

### LEGISLATION

Up to 1990, compensation for injured workers was based around a permanent disability award system which paid workers temporary benefits followed by lifetime awards where their injuries were permanent. The legislation called for the WSIB to estimate a worker's impairment of earning capacity based on a clinical rating schedule. The WSIB was given the authority to establish the rating schedule based on the estimated impacts of particular injuries on a worker's earnings. This created a "rough justice" form of compensation which did not take into account the real impact of injuries on individual workers.

In 1990, new legislation established a dual award system for compensating injured workers. Workers who suffered permanent injuries were entitled to receive a non economic loss award to recognize their loss of enjoyment of life and pain and suffering. As well, a future economic loss award was paid to compensate for wage loss based on the difference between what they were able to earn prior to the injury and their ability to earn in suitable and available work after their injury. The legislation also called for wage loss benefits to be locked-in 72 months after the date of injury.

An important support to the 1990 benefit scheme was a highly structured vocational rehabilitation system with legislatively prescribed intervention timelines for WSIB staff. This was aimed at ensuring early and ongoing vocational rehabilitation support to optimize return to work opportunities. In 1997, the WSIB employed a total of 450 vocational rehabilitation staff who worked with injured workers and employers to facilitate return to work.

## 1.2 ACA Program Background *(Continued)*

In 1998, new legislation was introduced which completely removed vocational rehabilitation from the legislation. The legislation also removed standardized periodic mandatory reviews of wage loss awards. The purpose of the legislation was to refocus the system on worker and employer self-reliance and reduce WSIB intervention in return to work.

The WSIB responded by creating new service teams with broader frontline roles to promote more customer-friendly “one stop shopping” opportunities for workers and employers and reduce the bureaucracy associated with the previous service model of specialized roles.

Customer satisfaction was the predominant objective of the WSIB in the post-1998 service model as staff “turned to face the customer”. Greater focus on delivering services by industry sector and reduced internal staff “handoffs” proved to be extremely positive from a customer satisfaction perspective. Annual satisfaction surveys showed significant improvement for workers and employers, most notably for employers. Over the seven year period (2000 to 2006) employer satisfaction rates with the claims process improved from 60% in 2000 to 81% in 2006, an increase of 35%. Over the same period, injured worker satisfaction with the claims process improved from 64% to 68%, an increase of 6%.

In spite of the success of the WSIB’s service approach, especially for the employer community, the impact of the new system on long term return to work outcomes for injured workers began to be evident in 2005 and 2006. The proportion of claims that were being locked-in 72 months post-injury were increasing due to deteriorating return to work results. In addition, despite declining injury rates, the level and frequency of permanent impairments has also increased since 1998.

## 1.2 ACA Program Background *(Continued)*

In 2007, the WSIB engaged with the Institute for Work and Health (IWH) to study its claims duration trends, particularly in regard to the increase in the proportion of claims for which LOE benefits were being locked-in to age 65. The IWH study identified three priority drivers for this shift in the duration trend.

- **Legislation:** There was a high correlation between longer duration outcomes and the changes made by Bill 99 to the legislation and the Board's service delivery model (for example, Bill 99's elimination of mandatory reviews and checkpoints, along with the Board's vocational rehabilitation programs).
- **Health Care:** There was a high correlation between duration and health care services being received, especially with prescriptions for narcotic medication.
- **Workplace Behaviour:** There was a high correlation between duration and changes in workplace behaviour that were affected primarily by the WSIB's workplace safety employer incentive programs. This included increasing rates of re-opened claims after the NEER window expires and growing utilization of Second Injury Enhancement Fund (SIEF) relief.

An excellent summary of the WSIB's challenge in administering Bill 99 is contained in the 2009 Annual Report of the Office of the Auditor General of Ontario. The report states in part (pages 329-330):

*...Before Bill 99, the legislative framework was highly structured and prescriptive regarding both the process and the timelines for handling claims. This system had numerous mandatory reviews or checkpoints, extensive WSIB interventions between worker and employer, and a strong focus on vocational rehabilitation. Bill 99 changed these processes significantly: its legislative reforms were based on a "self-reliance model", which follows the philosophy that workplace parties—employers and workers—are in the best position to make practical decisions about the management of workplace injuries and that the workplace parties should therefore co-operate. For the WSIB, these reforms resulted in fewer and less-prescriptive policies and interventions, eliminated vocational rehabilitation, and refocused the WSIB's role from one of direct intervention to one of monitoring the workplace parties.*

## 1.3 ACA Program: Addressing the Challenges

In response to the deterioration in long term return to work outcomes for injured workers which led to increasing duration and overall claim costs, the WSIB instituted a major review of its service delivery model. This review highlighted the need to renew a system-wide focus on recovery and return to work which had been lost following the implementation of Bill 99 in the shift to a “self-reliance” model. In particular, the review identified the need for the following:

- Onsite return to work support for workplace parties
- Improved case planning focused on early recovery and return to work
- Better alignment of case management activities to outcomes of return to work and recovery
- More direct information gathering through personal contact with the workplace parties
- Greater specialization and expertise within WSIB’s frontline roles
- Improved timeliness of decisions, especially initial entitlement

In late 2008, the WSIB commenced a phased implementation of a New Service Delivery Model (NSDM), including new training for all service delivery staff. This was marked by three significant operational reforms:

### 1) New and redesigned frontline roles:

- Creation of specialized frontline roles focusing on the three key phases of a claim (Eligibility Adjudicator, Short Term Case Manager, Long Term Case Manager)
- New roles to support case managers in return to work through onsite intervention and facilitation (RTW Specialist and Work Transition Specialist)
- Specialty teams to handle specialized, high impact decisions (SIEF, Recurrences)

## 1.3 ACA Program: Addressing the Challenges *(Continued)*

### 2) New case management approaches:

- Streamlined initial adjudication
- Earlier intervention in return to work
- Faster decision making

### 3) New tools and processes:

- Creation of case planning templates for staff
- Introduction of technology to support automated eligibility adjudication
- Establishment of business requirements and commence build for integrated case management system

The model shifted the focus of the ACA Program from customer satisfaction to customer service and return to work. The rollout has served to highlight a number of other important areas that need to be addressed to improve the efficiency and effectiveness of the ACA Program and effectively align the model to better support the key first principles of the system, return to work and recovery.

Additional changes to the Service Delivery Model in 2011 include a new Health Care Strategy, a focus on High Impact Claims and expanding the suite of eServices.

This audit is intended to help the WSIB sharpen its focus and alignment by identifying key improvement areas including:

- business processes
- policy support and direction
- supporting technology

## 1.4 Value for Money Audit Context: External Contextual Factors

The ACA Program operates within complex external and internal environments. The assessment of the value for money generated by the program must therefore be completed with appropriate consideration of key contextual factors generated by these environments. Key external contextual factors that were considered as part of our review included:

**Labour Market Conditions:** The success of the program, in particular with respect to return to work efforts, will be affected by the overall strength of the macro-economy and both the broader and sector-specific labour markets. Generally, the stronger the general macro-economy, the more successful return to work efforts will be for injured workers.

**Labour Market Demographics:** The success of the program, both in terms of the achievement of outcomes and the management of costs, can be significantly impacted by changes in labour market demographics. The most significant change with the potential to impact program success is the aging of the workforce. Between 2003 and 2010, the proportion of all lost-time injuries that were suffered by workers aged 51 years or older increased from 17.2% (2003) to 25.3% (2010). This represents an increase of 47%. A variety of research has been conducted on the impact of aging on workplace injury incidence and severity, particularly in the United States. The results of this research suggest that older workers:

- Suffer fewer traumatic injuries than younger workers – particularly male workers
- Have a greater propensity for impairments associated with aging, such as back conditions
- Have longer recovery/healing times from injury and suffer more, and more significant, permanent impairments from injury than younger workers
- May have greater difficulty obtaining post-injury employment than younger workers

While an aging workforce is most likely to result in a reduction in the overall number of lost time injuries, it's also anticipated that for this population:

- the average duration of the injury recovery period will rise and,
- the percentage of injuries resulting in a permanent impairment of some type will increase.

The impact on overall benefit costs will be more ambiguous as any increase in the duration of benefit payments and/or in benefits related to permanent impairments should be offset to some degree by the overall reduction in the number of lost time injuries.

## 1.4 Value for Money Audit Context: External Contextual Factors *(Continued)*

**Industrial Relations:** Individual RTW outcomes can be impacted by labour relations policies and practices at the injury employer and/or the socio-economic circumstances of the injured worker. The extent to which the employer and the worker have a positive relationship in any given situation contributes to the success of return to work.

**Health Care Service Delivery & Costs:** Finally, the overall success of the program is also influenced by the health care system within which the program must operate. In particular, delays in access to medical services can effect the cost and efficiency of program processes. Ongoing health care cost inflation has outpaced general inflation in recent years, in particular with respect to prescription drugs and puts upward pressure on program costs.

## 1.4 Value for Money Audit Context: Cultural Factors

The review considered several key cultural factors that influence the environment in which the WSIB's adjudication system operates within, including:

- Historically the principles of recovery and return to work have been paramount to the operation of the system. The no-fault approach was intended to remove litigation, simplify and speed up the adjudication of workplace injury issues, and facilitate the focus on recovery and return to work. What has become increasingly apparent is the shift in focus and resources to securing benefits or minimizing cost liability through inefficient litigious means. This has given rise to multiple stakeholders representing both employers and workers whose economic interests are in direct competition and detract from achieving the principles of recovery and return to work.
- This litigious culture has placed pressure on the WSIB to extend decision making timelines to respond to ever-increasing demands by the representative community to ensure that all possible evidence is gathered and considered as part of the decision making process. The representative community is highly focused on ensuring that their constituency's economic interests are well-served by the WSIB. These observations were consistent in previous value for money audits conducted on the Appeals Process (2008) and Labour Market Re-entry (2009). Ontario is unique compared to other Canadian jurisdictions in the level of representative involvement in the decision making process.
- The pressure on the WSIB and resources required to react to stakeholder demands, both at the corporate level and at the individual claim adjudication and case management level, is significant. In part, this was the result of a shift in focus from customer service to customer satisfaction in the post-1998 period. This subsequently led to policies and decisions being applied or designed to balance stakeholder interests, but ultimately with adverse impacts on the achievement of recovery and return to work objectives.

