17.0 WSIB CLAIMS MANAGEMENT

Purpose

Where a work related injury occurs, very specific action is required to ensure that the worker receives proper and appropriate treatment, that the situation that caused or contributed to the injury is investigated by the immediate supervisor and that corrections, if appropriate, are undertaken to prevent the injury from reoccurring. In accordance with the requirements of the Workers' Insurance and Safety Board (WSIB), all appropriate reports and forms will be sent to the WSIB to assist in the decision regarding the workers claim for compensation.

17.1 CLAIM MANAGEMENT PROCESS

The following steps will be taken where an injury to a worker may result in a WSIB Claim:

1. The injury will be reported to the immediate supervisor;
2. The worker will complete the Employee Accident Report Form 1.
3. The Supervisor/Principal will investigate and complete the Injury/Illness/Incident Report Form 2, as soon as possible. (Serious injuries will be reported to the Health and Safety Officer immediately.)
4. The Supervisor/Principal will immediately send the Employee Accident Report Form 1 to the WSIB Claims Administrator and will also send the Employee Accident Report Form 1 and Injury/Illness/Incident Report Form 2 to the Health and Safety Officer, who will review and comment as appropriate and will send to the WSIB Claims Administrator;
5. The Health and Safety Officer, will review and forward the Injury, Illness, Incident Report Form 2 to the WSIB Claims Administrator for review and attention;
6. The WSIB Claims Administrator will take all appropriate actions to ensure the provision of all necessary information required for WSIB claim purposes;
7. The WSIB Claims Administrator will, with the cooperation of the worker, the worker's union and the supervisor, initiate all necessary action in regards to the Early and Safe Return to Work (ESRTW) of the injured worker;
8. To ensure that all necessary injury information and discussions regarding ESRTW are complete, the worker will be contacted, on a regular basis and a record of this ongoing contact will be maintained.

17.2 EARLY AND SAFE RETURN TO WORK PROGRAM

The Nipissing-Parry Sound Catholic District School Board will make every effort to help an injured employee to stay at work or to return to work as soon as possible. The Early and Safe Return to Work program will ensure that as an organization we are committed and able to supply modified/accommodated duties and Work Reintegration opportunities to all employees, where possible, without undue hardship.

The Human Resources Department, in collaboration with the union(s), the worker and appropriate supervisor(s) and/or Superintendent(s) have implemented a modified duty program. The program will assist in promoting a timely return to work of employees with work related injuries/illnesses. The program will reduce the impact of Workplace Safety and Insurance costs.

17.3 MODIFIED DUTIES

Definition of "MODIFIED DUTY"
Modified Duty is the modification of an employee position, and related duties, that allows for the employee to carry out the work assigned within the employees' capabilities.

The Board recognizes that the temporarily disabled employee can and should be performing meaningful, productive employment. The modified duty program gives structure and organization to this principle and recognizes the employers, union(s), and employee(s) joint responsibility to participate in the rehabilitation of the employee.

Specifically:
(i) The work must be productive and the result must have value and dignity for the worker;
(ii) The work provided must not aggravate the employee's disability;
(iii) The workers' disability must not constitute an additional hazard to the employee or fellow employee(s) while performing the duties assigned;
(iv) The work must assist the employee in returning to their original position and regular work, if possible.

Principles of Modified Duty
The duration of the modified duty will be determined at the commencement of the program wherever possible.

- Prior to starting the modified duty the employee and employer will sign an agreement with respect to the hours of work, the reporting requirements and the nature of the modified duty position;
- The employee's physician statement and the requirements of the employer will be reviewed to assist in determining the modified duties/position;
- The employee will be required to schedule appointments and therapy at reasonable times so as not to conflict with the employer's timetable;
- The employee is required to supply medical progress reports every two weeks or as frequently as may be needed.

17.4 ROLES AND RESPONSIBILITIES

A. The Employer

- To provide a fair and consistent rehabilitation/work reintegration program for injured employees, on or off the job, or for employees disabled due to illness or injury;
- To provide meaningful employment for temporarily disabled employees and promote modified duty;
- To facilitate communication between the department, the employee, the treating agency of the employee, and the Human Resources department;
- To assist in the modification of the workplace;
- To involve the work forces and ensure co-operation from the bargaining units;
- To explain these objectives and requirements.