## 1.4 Value for Money Audit Context: Cultural Factors *(Continued)*

- The combination of WSIB’s legislative and policy framework creates a level of complexity that gives rise to multiple opportunities for disagreement and adjudicative reviews. The lack of clarity and simplicity in the rules undermines administrative efficiency and makes it difficult to bring finality to a claim. This creates a “faint hope” moral hazard.
- The WSIB stakeholder environment includes a large representative community (both worker and employer) with conflicting interests and perspectives on the role of the WSIB, the economic entitlements of injured workers and the responsibilities of employers. This has driven stakeholder demands that have resulted in a broadening of the WSIB mandate to address limitations in other areas of public policy, such as employment and disability policy, and the broader labour policy challenges associated with an aging workforce. This expanded mandate creates a social dependence that makes it more difficult to bring closure to individual cases.

## 1.4 Value for Money Audit Context: Fundamental Principles & Objectives

Fundamental to the WSIB becoming a leading practice organization is the adoption of several key principles of disability prevention. The guidelines\* contained in the American College of Occupational and Environmental Medicine (ACOEM) paper on Disability Prevention provide a synthesis of current leading practice that are foundational for this change. Some of the key principles in the paper are as follows:

*“Only a small fraction of medically excused days off work is medically required – meaning work of any kind is medically contraindicated. The remaining days off work result from a variety of non-medical factors such as administrative delays of treatment and specialty referral, lack of transitional work, ineffective communications, lax management and logistical problems. ...Participants in the disability benefits system seem largely unaware that so much disability is not medically required.”*

*“Early intervention is the key to preventing disability...the odds of a worker ever returning to work drop by 50% by just the 12<sup>th</sup> week.”*

*“Unnecessary prolonged work absence can cause needless, significant harm to a person’s well-being. While on extended disability many patients lose social relationships with co-workers, self-respect that comes from earning a living, and their major identity component – what they do for a living. Many key players in the Stay at Work/Return to Work (SAW/RTW) process do not fully realize the potential harm that prolonged medically excused time away from work can cause. Many think that being away from work reduces stress or allows healing and do not consider that the worker’s daily life has been disrupted. With these attributes, system-induced disability becomes a significant risk.”*

*\*ACOEM Guideline: Preventing Needless Work Disability by Helping People Stay Employed*

# 1.4 Value for Money Audit Context: Fundamental Principles & Objectives

(Continued)

The review also considered the fundamental principles that shape the WSIB and its service delivery objectives and models. The value for money generated by the program is in large part a function of the extent to which the program is designed and administered in a manner that is aligned with these principles.

Research conducted for the purposes of the review identified a number of fundamental performance objectives with respect to both the broader workplace compensation system and the adjudication and administration of individual claims. Fundamental system-level objectives, which are embedded in the purposes of the *WSIA*, would include:

- Minimizing the incidence of workplace injuries and illness
- Maximizing return to work and recovery outcomes
- Ensuring the fairness and equity of benefits as defined by the legislation
- Clear eligibility criteria and decision making rules
- Ensuring that system resources are applied through a risk-based framework
- Ensuring appropriate levels of customer service

The fundamental principles that relate to the adjudication and administration of individual claims are as follows:

- Fair and equitable outcome for all parties is for the worker to recover as fully as possible, and an early and safe return to his or her pre-injury job at full wage as quickly as possible
- Every effort should be made to alleviate the economic burden of the injury from the injured worker as quickly as possible in particular to allow the worker to focus on recovery and return to work efforts
- Return to work is most likely to occur at the pre-injury workplace and is an element of the recovery process, not a consequence of that process, so an integrated recovery/return to work plan should be executed
- Return to work will most generally occur within the first 3-6 months post-injury. Research suggests the probability of successful return to work drops significantly after that 3-6 month period has elapsed
- Behaviour of all parties will be driven to a considerable extent by the structure of incentives created by the claim administration process – where incentives exist, whether intentional or unintentional, the various parties will act to take advantage of these incentives

## 1.4 Value for Money Audit Context: Leading Practice

The vision for a leading practice ACA Program would be to optimize recovery and early and safe return to work opportunities for injured workers and to ensure timely, consistent, fair and accurate decision making within a structure of processes and procedures that maximize program efficiency and minimize program costs.

While there is no authoritative leading practice with respect to the design of an ACA Program, research conducted for the purposes of the report and comparison with other Canadian jurisdictions identified a range of potential leading practice, such as:

- Policy development and management framework that ensures ongoing review and renewal of policies to give clear, concise and consistent direction to WSIB staff and stakeholders
- Implementation of a formal case management approach that is consistent with relevant leading practice principles
- Processes, procedures and information systems that focus resources on high-risk claims and complex case management activities
- Systems and tools that automate routine administrative tasks and that provide flexible and adaptable support for non-routine tasks
- Management oversight and continuous improvement processes supported by effective real-time, outcome-focused performance monitoring and reporting

## 2.0 DETAILED REVIEW: FIVE DECISION POINTS

## 2.1 ACA Program: High Level End to End Overview

Each claim submitted to the WSIB is received and registered in the Central Claims Processing (CCP) area. If submitted electronically by the employer, claims that require no lost time from work, and are simple and straightforward, can be system (or auto) adjudicated. All other straightforward claims, including those reported as having lost time from work, which can be allowed are adjudicated by a Primary Adjudicator. More complex claims, such as those with significant delays in reporting or where entitlement might not be granted, are adjudicated by an Eligibility Adjudicator.

If a return to work is not indicated at the time of the eligibility decision, the case moves to a Case Manager specializing in short term case management. Additional resources, such as that of a Nurse Consultant and Return to Work Specialist, assist in the recovery and return to work activities.

Cases where return to work has not been achieved and the worker has a permanent impairment are managed by a Case Manager specializing in long term case management. These Case Managers work with Nurse Consultants to assist with the worker's recovery and with Work Transition Specialists to assist with return to work with the accident employer or with activities to secure work with a new employer, where required.

Key case management decisions in the life of a case include:

- establishing whether a permanent impairment has resulted from the injury, and a Non Economic Loss (NEL) award assessment is required, and
- entitlement to ongoing loss of earnings (LOE) benefits, including a decision at 72 months post-injury as to what amount the worker's LOE should be locked-in at until age 65.

A number of specialty teams are also in place within the ACA Program to assist with specialized decision making, including decisions regarding recurrences of an injury or entitlement to SIEF relief, where a pre-existing condition is delaying recovery.

## 2.2 ACA Program: Methodology

Decisions made within the ACA Program span a wide spectrum of entitlement considerations. Each year WSIB staff make well over a million adjudicative decisions including – but not limited to – initial claim entitlement, setting of wage loss benefits, health care and return to work.

In order to provide an audit opinion on the effectiveness and efficiency of the ACA Program, the VFMA undertook a detailed analysis of five key decision points in the life of a claim. These decision points were selected by the WSIB for review based on their complexity, associated cost factors and critical importance in the adjudication process and included:

- Initial Entitlement Decisions (Eligibility)
- Recurrence Decisions
- Second Injury Enhancement Fund (SIEF) Decisions
- Non Economic Loss (NEL) Decisions
- Loss of Earnings (LOE) 72 month Lock-in Decisions

The findings gathered from this analysis informed the VFMA's recommendations regarding the ACA Program's overall effectiveness and efficiency, while also identifying opportunities for improvements within each of the five key decision points themselves.

## 2.3 Eligibility Decision

### OVERVIEW

The Eligibility Branch (EB) was created in September 2008 as a critical component of the NSDM. The EB was phased in across the eight WSIB Offices from September 2008 to March 2009 and currently delivers services through approximately 170 Eligibility Adjudicators (EAs).

The EB receives cases from either Primary Adjudication or through CCP. A total of 20 Primary Adjudicators decide the most straightforward cases. EAs decide more complex adjudication claims. This includes disablement cases, claims where conflicting information needs to be resolved, and situations involving problematic causation issues.

In recent years, the WSIB has introduced through the NSDM a variety of process and system improvements that have increased the efficiency of the ACA Program, including the introduction of automated claims registration and adjudication.

A key performance measure for the EB is the percentage of claims for which eligibility decisions are rendered within 14 days of claim registration. The performance objective is 85% of claims decided within 14 days of registration.

A second key performance measure is the quality of adjudication decision making – i.e. the extent to which decisions are made fairly, accurately, and consistently within the scope of legislation and policy. To monitor this performance measure, the EB has instituted a Manager Quality Assurance Program under which managers review a sample of decisions each month and provide feedback and direction to EAs.

## 2.3 Eligibility Decision Findings

### STRENGTHS

The average time to render an initial eligibility decision has decreased since the introduction of the EB – e.g. the percentage of decisions made within two weeks from the claim registration date was 87% in 2010. This is a significant improvement from the 65% rate in 2008. This supports earlier return to work efforts by the workplace parties and the WSIB.

There has been greater consistency and quality in eligibility adjudication. In 2010, 11.3% of registered claims did not meet eligibility criteria, as compared to 2009, where 7.9% of registered claims did not meet eligibility criteria. This reduction can be attributed primarily to three things. First, eligibility adjudication is now done by 170 EAs with specialized training, compared to over 800 consolidated adjudicators under the previous service delivery approach. Second, the level of management oversight has been significantly improved. In 2010, eligibility managers reviewed over 48,000, or 23% of the close to 210,000 eligibility decisions made and provided regular feedback on quality and consistency of decision making. Third, decision making for SIEF relief was segregated to a separate team to ensure the independence of these decision making functions.

## 2.3 Eligibility Decision Findings *(Continued)*

### POLICY ISSUES

Within the Eligibility policy suite two policies were identified in this audit as needing to be addressed:

**Aggravation Basis Policy (11-01-15)** This is a companion document to the SIEF policy and was intended to limit entitlement to only the portion of impairment that is work-related. Contrary to this intent, application of this policy has extended beyond the acute period of work-related disability. This has provided for entitlement to benefits for relatively minor work-related injuries which are considered to have aggravated a pre-existing condition. This problem arises especially in cases where the pre-existing condition is age-related (e.g. degenerative disc disease in the low back). In those cases, it is very difficult to separate out the work-related impairment from the permanent age-related impairment because the pre-existing condition continues to deteriorate with age. This results in WSIB payments continuing beyond what was envisioned by the policy. The policy should be revised.

**Employers Initial Accident Report Obligations (15-01-02)** Timely and complete reporting is important to the return to work and recovery process, and untimely reporting can result in unfair delays in benefit payments and additional costs resulting from interest payments. This policy requires employers to notify the WSIB of a work-related injury within seven business days of occurrence and confirms the levying of a \$250 penalty in cases of late or incomplete reporting. The *WSIA* stipulates a reporting period of three days but the actual timeframe for reporting is currently averaging 19.3 days. The use of the current \$250 penalty has not proven to be an effective deterrent to late reporting of injuries.

## 2.3 Eligibility Decision Findings *(Continued)*

### IMPROVEMENT OPPORTUNITIES

The WSIB has introduced an auto-adjudication capability as part of the rollout of phase one of its eBusiness/eRegistration plan. Auto-adjudication enables automated, system-based adjudication of non-complex claims and thereby focuses manual decision making on the more complex eligibility cases. The number of claims auto-adjudicated has been considerably less than the target of 70% set by the WSIB for NLT injury claims. In 2010, approximately 30% of NLT injury claims were auto-adjudicated, which is in part due to lower than expected uptake of web-based employer claim registration. This results from design issues and usability problems with the eForm 7. For those reasons, there is significant under-utilization of the eForm 7 and a significant missed opportunity to expand auto-adjudication. Auto-adjudication could be improved by:

- Redesigning the eForm 7 and increasing the technical capabilities of the WSIB eBusiness platform
- Increasing the breadth and scope of auto-adjudication by expanding the criteria to include a greater number of uncontested injury claims
- Creating incentives to encourage electronic registration of claims by employers

With an expanded auto-adjudication process, the Primary Adjudication function could be discontinued, resulting either in a savings or redeployment of resources to higher value work.

## 2.3 Eligibility Decision Findings *(Continued)*

### OVERALL ASSESSMENT

The introduction of the EB has improved both the efficiency and effectiveness of initial eligibility decision making.

Efficiency improvements have in part reduced the interest costs associated with delays in the payment of benefits and have contributed to improved return to work outcomes in the early stages of claims. Interest payments to injured workers in 2010 (\$12.7M) were \$9M less than in 2009 (\$21.8M). A significant portion of this savings can be attributed to earlier eligibility decisions.

The value generated by the EB could be enhanced through revisions to key policies (Aggravation Basis, Accident Reporting) that will support more consistent decision making. Improvements to eRegistration capabilities and the expansion of auto-adjudication will provide efficiencies in the form of potential administrative savings.

## 2.4 Recurrence Decision

### OVERVIEW

The Recurrences (REO) Team was established in February 2009 with full rollout of the team completed by January 2010. The team removes complex entitlement decisions related to recurrences and entitlement following work disruptions from the Case Managers in order to allow them to concentrate more fully on recovery and return to work related activities.

The objective of the team is to provide accurate, consistent and timely decisions for claims involving recurrences and work disruptions. Team performance objectives focus on the decision making process and include specific key performance indicators related to the timeliness of decisions (rendering decisions within 14 days of referral to the team) and the accuracy and consistency of decisions (90% of decisions are 100% correct).

Cases are referred to the team from the responsible Case Manager if the circumstances of the case are consistent with the team referral criteria. Team adjudication staff review the case for benefit entitlement either as a recurrence or due to a work disruption and render and communicate a decision. The team rendered over 7,200 decisions in 2010 with a complement of 20 decision makers.

## 2.4 Recurrence Decision Findings

### STRENGTHS

Recurrence decisions are highly technical eligibility decisions – internal decision reviews/audits conducted by team management indicate that the focused team is resulting in high quality decisions being rendered, i.e. consistent and accurate application of relevant policies.

Removal of the responsibility for complex recurrence decisions allows Case Managers greater flexibility to focus time and effort on critical recovery and return to work efforts and activities.

The number of active re-opened claims has fallen from 5,082 in December 2009 to 3,475 in December 2010, reflecting in part greater consistency and quality in the application of allowance criteria for recurrences.

Turnaround times for recurrence decisions was 16 days in 2010. No reliable baseline data exists for previous years however, the 16 days came close to meeting the 14 day target established for this work.

## 2.4 Recurrence Decision Findings *(Continued)*

### POLICY ISSUES

Recurrence decisions are guided by several key policies: Recurrences (15-03-01) and Entitlement Following Work Disruption (15-06-01 to 15-06-05). Approximately 75% of the decisions are made under the Recurrences Policy while the remaining 25% are made under the Entitlement Following Work Disruption Policies. These policies are overly complicated and difficult to apply consistently to different fact situations. In addition, the language of the policies has been used to expand coverage to economic circumstances rather than disability-related circumstances. In particular:

- **Recurrences Policy (15-03-01)** The intent of this policy is to ensure that workers who have returned to work and experience an increase in symptoms related to the original injury are provided benefits. Similar to the challenges with the Aggravation Basis Policy, this policy can give rise to an expansion of entitlement by covering increased symptoms related to the aging process. In addition, the operation of the Experience Rating window (e.g. three years for NEER Program) and the lack of a time limit for recurrences to re-enter the system, creates an incentive for employers not to contest the allowance of recurrences at later durations of a claim. It is to the benefit of employers to have these cases treated as recurrences rather than as new injuries. However, this can act to the detriment of a worker who may lose out on return to work opportunities that otherwise may have been provided. This dynamic has the effect of reducing the natural checks and balances in the system for disciplined decision making.
- **Work Disruption Policies (15-06-01 to 15-06-05)** The intent of these policies is to address situations where injured workers are disadvantaged in the labour market because of their work-related impairment. In practice, these policies can act to the advantage of an injured worker over a non-injured worker. For example, in cases of strike, lockout or seasonal layoff, where many non-injured workers would remain off work awaiting a recall, injured workers are entitled to receive full LOE benefits.

## 2.4 Recurrence Decision Findings *(Continued)*

### IMPROVEMENT OPPORTUNITIES

The REO Team has brought improved discipline and oversight to recurrence decisions, however significant improvement opportunities exist through structural change and improvements to policy. Structurally aligning the recurrence decision making with initial entitlement would allow for a more comprehensive review of the eligibility issue and would lead to greater consistency in outcomes. Efficiencies and savings could be achieved by better utilization of resources and the elimination of hand-offs between decision makers.

Recurrence decisions would be further enhanced through revisions to key policies to support more consistent decision making. It would also provide greater clarity to decision makers, particularly with respect to circumstances where the worker's injury is not the cause of the layoff or work disruption. This would also bring the policy in line with the intent of the legislation.

### OVERALL ASSESSMENT

Through its specialized focus, the REO Team has generated some value in the making of recurrence decisions. However, significant opportunities to improve efficiency and effectiveness in this critical area of decision making exist as identified above.

## 2.5 Second Injury Enhancement Fund Decision

### OVERVIEW

SIEF relief is granted to employers in cases where a worker's prior disability caused or contributed to the compensable accident, or if the period of disability resulting from an incident becomes prolonged due to a pre-existing condition. All or part of the compensation and health care costs may be transferred from the accident employer in Schedule 1 to SIEF. There is no actual "fund". Costs relieved under the application of the SIEF policy are removed from an individual employer's cost experience but are absorbed by the system as a whole, impacting costs for all Schedule 1 employers. As a result, individual employers in the NEER and CAD-7 experience rating programs are strongly motivated to apply for cost relief.

Ontario is the leading Canadian jurisdiction for granting SIEF relief. In 2007 over 30% of all claim costs were relieved through SIEF for the eight most recent injury years. Conversely, in 2010, this number was just under 25%.

In an effort to improve the quality and consistency of SIEF decisions, a centralized dedicated team was established in September 2009 with a mandate to ensure greater consistency and accuracy in decision making. Prior to this, decisions regarding SIEF were made by all Eligibility Adjudicators and Case Managers within the ACA Program. The SIEF Team includes 13 SIEF Case Managers. In 2010, the team made a total of 11,488 decisions. Of those decisions, 2,732 or 24% were allowed.

SIEF relief applications are received by the Case Manager responsible for the relevant claim and referred to the team for review and decision. The team has established a number of performance objectives and metrics associated with its mandate, including objectives related to decision making timeliness, consistency and accuracy and the costs associated with SIEF decisions. With respect to the decision making process, the team has established several process efficiency performance indicators:

- Acknowledgement of requests within 3 days of referral
- Review of initial requests within 12 weeks of referral
- Review of reconsiderations within 30 days of receipt

## 2.5 Second Injury Enhancement Fund Decision Findings

### STRENGTHS

The creation of a specialized adjudication team with improved training and oversight has led to improved efficiency and better discipline being exercised in the adjudication of SIEF cases:

- At the end of 2009, there was a large inventory of 2,444 cases waiting to be decided. By the end of 2010, the inventory of outstanding cases was reduced to 377.
- The average relief granted for decisions allowed in 2010 was 49.3% compared to an average of over 66% for decisions over the previous three years.
- 34% less cost relief was granted in 2010 compared to 2009, which represents a \$108M savings compared to 2009.

## 2.5 Second Injury Enhancement Fund Decision Findings *(Continued)*

### POLICY ISSUES

The current SIEF policy has not had any substantive changes since 1978. The original intent of the SIEF policy was to encourage employers to hire workers who suffered previous injuries by providing assurance to the new employer that they would not be required to absorb the entire cost related to a new workplace accident where the prior injury interfered with or delayed recovery. Currently, the policy provides for transfer of all or part of the compensation and health care costs from the accident employer to SIEF where a prior disability caused or contributed to the compensable accident, or if the period resulting from an accident becomes prolonged or enhanced due to a pre-existing condition. Approximately 80% of SIEF claims relate to the pre-existing condition component of the policy. SIEF relief applies only to Schedule 1 employers. The most common usage of the policy relates to circumstances of low back injury where a worker has a pre-existing age-related degenerative disc disease. Given an aging workforce, SIEF has become overused and no longer operates to incent employers to hire previously injured workers.

Since an aging workforce is an issue affecting all employers, a more optimal approach would be to spread the risk of longer durations for older workers to all employers equally and discontinue the application of SIEF to specific instances of age-related duration risk.

Key issues include:

- The policy creates perverse incentives with respect to return to work with the injury employer as, once relief is granted, the cost to the employer of not re-employing the worker is significantly reduced. Thus, the policy as currently designed and applied effectively reduces the incentive and opportunity for return to work with the injury employer.
- The policy as it is currently written includes terminology around “Minor/Moderate/Major” with respect to the significance of the pre-existing condition and severity of the accident that are not sufficiently defined and difficult to apply consistently to specific fact situations.

## 2.5 Second Injury Enhancement Fund Decision Findings *(Continued)*

### OVERALL ASSESSMENT

The SIEF Team has improved decision making efficiency and encouraged more appropriate and consistent application of the SIEF policy and thereby reduced the level of SIEF relief granted.

Segregation of duties – i.e. separation of decision making authority with respect to granting of initial worker entitlement and granting of SIEF relief – has largely eliminated the previous practice of using SIEF relief as a case management strategy to avoid employer objections to worker entitlement and thereby improved the overall effectiveness of the ACA Program.

Despite these improvements, the policy remains very broad and will continue to give rise to litigation and dispute if it is not appropriately revised. The SIEF policy as currently designed and applied is not consistent with the first principles of recovery and return to work and thereby reduces the overall value generated by the ACA Program and related claims administration and adjudication process.

Revising the SIEF policy and narrowing its application would also create administrative savings and/or allow for the re-deployment of critical case management resources to other high value work across the ACA Program. In so doing, it would also strengthen employer accountability for return to work and leave the broader issue of employment hiring practices to be managed by existing disability and human rights legislation.

## 2.6 Non Economic Loss Decision

### OVERVIEW

The Non Economic Loss (NEL) Branch makes decisions on entitlement to NEL Awards. A NEL Award recognizes a Permanent Impairment (PI) resulting from a workplace injury or illness. A worker is assessed for the award when the Case Manager determines they have reached MMR, with evidence of impairment and refers the file to the NEL Branch.

NEL Branch staff will first determine if the PI Assessment can be completed based on the medical information on file (“rate by file”). If the medical information on file is insufficient, the injured worker will attend a NEL Medical Assessment either at a Regional Evaluation Centre (REC) or with a doctor chosen by the worker from a list of physicians provided by the WSIB.

The amount of the NEL Award is determined by the NEL Branch having regard for the level of PI, base amount of the award provided under the *WSIA* and the age of the worker at the time of the injury. The NEL decision is made using the American Medical Association’s (AMA) Guide to the Evaluation of Permanent Impairment 3<sup>rd</sup> Edition.

The NEL Branch currently operates with 36 staff and reviewed over 21,000 claims in 2010.

## 2.6 Non Economic Loss Decision Findings

### STRENGTHS

The re-engineering of NEL business processes in 2008 and 2009 have resulted in a number of efficiencies including:

- In PIs where the information can be rated “by file” (no additional medical assessment required), the average time to complete a NEL determination has decreased from 16 weeks to 3 weeks. Referral out for a REC assessment adds 10 weeks to the end-to-end duration.
- By moving to “by file” ratings, the cost of external assessments has gone down by a cumulative total of \$3.2M over 2009 and 2010.
- The use of RECs to assess musculoskeletal injuries provides more accessible, timely and efficient assessments of PIs than those previously provided by the WSIB’s roster of external physicians. RECs now account for 80% of all external NEL assessments. Customer satisfaction with REC NEL assessment services is extremely positive with 87.5% of workers reporting a high rate of satisfaction with the service. The WSIB continues to access a roster of specialized physicians to assess a smaller number of more complex injuries.
- The inventory of claims awaiting an external assessment has been reduced from approximately 9,000 in 2008 to 2,300 at the end of 2010. The number of claims with a completed assessment and awaiting a NEL Award decision fell from approximately 3,500 to approximately 1,200 over the same period.

## 2.6 Non Economic Loss Decision Findings *(Continued)*

### POLICY & LEGISLATIVE ISSUES

NEL decision making process is guided by three policies: Determining the Degree of Permanent Impairment (18-05-03), Calculating NEL Benefits (18-05-04) and Redeterminations and Recalculations (18-05-09).

Existing policy is found to provide for adequate guidance and direction as related to the rating of PIs. However current regulation requires the use of the AMA Guide 3<sup>rd</sup> Edition to conduct PI Assessments, which presents a number of issues. The guide is:

- 15+ years old and medically out of date
- not user friendly or easily understood by non-medical professionals
- not specific to occupational injuries

Legislation provides the worker with the right to request a redetermination of his or her PI Assessment a minimum of 12 months after the previous assessment. This short minimum period results in the re-assessment of over 2,000 cases annually, impacting on both the efficiency and effectiveness of the program.

## 2.6 Non Economic Loss Decision Findings *(Continued)*

### IMPROVEMENT OPPORTUNITIES

The overall efficiency of the NEL Branch is highly dependent on efficient and effective case management, in particular the timely determination of MMR and potential NEL Award eligibility and the collection of medical information capable of facilitating a paper-based review throughout the life of the claim.

In particular:

- Improvements could be made in the average time to NEL referral, particularly through the improved management of more complex cases.
- WSIB collection of medical information is heavily paper-based and lacks the capability to collect and share medical information electronically with authorized parties.
- To mitigate risks associated with these cases, oversight should be provided over the PI decision.

Outcomes in Ontario with respect to PIs are not consistent with peer organizations. In particular Ontario grants:

- a higher proportion of NEL Awards relative to lost time injuries compared with the WSIB's peer organizations
- a higher average NEL Award percentage compared to the WSIB's peer organizations (Ontario: 14.6%; Alberta: 9.6%; BC: 9.1%; Quebec: 8.7%)\*

The differences between Ontario and peer organizations appear to relate more to the use of the AMA Guide 3<sup>rd</sup> Edition than to the severity of injury. The WSIB should consider creating its own rating schedule, much like other provinces have done. This would bring greater consistency, transparency and fairness to the rating of PIs.

In addition, Case Managers would benefit from improved skills development in relation to determining MMR and identifying claims where a PI is likely.

\* Source: Financial Data & Key Statistical Measures - published by the Association of Workers Compensation Boards of Canada.

## 2.6 Non Economic Loss Decision Findings *(Continued)*

### OVERALL ASSESSMENT

Changes in recent years have contributed to efficiency gains in the NEL process. However, further opportunities for improvements exist in relation to the rating schedule used to assess PIs and the effectiveness of Case Managers in making timely decisions on MMR and referrals for PI Assessments.

Inter-jurisdictional research on peer organizations identified a variety of factors to drive improvements in efficiency and effectiveness, specifically in the tools used in the NEL process. In addition, the electronic exchange of medical information with authorized professionals (e.g. RECs) would improve the overall efficiency of the NEL process by reducing the number of resources required to support the current paper-based rating process. Improved overall collection of medical information over the entire life of the claim would increase the proportion of claims that can be “rated-by-file” thereby reducing cost and improving decision making timeliness.

## 2.7 Loss of Earnings Lock-In Decision

### OVERVIEW

LOE benefits are paid as long as the worker continues to experience a wage loss related to the compensable injury. Under the *WSIA*, WSIB will render a final decision on LOE benefits and lock this level of benefits to age 65 no later than the end of the 72<sup>nd</sup> month (six years) from the date of injury, unless the 72 month mark occurs while the worker is in a work reintegration or formal return to work program.

The first lock-in decisions under the *WSIA* commenced in 2004 and approximately 3,200 claims have been locked-in annually since that time. Of these, approximately 45% have been locked in at 100% LOE. As a group, these claims represent the most costly claims in the system and exert the biggest impact on the WSIB's funding status of any claims in the system. Cases that reach the final review stage also tend to be among the more complex cases managed by the system, involving higher rates of prior claims, worker appeals and chronic pain disability or psychological impairment than the general claim population. The most important external driver of lock-in volumes is the success of return to work efforts. Most lock-in cases result from the inability or unwillingness of the accident employer to provide sustainable work that is consistent with the injured worker's post-accident vocational and physical abilities.

The LTCM Program was established to improve the management of long duration claims, through improved return to work and recovery outcomes. To achieve its objectives, the program has implemented oversight measures that include an annual review of LOE cases and an approval process for the 72 month reviews.

The lock-in decision is administered by approximately 370 Long Term Case Managers as part of their broader case management responsibilities with the oversight and approvals being completed at the Manager, Director, Executive Director and Vice President level, depending upon the particular circumstances of the claim subject to the review.

## 2.7 Loss of Earnings Lock-In Decision Findings

### STRENGTHS

The introduction of the LTCM role, and increased emphasis across the ACA Program on work reintegration, have significantly strengthened the LOE lock-in decision process.

In particular:

- In 2009-2010 staff were provided with updated skills development, focused on the introduction of improved case management practices and reinforcing key legislative and policy requirements.
- Long duration claims are now subject to more extensive case planning and oversight – including review at time of file transfer to Long Term Case Manager, annual reviews and management approval in specific cases (e.g. 100% lock-ins for those under the age of 50).
- Outcomes for 2010 show that 27.6% fewer workers needed the full 100% loss of earnings replacement at 72 months compared to 2009.
- The average annual benefit payment to workers being locked-in at the statutory six year mark in 2010 was \$15,624. This compares to the average payment of \$21,144 for the pool of locked-in benefits per worker for all previous years.

The rollout of the WSIB's Work Reintegration Program in 2010, and the provision of more intensive and worker focused RTW services in LTCM cases, should contribute to further improvements in LOE lock-in decision making.

## 2.7 Loss of Earnings Lock-In Decision Findings *(Continued)*

### POLICY ISSUES

Long Term Case Managers are responsible for managing the application of a variety of policies related to the ongoing provision of LOE benefits and the final review and LOE lock-in decision. Two policies essential to the activities of the LTCM team with respect to the lock-in of LOE benefits are Final LOE Benefit Review (18-03-06) and Calculating CPP Offset (18-01-13).

Current policies guiding LOE lock-in decisions are considered to provide appropriate direction for fair and consistent decisions. However, the policies could be strengthened to support improved efficiency and savings in cases involving CPP offset. Legislation contemplates that CPP benefits paid to a worker in relation to the same disability as the one for which a worker receives WSIB LOE benefits will be taken into account when determining the level of LOE benefits to be paid. However, WSIB's policies do not permit the WSIB to adjust LOE benefits for any CPP granted after the 72 month lock-in even where such benefits are granted retroactively to a period prior to the date of lock-in. This creates an incentive for delaying application for CPP benefits until after the 72 month review period has expired and results in unequal compensation for workers depending upon when CPP benefits are awarded. To be consistent with the intent of the legislation with respect to CPP offset, WSIB policy should enable the adjustment of benefits regardless of when CPP is awarded.

LOE lock-in policies could also be strengthened by requiring that a worker applies for CPP benefits in cases where the worker presents themselves to the WSIB as unable to work.

## 2.7 Loss of Earnings Lock-In Decision Findings *(Continued)*

### IMPROVEMENT OPPORTUNITIES

The effectiveness of the lock-in process is heavily dependent upon efficient and effective case management practices and, in particular, the effectiveness of efforts to identify and actively manage higher risk claims and the efficacy of recovery and return to work efforts at earlier stages in the claims administration process.

Long Term Case Managers currently manage a caseload consisting of claims where both the final LOE determination has been made, and those still in the active return to work and recovery phase. The business and client needs of each stream are different, and a separation of the two would allow for improvements in the efficiency and effectiveness of the delivery of LTCM services, including those activities leading to the final LOE lock-in decision.

Also of note is the fact that lock-in rates were approximately 2.5 times higher for Schedule 1 employers than Schedule 2 employers for those claims originating from 1998-2003 and reaching lock-in between 2004-2009. A reasonable inference can be drawn that part of this difference is driven by the direct financial incentive on Schedule 2 employers to secure sustainable return to work outcomes for injured workers. While the WSIB's recently announced policy change to expand the NEER window to four years is a positive step in the right direction, further changes to the WSIB's experience rating programs are likely required to improve LTCM outcomes for injured workers and to drive LOE costs down.

## 2.7 Loss of Earnings Lock-In Decision Findings *(Continued)*

### OVERALL ASSESSMENT

Improved work reintegration approaches, supported by enhanced case management practices and better management oversight, have resulted in a reduction in both the number of 100% LOE lock-in awards and the actual wage loss percentage of partial awards granted.

Continued and enhanced focus – for example, through better identification and management of potential high risk claims, continued improvements in periodic case management reviews and ongoing strengthening of management oversight and review – will generate significant benefit savings for the WSIB over the longer-term and will improve recovery and return to work outcomes for injured workers.

The value generated by the program could be enhanced through a number of avenues, including:

- Establishing a dual work stream model within LTCM with one work stream focused on cases where adjusted LOE determinations have been made and the second focused on cases requiring active management to improve recovery and return to work outcomes.
- Making policy changes to create incentives for Schedule 1 employers to reduce the number of claims ultimately resulting in LOE benefit lock-in – e.g. increasing the financial responsibility of Schedule 1 employers for these claims by extending the experience rating windows (for both the NEER and CAD-7 incentive programs) to match the 72 month lock-in.
- Making policy changes that would require workers claiming to be unemployable to apply for CPP disability benefits and allowing the WSIB to adjust benefits to take into account any CPP disability award that is payable for any period prior to lock-in. This would promote greater fairness among injured workers and would be aligned with the intent of the legislation.

## 3.0 VALUE FOR MONEY AUDIT OPINION

## 3.1 Value for Money Audit Opinion

The ACA Program provides value for money. The value generated by the program is evidenced in its ability to achieve positive return to work and recovery outcomes for the majority of injured workers, with 87% of all lost time claims being resolved within three months of the injury date. This outcome is achieved while adjudicating large volumes of new claims annually, providing ongoing service to workers and employers for existing claims, and maintaining administrative costs that are consistent with comparator organizations. All of this occurs within a complex legislative framework which includes the administration of three distinct benefit schemes and the provision of compensation and services to a diverse stakeholder group.

The value for money generated by the program has been enhanced through a variety of recent reforms, in particular, the introduction of the New Service Delivery Model (NSDM) as evidenced by the early success observed in short term claim durations and the five decision making areas reviewed for the purposes of this report. These reforms have improved return to work outcomes and the quality, consistency and speed of decision making during the period under review. Major indicators of improvement are:

- 87% of all eligibility decisions are made within 14 days of claim registration compared to approximately 65% in 2008
- More timely decision making is associated with improved return to work outcomes in the early durations of a claim. From 2009 to 2010, the percentage of workers returning to work improved at 3 months, 6 months, 12 months and 24 months post-injury. This demonstrates the importance of resolving the eligibility issue quickly so that the focus can be placed on return to work. These earlier return to work outcomes appear to lead to more sustainable employment as suggested by the reduced number of active recurrences in December 2009 (5,082) compared to December 2010 (3,475).
- Improved work reintegration efforts in longer duration claims resulted in a reduction of the proportion of claims requiring full LOE benefits at lock-in. In 2009, 42% of lock-ins were awarded full wage loss while only 30% required full wage loss for cases locked-in in 2010.
- Ontario has the highest rate of SIEF relief in any Canadian jurisdiction. This has had a negative impact on return to work. In late 2009 the WSIB began to address the overuse of SIEF and by 2010 34% fewer costs were relieved than the previous year. The \$108M reduction in total relief incented employers to take injured workers back to work and contributed to the improved return to work outcomes, especially for the shorter duration claims.

## 3.1 Value for Money Audit Opinion *(Continued)*

In spite of these improvements, a number of efficiency and effectiveness improvements are available across the ACA Program and are reflected in the various report recommendations. In particular:

- The current legislative and policy framework introduces significant complexity around issues of eligibility and limits the ability of the WSIB to bring resolution to a claim in a timely fashion. The complex policy framework provides multiple avenues for reconsideration and/or appeal of decisions and/or the reactivation of claims. Therefore, the current framework can encourage extended claim durations.
- The ACA Program has been less effective in managing certain high risk complex claims. Three injury types – low backs, shoulders and fractures – contribute close to 50% of total claim costs. These claims also require a disproportionate level of staff resources. These injury types result in poorer recovery and return to work outcomes.
- The claims administration process has not provided for sufficient discipline with respect to timely case management/claim adjudication decision making which has allowed complex claims to remain active for prolonged periods.
- ACA Program resources have key skill and training gaps and supporting information systems do not support the automation of key program processes and do not include critical case management functionality.

The report's conclusion is that while the recent improvements to the design of the program have increased its value by improving return to work and recovery outcomes and reducing program costs, additional changes are required in order to maximize program outcomes. The recommendations set out in the following pages are designed to improve administrative efficiency and program outcomes. The recommendations are also intended to build upon and leverage the initiatives currently underway at the WSIB. These recommendations are grouped into the following categories:

- High risk claim identification and management
- Claims administration processes
- Policies
- Resources – skill development and systems support
- Management oversight and performance monitoring

## 3.2 Observations, Conclusions & Recommendations

### High Risk Claims Identification & Management

#### **Observations:**

High risk claims generate a significant amount of resource activity within the ACA Program and represent a disproportionately large share of ACA Program-related benefit costs. ACA Program resources could be better utilized through a more robust front-end risk assessment process. While there is a mechanism in place to stream certain high risk cases to special programs for serious injuries, occupational disease and traumatic mental stress, there is significant opportunity for the WSIB to differentiate other high risk cases based on injury type and other risk factors. In March 2011, a low back program was initiated with phased province-wide implementation by Q4 2011.

The claims administration process has not provided for sufficient discipline around the timeliness of case management and adjudication decision making. More complex, longer duration claims ultimately result in greater WSIB work effort and claim costs.

#### **Conclusions:**

The lack of a high risk claims management process contributes to delays in adjudication decision making, extended claim durations and increased benefit liabilities for complex claims.

A risk assessment and triage function must be introduced at the initial stages of a claim to ensure that high risk or complex cases are given special attention and follow disability prevention leading practice specific to the nature of the injury in order to facilitate return to work and thereby minimize the likelihood of a permanent impairment.

**Recommendation #1:** WSIB should enhance its current case management by developing a comprehensive risk assessment framework to identify all high risk claims and by developing specific processes and procedures to manage these claims more quickly, in order to improve recovery and return to work outcomes and reduce the benefit duration of high risk claims.

**Recommendation #2:** WSIB should establish a new work stream model within the Long Term Case Management (LTCM) Program which differentiates services to high leverage cases from those cases where only maintenance activity is required. For example, claims with adjusted long term LOE benefits would be streamed to a different unit supported by a separate staffing model.

## 3.2 Observations, Conclusions & Recommendations *(Continued)*

### Claims Administration Processes

#### **Observations:**

In recent years, the WSIB has introduced through the NSDM a variety of process and system improvements that have increased the efficiency of the ACA Program, including the introduction of automated claims registration and adjudication processes. Initiatives to automate claim registration and claim management processes have been in progress for the last decade. In spite of this, many processes remain significantly paper-based and routine activities have not been fully automated. A continuing problem relates to the time it takes for the WSIB to receive a report of injury. In 2010, the average time was 19.3 days. Although that timeframe is made higher by Schedule 2 and Occupational Disease claims, which have higher average reporting times than Schedule 1 claims, even when normalized it is significantly above the three day legislative requirement to report. In practical terms, this means a worker could be without benefits or access to return to work assistance for 4-6 weeks. These delays are inconsistent with the principles of disability prevention and are unfair to workers, putting them at a financial disadvantage. Further action is needed to improve reporting and support the principle of early return to work.

Through the course of this audit, additional opportunities to improve the timeliness and/or quality of claim processing and decision making were identified in two key decision making areas – front-end claims administration and the determination of Permanent Impairments (PIs). Key audit observations are as follows:

#### i. Front-End Claims Registration & Adjudication:

- Channels available to register claims are limited and cumbersome. The current Employer's Report of Injury/Illness (Form 7) does not lend itself easily to electronic submission due to the number of fields and does not adequately support long term earnings basis calculations (required under legislation at 12 weeks).
- Auto-adjudication of claims is limited to No Lost Time (NLT) claims and only 30% of such claims filed via eForm 7 are currently auto-adjudicated. This percentage has been based on the rules established through the WSIB's risk assessment, which needs to be revisited. Although 40,000 claims were auto-adjudicated in 2010, there is significant opportunity to expand the use of auto-eligibility. This can be further supported by simpler adjudication rules.

## 3.2 Observations, Conclusions & Recommendations *(Continued)*

### ii. Permanent Impairment Assessments:

- Current mechanisms to collect and share medical information with approved providers to support claims decision making are largely paper-based, time-consuming and resource-intensive.
- Guide used to identify and quantify permanent impairments (American Medical Association [AMA] Guide 3<sup>rd</sup> Edition) is outdated, not easily understood by those outside the medical profession and not specifically intended to deal with work-related disabilities.

### Conclusions:

#### i. Front-End Claims Registration & Adjudication:

- WSIB claims administration processes remain heavily paper-based, which results in administrative delay and extends decision making timelines. In addition, lack of timely reporting on the part of the workplace parties contributes to the overall delays. Delays in reporting, adjudication and management of claims can undermine the worker's wellbeing and increase the likelihood of longer term disability. Time and resources devoted to claim processing activity could be better allocated to more high value, adjudication decision making and case management activities.

#### ii. Permanent Impairment Assessments:

- Changes made by the WSIB to its NEL process in 2009 and 2010 have contributed to efficiency gains. Further opportunities for improvement exist in relation to the effectiveness of the flow of up-to-date medical information to the case manager in order to reduce time delays and improve the accuracy and quality of decision making. In addition, some of the differences between Ontario and peer organizations relate to Ontario's use of the AMA Guide 3<sup>rd</sup> Edition to rate permanent impairments. The guide is out of date, not user friendly and not specific to occupational injuries.

**Recommendation #3:** WSIB should improve the time to registration by enhancing electronic registration channels, and expand the use of auto-adjudication in order to expedite eligibility adjudication and facilitate earlier claims management. WSIB should pursue regulatory and/or policy change to increase the level of the administrative penalty that can be assessed for late reporting and the timeline for reporting.

## 3.2 Observations, Conclusions & Recommendations *(Continued)*

**Recommendation #4:** WSIB should improve the collection of medical information to support more timely decisions on Maximum Medical Rehabilitation (MMR) and improve the accuracy and efficiency of permanent impairment ratings. WSIB should also seek efficiency opportunities to allow for the electronic exchange of medical information with approved providers. WSIB should reassess its application of the AMA Guide 3<sup>rd</sup> Edition, in order to establish easily understood, less generic and more occupational-injury based guidelines to assess permanent impairments using accepted objective standards.

### Policies

#### **Observations:**

The current legislative and policy framework does not encourage the final resolution of claims and provides for multiple opportunities for the reconsideration or appeal of adjudication decisions and multiple avenues for benefit entitlement and premium management. In addition, the complexity of this framework can lead to protracted and delayed decision making which ultimately drives costs and shifts the focus away from recovery and return to work objectives.

The legislative lock-in provisions are contrary to leading practice. There is no clear correlation between the lock-in provisions and leading practice for successful return to work. Ontario is the only jurisdiction in Canada that has a lock-in provision. The original intent was to bring finality to workers and employers. However, what was clear from the stakeholder community was that return to work has often become a secondary objective, while securing long term benefits has become a primary objective. This has resulted in multiple adjudications and appeals, extending the life of claims with negative economic, emotional and social consequences to the injured worker.

The combination of the six year legislative lock-in and the three year NEER experience rating window creates a period between year three and year six post-injury where negative incentives exist for both workers and employers to pursue successful return to work.

The WSIB must review its suite of policies to ensure that they are fully aligned with the first principles of recovery and return to work and support timely decision making. This applies to policies relating to benefits, services and employer incentives. In addition, the WSIB currently lacks a formal policy management framework that would ensure the ongoing review and renewal of policies in the context of first principles.

## 3.2 Observations, Conclusions & Recommendations *(Continued)*

At present, the policy-making process is long and requires multiple stakeholder reviews. As a result, WSIB is unable to adjust policy quickly to reflect changes in its operating environment and/or to address emerging issues. For example, the application of a variety of policies has become more problematic within the context of an aging workforce. In addition, a number of policies are outdated and contain terminology that complicates understanding and application. As a result, policies have become outdated and in a number of cases operate at cross purposes with the objectives of recovery and return to work. As well, policies such as Reimbursement for Health Care Travel and CPP LOE Benefit Offset may contribute to compensation beyond what was contemplated in the legislation.

### **Conclusions:**

The current policy suite introduces significant complexity around issues of eligibility and limits the ability of the WSIB to bring resolution to a claim in a timely fashion. The complex policy suite provides multiple avenues for reconsideration and/or appeal of decisions and/or reactivation of claims. Therefore, the current policy suite can encourage extended claim durations.

The policy making process at WSIB has been strongly influenced by a plethora of competing and conflicting stakeholder demands, including rate relief pressures from employers, benefit expansion pressures from injured worker representatives, and a broadening of the WSIB's mandate to address wider range of disability, employment and employment equity issues.

Various policies have become more problematic within the context of an aging workforce and have contributed to the expansion of cost relief provided to employers and the expansion of eligibility potentially beyond the scope envisioned by legislation.

**Recommendation #5:** WSIB should examine the value of the six year lock-in window in supporting effective return to work and recovery outcomes for injured workers and promoting efficient resolution of claims, and develop an options paper assessing the benefits and costs associated with eliminating this provision to be provided to the government.

## 3.2 Observations, Conclusions & Recommendations *(Continued)*

**Recommendation #6:** WSIB should design a policy renewal framework that ensures the timely identification of policies that are inconsistent with the first principles of recovery and return to work. In addition, the policy framework should focus on encouraging adjudication decision making finality and more timely resolution of active cases. Such a framework would also reasonably balance stakeholders' need to be consulted with the WSIB's obligation to respond to changing circumstances and emerging needs in a timely manner and in order to effectively manage the system. In addition, through this framework, WSIB should review its current adjudication policy suite and prioritize policy changes required to support the achievement of return to work principles. The review should also consider the impact of an aging workforce on the effectiveness of its current policy suite. An objective of the new framework should be to simplify policy language wherever possible.

**Recommendation #7:** WSIB should immediately address the following policies negatively impacting on return to work and recovery outcomes. The WSIB should review and revise the following policies:

- SIEF (subject to Arthurs' review mandate)
- Aggravation Basis Entitlement
- Work Disruptions
- Recurrences
- CPP LOE Benefit Offset
- Assessing Permanent Impairments
- Claims Reporting
- Reimbursement for Health Care Travel Expenses
- Relevant Experience Rating windows

## 3.2 Observations, Conclusions & Recommendations *(Continued)*

### Resources – Skills Development & Systems Support

#### **Observations:**

The New Service Delivery Model has better aligned the ACA Program's resources to priority activities (e.g. Eligibility Adjudicator, Return to Work Specialist) and highlighted a number of key skill and training gaps of staff, particularly with respect to the understanding and application of more complex adjudication policies and the interpretation and application of medical evidence to adjudication decision making.

The ACA Program's current claims administration roles and responsibilities and resourcing model does not include sufficient subject matter expertise to support adjudication decision makers. Operations Managers have struggled to balance their responsibilities around case management decision support and personnel management.

Despite ongoing efforts to increase the automation of claims administration, many processes remain heavily paper-based and require significant manual intervention. In addition, current claim information systems do not include critical case management capabilities.

#### **Conclusions:**

WSIB adjudication decision makers have difficulty applying complex adjudication policies and understanding and interpreting medical evidence to support adjudication decision making. This can result in inconsistent adjudication decisions and/or delay adjudication decision making.

WSIB information systems lack the capability to increase the administrative efficiency of the claim administration process. In addition, these systems provide limited case management decision support capability for decision makers. The systems are also weak with respect to capturing and reporting key performance indicators for adjudication and case management.

## 3.2 Observations, Conclusions & Recommendations *(Continued)*

**Recommendation #8:** WSIB should identify and address knowledge gaps and develop additional technical support capabilities. This would include emphasizing technical training related to policy and administrative decision making, expanding technical advice capabilities and identifying and addressing the most significant limitations of current claim information systems over the next six to nine months. WSIB should conduct a strategic review of its current information management strategy.

### Management Oversight & Performance Monitoring

#### **Observations:**

Management oversight mechanisms have improved in the ACA Program since the introduction of the NSDM. For example, over 48,000 manager reviews were conducted on eligibility decisions in 2010. Also in 2010, requirements were established for management approvals of all 100% locked-in awards and SIEF decisions granting over 50% cost relief. In addition, a formal process for periodic manager case file reviews was just implemented in 2011 and a formal requirement for manager level review of referrals for PI Assessments relating to low backs has also been implemented. However, there are opportunities to formalize timelines and broaden the level of oversight across the entire claim lifecycle.

#### **Conclusions:**

Although significant progress has been made in this area, it is important that the WSIB develop a comprehensive framework covering its critical decision making functions. There are key decision points in the claim lifecycle, including MMR and some NEL Award decisions, for which no formal decision making timelines or manager level review requirements and authorities have been established. Therefore, there are opportunities to formalize timelines and broaden the level of oversight across the entire claim lifecycle.

**Recommendation #9:** WSIB should assess its timelines with respect to all critical adjudication activities to ensure appropriate review deadlines have been established to support timelier decision making with respect to recovery and return to work.

**Recommendation #10:** WSIB should strengthen its management oversight by developing a formal review and approval framework for key decisions, including all referrals for PI Assessments.

## 3.3 Management Responses

**RECOMMENDATION #1:** WSIB should enhance its current case management by developing a comprehensive risk assessment framework to identify all high risk claims and by developing specific processes and procedures to manage these claims more quickly, in order to improve recovery and return to work outcomes and reduce the benefit duration of high risk claims.

***Management Response:** WSIB agrees with the recommendation. The WSIB will implement new internal processes for the management of the three highest risk injuries (low back, shoulders and fractures) by the end of Q4 2011. The WSIB is committed to developing a robust front-end risk assessment process to differentiate other high risk cases based on injury type and other risk factors by the end of Q1 2012.*

**RECOMMENDATION #2:** WSIB should establish a new work stream model within the Long Term Case Management (LTCM) Program which differentiates services to high leverage cases from those cases where only maintenance activity is required. For example, claims with adjusted long term LOE benefits would be streamed to a different unit supported by a separate staffing model.

***Management Response:** WSIB agrees with the recommendation. In Q2 2011, a new Permanent Benefits Services Branch will be established to provide ongoing claims administration functions for cases in receipt of Future Economic Loss (FEL) and LOE lock-in awards.*

*To further enhance focus on cases requiring active management to improve recovery and return to work outcomes, the WSIB will implement a separate work stream for pre lock-in cases where Labour Market Re-Entry/Work Transition services have been completed and LOE payments have been adjusted. This will be in place by the end of Q1 2012.*

### 3.3 Management Responses *(Continued)*

**RECOMMENDATION #3:** WSIB should improve the time to registration by enhancing electronic registration channels, and expand the use of auto-adjudication in order to expedite eligibility adjudication and facilitate earlier claims management. WSIB should pursue regulatory and/or policy change to increase the level of the administrative penalty that can be assessed for late reporting and the timeline for reporting.

**Management Response:** *WSIB agrees with the recommendation. Under the WSIB eClaim Services Project, work is currently in progress to improve the online reporting to increase uptake of the WSIB electronic claim reporting channel. This will result in more efficient claim registration, expanded use of auto-adjudication and improved routing of claims for timely decision making and better return to work outcomes. Implementation to occur by the end of Q3 2011.*

*The WSIB will pursue regulatory and/or policy change to improve compliance with statutory reporting obligations. Any necessary policy changes will be implemented by the end of 2011 and submissions to the government on any required regulatory changes will be made by the end of 2011.*

## 3.3 Management Responses *(Continued)*

**RECOMMENDATION #4:** WSIB should improve the collection of medical information to support more timely decisions on MMR and improve the accuracy and efficiency of permanent impairment ratings. WSIB should also seek efficiency opportunities to allow for the electronic exchange of medical information with approved providers. WSIB should reassess its application of the AMA Guide 3<sup>rd</sup> Edition, in order to establish easily understood, less generic and more occupational-injury based guidelines to assess permanent impairments using accepted objective standards.

**Management Response:** *WSIB agrees with the recommendation and will take the following action:*

- *Revise standardized health care provider reports to include better information regarding MMR and PIs, with implementation to occur in Q4 2011.*
- *Seek efficiency opportunities to allow for the electronic exchange of medical information by expanding its eServices program. The first priority is the exchange of information with contracted providers will be implemented by the end of Q4 2011.*
- *Using the AMA Guide as a foundation, WSIB will develop new guidelines for assessing permanent impairments that will represent a more appropriate application of this general disability guide to work-related injuries. The new guidelines will be in place by the end of Q1 2012.*

### 3.3 Management Responses *(Continued)*

**RECOMMENDATION #5:** WSIB should examine the value of the six year lock-in window in supporting effective return to work and recovery outcomes for injured workers and promoting efficient resolution of claims, and develop an options paper assessing the benefits and costs associated with eliminating this provision to be provided to the government.

**Management Response:** *WSIB agrees with the recommendation and will assess the issue.*

**RECOMMENDATION #6:** WSIB should design a policy renewal framework that ensures the timely identification of policies that are inconsistent with the first principles of recovery and return to work. In addition, the policy framework should focus on encouraging adjudication decision making finality and more timely resolution of active cases. Such a framework would also reasonably balance stakeholders' need to be consulted with the WSIB's obligation to respond to changing circumstances and emerging needs in a timely manner and in order to effectively manage the system. In addition, through this framework, WSIB should review its current adjudication policy suite and prioritize policy changes required to support the achievement of return to work principles. The review should also consider the impact of an aging workforce on the effectiveness of its current policy suite. An objective of the new framework should be to simplify policy language wherever possible.

**Management Response:** *WSIB agrees with the recommendation. The WSIB has developed a draft framework for policy development and renewal that will be released for public consultation in July 2011. The document outlines what is policy, the role of policy at the WSIB and the process for developing/renewing policies, including the internal and external consultations that may be necessary before a policy is finalized. An annual policy agenda with a five year rolling plan will accompany the policy framework and will set out the policy priorities for 2011/2012. Implementation of the new policy framework will occur by the end of Q3 2011.*

## 3.3 Management Responses *(Continued)*

**RECOMMENDATION #7:** WSIB should immediately address the following policies negatively impacting on return to work and recovery outcomes. The WSIB should review and revise the following policies:

- SIEF (subject to Arthurs' review mandate)
- Aggravation Basis Entitlement
- Work Disruptions
- Recurrences
- CPP LOE Benefit Offset
- Assessing Permanent Impairments
- Claims Reporting
- Reimbursement for Health Care Travel Expenses
- Relevant Experience Rating windows

***Management Response:*** *WSIB agrees with the recommendation. These policies will be included in the policy priorities for 2011/2012.*

### 3.3 Management Responses *(Continued)*

**RECOMMENDATION #8:** WSIB should identify and address knowledge gaps and develop additional technical support capabilities. This would include emphasizing technical training related to policy and administrative decision making, expanding technical advice capabilities and identifying and addressing the most significant limitations of current claim information systems over the next six to nine months. WSIB should conduct a strategic review of its current information management strategy.

**Management Response:** *It is well recognized that WSIB must make eligibility decisions in a complex medical, policy, social and legal environment. To this end, we are renewing and simplifying our policy suite as recommended in other sections of this audit report, to provide our adjudicators with as much guidance and clarity as possible. In addition, as this audit report acknowledges, 'key' decision points in the ACA process have been considerably strengthened through the creation of specialized roles and training to handle the more complex adjudication stages of a claim. As well we have instituted increased oversight by experienced managers. These specialized areas include initial entitlement, SIEF, permanent impairments, recurrences and LOE lock-in decisions.*

*Starting in Q1 2011, the WSIB established a new Skills Development Branch within the Operations Cluster to ensure the continuous improvement of staff skills and knowledge, including the development of effective desktop tools for decision makers.*

## 3.3 Management Responses *(Continued)*

**RECOMMENDATION #9:** WSIB should assess its timelines with respect to all critical adjudication activities to ensure appropriate review deadlines have been established to support timelier decision making with respect to recovery and return to work.

**Management Response:** *WSIB agrees with the recommendation. In Q1 2011, the WSIB established and began installing operational benchmarks (process measures) that describe all critical adjudication activities with corresponding management measures and targets for all phases of a claim. Full implementation is expected to be completed by the end of 2011.*

**RECOMMENDATION #10:** WSIB should strengthen its management oversight by developing a formal review and approval framework for key decisions, including all referrals for PI Assessments.

**Management Response:** *WSIB agrees with the recommendation. In addition to existing manager reviews and touch points, the WSIB will establish an oversight and approval framework to ensure an appropriate level of quality, consistency and risk management in relation to key decisions. This would include all referrals for permanent impairment assessments. The framework will be implemented by the end of Q4 2011.*

## 3.4 Recommendations: Impact

The recommendations are designed to work in concert to improve the efficiency with which all claims are administered and adjudicated and to improve the effectiveness with which more complex, longer duration claims are managed.

The **efficiency** of the claims administration process will be increased through a number of key initiatives:

- Automation of more routine administrative tasks related to the registration of a claim and the collection and dissemination of claim-related information
- Reallocation of resources and effort from routine administrative tasks to more high value-added case management and adjudication activities, particularly for cases that show early indication of decision making complexity which could result in delays
- Establishment and application of formal case review timelines to ensure decision making timeliness
- Prioritizing work effort by focusing the work of Case Managers and specialized adjudicators on cases of highest risk and highest return, and streaming “maintenance” cases to less expensive resources

The **effectiveness** of the management of more complex claims will be increased through a number of key initiatives:

- Adjustments to the legislative and program policy frameworks that will reduce program complexity, promote the expeditious resolution of claims and ensure greater alignment between adjudication policies and return to work and recovery objectives
- Early identification of complex/high risk claims through enhanced front-end claim risk assessment and earlier and more focused intervention
- Standardized review, oversight and management of cases with permanent impairment and/or long duration to maximize return to work, minimize wage loss and promote earlier case resolution
- Improvements to the decision making skills of adjudication decision makers and increases in the level of technical support available to these decision makers

## 3.4 Recommendations: Impact *(Continued)*

It is beyond the scope of the audit to assess the scale of the potential efficiencies and any associated cost savings that could result from the implementation of the various recommendations, as these will be highly dependent upon the manner in which the recommendations are implemented. However, if implemented, the cumulative impact of these recommendations will have a positive effect on return to work and recovery outcomes. This would translate into annual benefit savings and long term liability savings. This is supported by the following examples:

- A single day on LOE benefits for an individual injured worker averages \$100 (based on WSIB actuarial analysis). In 2010, the WSIB allowed just over 61,000 lost time claims, with approximately 20,000 of these claims remaining on benefits beyond one month. If the WSIB's improved return to work and recovery initiatives were to result in a reduction of five days in lost time benefits for this population, it would translate into approximately \$10M in annual benefits savings.
- The average lifetime cost of a lost time injury with no permanent impairment is \$5,600 (\$5,800 for low back injuries). The average lifetime cost of a lost time injury with a permanent impairment is \$250,000 (\$310,000 for low back injuries), of which a large proportion are locked-in LOE awards. Assuming the WSIB locks-in on average between 3,000-3,500 claims each year, and return to work and recovery initiatives reduce the number of lock-ins required by 10%, this would result in a reduction in benefit liabilities of between \$75-90M.

# Appendix A: Statistical Overview

# Appendix A: Statistical Overview – Claims Administration & Adjudication

As highlighted throughout this audit, the New Service Delivery Model introduced by the WSIB in 2008 has resulted in improved return to work and recovery outcomes, in addition to efficiency and effectiveness improvements, across the ACA program including:

## Decision Timeliness & Accuracy

- 87% of eligibility decisions are now being made within 14 days compared to 65% in 2008
- Average turnaround time for recurrence decisions in 2010 was 16 days, 2 days off target of 14 days
- 11.3% of registered claims in 2010 determined not to meet eligibility criteria, compared to 7.9% in 2009
- Average time to render a “rate-by-file” NEL decision decreased from 16 weeks to 3 weeks in 2010
- Inventory of claims awaiting SIEF decision fell from 2,444 at the end of 2009 to 377 at the end of 2010
- Number of claims awaiting external NEL assessment dropped from approximately 9,000 claims in 2008 to 2,300 in 2010. During the same period, the inventory of claims with completed NEL assessments, and awaiting award decision, fell from approximately 3,500 to 1,200

## Recovery & Return to Work

- For the period 2008 - 2010, in addition to fewer registered claims, the WSIB returned over 3,000 more injured workers to work. Return to Work Specialists are now on-site no later than 12 weeks and, where necessary, the expertise of Work Transition Specialists is provided between 6-9 months
- Timelier return to work and recovery outcomes, has also reduced time on benefits at 3, 6, 12 and 24 months post-injury
- Improved return to work outcomes and recovery efforts, have also contributed to a reduction in the number of active recurrences (claims back on benefits) from 5,082 in December 2009 to 3,475 in December 2010

# Appendix A: Statistical Overview – Claims Administration & Adjudication

(continued)

## Administrative Efficiencies

- Interest costs associated in payment delays, dropped from \$21.8M in 2009 to \$12.7M in 2010, of which a significant portion of this savings can be attributed to timelier eligibility decisions
- Average percentage of SIEF relief fell to 49.3% in 2010, from an average of 66% for the three prior years
- Introduction of “by file” ratings reduced the costs of external NEL assessments in 2009-10 by \$3.2M
- In 2010 27.6% fewer workers needed the full 100% loss of earnings replacement at the statutory 72 month lock-in date, as compared to 2009
- Average annual benefit payment to workers being locked-in at the 72 month mark in 2010 was \$15,624, compared to the average payment of \$21,144 for the pool of locked-in cases from all previous years
- 34% less SIEF cost relief was granted in 2010 compared to 2009, for a savings of \$109M

## Opportunities for Improvement

This VFMA’s statistical findings also identified several areas of opportunity for improvement within the ACA Program, as the New Service Delivery Model introduced in 2008 continues to mature and the WSIB makes adjustments to further improve return to work and recovery outcomes including:

- In 2010, average time to receive a report of injury was 19.3 days versus the legislative requirement of 3 days
- Only 30% of all No Lost Time claims are auto adjudicated, considerably less than WSIB’s 70% target
- Percentage of allowed Lost Time claims resulting in permanent impairments, has steadily risen from 8.7% in 1997 to 11% in 2005, the most recent year for mature data. This figure is higher than peer worker’s compensation boards
- Average percentage of a permanent impairment award in Ontario is 14.6%, compared to peer Canadian compensation boards, suggesting further opportunity for improvements in recovery and return to work activities across the workplace safety and insurance system
- In 2010, WSIB processed over six million pieces of paper in order to register and manage claims; this suggests the importance of optimizing automation and electronic business opportunities

# Appendix B: Inter-jurisdictional Themes

# Appendix B: Inter-jurisdictional Research – Introduction

## Approach & Scope

- Research was conducted on the approaches adopted by various workplace compensation insurance provider organizations in the areas that were the focus of the review: eligibility, recurrences, second injury enhancement fund, non economic loss awards, loss of earnings awards and the broader claim administration process.
- The review was designed to identify common and innovative approaches in these jurisdictions
- Jurisdictions reviewed focused on other Canadian provinces and included selected US jurisdictions
- Inter-jurisdictional research was supplemented by commentary from internal WSIB resources and various external stakeholder groups and discussions with various private insurance subject matter advisors

## Research Activities

- The engagement team conducted a number of research activities:
  - Review of publicly available documentation
  - Discussions with organization representatives
  - Discussions with researchers from the Institute for Work and Health
  - Review of leading practice research conducted by academic and research organizations such as the Upjohn Institute for Institute Research and the Workers Compensation Research Institute

# Appendix B: Inter-jurisdictional Research – Key Observations

## Key Observations

- No clear leading practice with respect to adjudication service delivery models with the features adopted by various jurisdictions reflecting legislative priorities, strategic direction and operational environment of various workplace compensation boards
- Across Canada (and North America) boards have experimented with a variety of service delivery models designed to improve recovery and return to work outcomes and manage benefit and administrative costs
- Service delivery changes have been driven by a variety of key issues faced by all Canadian boards, including:
  - Increased claim complexity
  - Rising health care costs
  - Aging labour force
  - Escalating claim costs
  - Rising stakeholder expectations

# Appendix B: Inter-jurisdictional Research – Findings

Decision Program	Research Findings
<p><b>Overall Claim Administration</b></p>	<p>Jurisdictions have adopted a variety of adjudication decision making models with a variety of levels of specialization in adjudication decision making and claims administration roles and with respect to industry-specialization amongst case management teams.</p> <p>Several jurisdictions have made significant investments in information system upgrades intended to improve service delivery efficiency and effectiveness.</p> <p>For example:</p> <ul style="list-style-type: none"> <li>• Recurrence and SIEF decisions remain with Case Managers in British Columbia and Alberta</li> <li>• Nova Scotia has adopted a service delivery model that provides tailored services based on industry and firm size</li> <li>• Several jurisdictions have specialized payment resources responsible for determining average wage/benefit levels</li> <li>• British Columbia and Newfoundland have made significant investments in their information management systems, including case management systems</li> </ul> <p>Number of innovative approaches adopted by private insurance providers, some of which have been adopted by workplace safety insurance providers in various North American jurisdictions were also identified. For example:</p> <ul style="list-style-type: none"> <li>• Call Centres – Many private insurers utilize call centres to manage the customer relationship and to process the initial registration of claims. Call centres have also been established in a number of public providers including British Columbia and Alberta.</li> <li>• Waiting Periods (Deductibles) – Most US jurisdictions, most of which are based upon private providers of workplace safety insurance, have waiting periods before wage loss indemnity benefits are paid out. In general, wage loss benefits for the waiting period will be paid to injured workers whose claims last beyond a pre-determined duration that varies across jurisdictions. Waiting periods are also applied in a number of Canadian jurisdictions, including: Nova Scotia, New Brunswick and Prince Edward Island.</li> <li>• Claim Closure &amp; Settlement – Most US jurisdictions allow providers to close claims via settlements (a mutually acceptable amount of money paid to the injured worker to allow the provider to close the claim and not be responsible for future payments), which are most often used in claims where the injured worker has been seriously injured or is very unlikely to work again.</li> </ul>

## Appendix B: Inter-jurisdictional Research – Findings *(Continued)*

Decision Program	Research Findings
<b>Policy</b>	Several Canadian jurisdictions have publicly-available policy guidelines that provide comprehensive guidance for decision makers and stakeholders, including British Columbia, Alberta and Saskatchewan
<b>Eligibility</b>	<p>Various jurisdictions, including British Columbia and Alberta, provide multiple registration channels for employers and workers, including call centers, web-portals and traditional paper-based registration, with a view to automating the registration process to the greatest extent possible</p> <p>Variety of US jurisdictions have reviewed and revised their eligibility policies and processes to address issues related to the aging of the labour force, including the increasing prevalence of pre-existing conditions</p>
<b>Recurrences</b>	Several jurisdictions, including British Columbia and Alberta, have specific legislative provisions related to injury recurrence with no specific legislative provisions related to eligibility based on work disruptions
<b>SIEF</b>	Many US jurisdictions have eliminated SIEF funds. Canadian jurisdictions have maintained their funds with a tendency to focus their cost relief on those pre-existing conditions that extend duration or increase level of disability but not on injuries that can be attributed to a pre-existing condition
<b>Permanent Disability (NEL) Awards</b>	<p>Most jurisdictions maintain a dual-award system whereby workers who suffer permanent disabilities are eligible for both economic (wage loss) benefits and non economic loss benefits. British Columbia has adopted a model that generally provides loss of function rather than loss of earnings awards for permanent disability claims</p> <p>Several jurisdictions maintain their own Permanent Impairment Guide – rather than an edition of the AMA Guide – to complete their permanent disability assessment</p>
<b>Loss of Earnings Lock-In</b>	No other Canadian jurisdiction has a legislative “lock-in” – i.e., a point-in-time after which a final review of LOE benefit levels is legislatively prescribed with many jurisdictions. Several jurisdictions, including Alberta, have established standard schedules for the review of wage loss benefits related to permanent disability

# Appendix C: Stakeholder Themes

## Appendix C: Stakeholder Themes

The following appendix provides an overview of the key themes that emerged from our various meetings and workshops with external stakeholders, both employers and employee representatives. The themes are presented by stakeholder group and decision program.

A wide range of stakeholders was consulted for the purposes of the VFMA, including workshops conducted with representatives from:

- WSIB Chair Advisory Committees (General Business & Construction Employers)
- Ontario Federation of Labour
- Injured Workers Outreach Service

A number of individual meetings were also held with individuals representing employers, workers and/or their representatives.

In addition, individual meetings were held with both the Fair Practices Commissioner and researchers from the Institute for Work and Health.

## Appendix C: Stakeholder Themes *(Continued)*

Decision Program	Employer Themes	Worker Themes
<p><b>Eligibility</b></p>	<p>Employer groups felt that eligibility decision makers in NSDM lack experience and comprehensive understanding of their role with respect to the administration of the Act</p> <p>Employers groups generally favour the move toward expanding e-business opportunities – e.g., claim registration and faster issuance of claim number</p> <p>Employer groups noted some concern about the perceived WSIB emphasis on decreasing the time to decision – i.e., concerned that this would affect the quality of decision making</p> <p>Employer groups suggested that WSIB should bring its eligibility criteria into closer alignment with its peers – i.e., should ensure that Ontario does not provide overly-broad entitlement with respect to items such as “soft tissue” injuries</p> <p>Employer groups indicated that the WSIB should explore further the option for an appropriately structured “deductible period” during which the employer would cover all costs related to a worker’s injury with no impact on employer WSIB premiums</p>	<p>Worker groups encouraged WSIB to focus on making decisions related to benefits quickly and then shifting focus to recovery and return to work – i.e., “resolving the economic argument” early in the process to allow worker to focus on recovery and return to work efforts</p> <p>Suggested that WSIB should re-evaluate its approach to older injured workers with low recovery and return to work probabilities – i.e., options should be available to close these files within two years maximum either through pension provisions or settlements</p> <p>Worker groups indicated their belief that some employers were using WSIB entitlement – in particular, entitlement related to psycho-emotional issues – as a means of managing “problem” employees</p> <p>Worker groups indicated that a “deductible period” would resolve any early economic anxieties on the part of the injured worker and allow the injured worker to focus on recovery</p>

## Appendix C: Stakeholder Themes *(Continued)*

Decision Program	Employer Themes	Worker Themes
<p><b>SIEF</b></p>	<p>Employer groups suggested that the Program had morphed from its original policy intent of providing employers with an incentive to hire previously disabled workers to a benefits negotiation tool</p> <p>Employer groups tend to see the Program as shifting costs within the pool of premiums</p> <p>Certain employers, while recognizing the moral hazards embedded in the Program, felt compelled to take advantage of the Program simply because it exists (“it is there, we have to play”)</p> <p>A number of larger employers indicated that hiring or accommodating workers with disabilities is part of their corporate HR Policy and largely unaffected by existence of SIEF – i.e., SIEF viewed as a form of rate relief not an incentive to hire or accommodate disabled workers</p>	<p>Worker groups view SIEF as a way of exonerating the employer from their legislative obligations</p> <p>Worker groups suggested that the Program had morphed from its original policy intent of providing employers with an incentive to hire previously disabled workers to a benefits negotiation tool</p> <p>Worker groups felt that there should be some form of incentive for employers to hire workers with disabilities (note: the issue becomes should the WSIB be responsible for providing such incentives)</p>
<p><b>Recurrences</b></p>	<p>Employers felt that WSIB should provide greater clarity through its policies with respect to pre-existing conditions and how they affect entitlement and employer costs</p>	<p>Worker groups stated concerns about tightening criteria for eligibility based on recurrence due to the uncertain impact this would have on the timing of return to work – i.e., workers returning too quickly – or limited efforts to provide modified work resulting in injury recurrence</p>

## Appendix C: Stakeholder Themes *(Continued)*

Decision Program	Employer Themes	Worker Themes
<p><b>Non Economic Loss</b></p>	<p>Certain employers indicated concerns with respect to the timeliness of decision making related to PI determination</p> <p>Employer groups also indicated concerns that the threshold for granting a NEL Award was set too low – i.e., some workers receiving Awards were not impaired in any meaningful sense and/or that Awards were reflecting aging workforce with pre-existing conditions unrelated to compensable accidents</p>	<p>Component of worker representative community believes that WSIB is responsible for providing broad compensation to worker regardless of pre-existing conditions or other extenuating circumstances</p>
<p><b>LOE Lock-Ins</b></p>	<p>Larger employers favour the use of sector-specialist adjudicators who understand the sector health and safety risks, employer-specific health and safety issues and track record and the unique characteristics of their collective agreements</p> <p>Employers believed that there was a component of the worker representative community that was advising their clients not to apply for CPP/QPP disability until after lock-in was reached</p>	<p>Worker groups recognized the need for some form of lock-in but that there was no apparent clinical rationale supporting the 72 month deadline (“this is a political deadline”)</p> <p>Worker groups believed that this 72 month time frame could be accelerated for workers with lower probability for successful recovery and return to work</p> <p>Worker groups believed that protracted case management decision making tended to lengthen claim duration and thereby contributed to poorer recovery and return to work outcomes (“delays led to worsening of worker’s health and psychological well-being and negative effects on family stability”)</p>