B. Human Resources Department/WSIB Claims Administrator

- To advise the employee of the availability of the modified duties or transitional work program and provide the required documentation;
- To determine in consultation with the manager or designate and appropriate supervisor, if the position can be modified;
- To maintain regular contact with the worker and to monitor the progress of the employees modified duties through regularly scheduled meetings with the employee and supervisor;
- To ensure medical follow-up is obtained at a schedule defined by the employer; the schedule of the meetings can be decided on a case by case approach;
- To liaise with the employees treating agency and other agencies when required;
- To meet with the employee and establish written goals and objectives. Written goals and objectives will be established and agreed upon by the employee, appropriate supervisor and the employer;
- To develop, in consultation with the employees treating agency, the employee and the immediate supervisor, a modified duty program;
- To ensure that there is no conflict with the collective agreements (where applicable);
- Determine and maintain medical monitoring and treatment with the use of the Functional Abilities Form; the frequency of medical contacts can be determined on a case by case basis
- Communicate regularly with the injured worker and document the communication on the Contact Log; this communication will take place on a regular basis, at least once a week or as frequently as may be required
- To schedule ongoing meetings with the worker and his/her union and the appropriate supervisor, as required.

C. Immediate Supervisor

- To assist in the creation of, and support the employee's modified duty program;
- To maintain communication with the employee on modified duty and monitor the progress and the effectiveness, on an individual case by case basis;
- To inform other employees in the department/school of program goals and objectives;
- To communicate and assist in the evaluation of the program's effectiveness; regular meetings will be scheduled with the employee;
- required frequency of communication will be determined on a case by case basis.

D. The Employee

- To maintain regular contact with the supervisor;
- To take an active role in developing their modified duty program;
- To communicate any problems or concerns to their immediate supervisor and the Human Resources Department in a timely manner, so that problems can be addressed and resolved as they may arise; to obtain the necessary forms from the treating agencies as may be required by the employer; the employee may be responsible for the costs of any forms that are required;
- To ensure that other scheduled rehabilitation activities such as physical therapy or doctor's appointments are continued while on modified duty. These appointments are to be arranged, whenever possible, during non-work hours.
- To cooperate with all requests for documentation as required by the WSIB and the Employer.

E. Health Care Providers

- To provide up to date medical information;
- Complete all required forms when requested;
- Act as a resource.

F. Workplace Safety and Insurance Board

- Process claims on a timely basis;
- Act as a resource;
- Follow the Workplace Safety and Insurance Act.

G. The Union

- To counsel its members on the benefits of cooperation in the "MODIFIED DUTY" program;
- To cooperate in inter-union placement of temporary modified duty employees.

17.5 WORKPLACE SAFETY AND INSURANCE BOARD REPORTING REQUIREMENTS

- Wage changes;
- Changes in duties/hours of work/duration of program;
- Changes in employee abilities, limitations and/or restrictions;
- Failure to cooperate in the modified duty program by the employee, the applicable union or appropriate Supervisor;
- End of program.

Supporting Forms/Records

- Contact Log
- Return to Work Case Plan
- Return to Work Progress Report
- Return to Work – Closure/Evaluation Report
- Functional Abilities Form

17.6 RETURN TO WORK PROGRESS REPORT

Nipissing-Parry Sound Catholic District School Board

Return to Work Progress Report

Date: _____

Employee Name: _____

Supervisor Name: _____

Anticipated Outcome(s): (as written in the case plan)

_____
_____
_____
_____

Did the Case Plan actions result in the anticipated outcome(s)?

❑ Yes ❑ No

If No, Why?_____
_____
_____

Is the Case Plan still current?

❑ Yes ❑ No

If No, Why?_____
_____
_____

Next Steps: (e.g. continue, revise or close the existing case plan)

_____
_____
_____
_____

Next follow-up date:

_____

Original copy is retained in the employee file
Copies to: Employee, Supervisor, Union and Human Resources

Nipissing-Parry Sound Catholic District School Board

17.7 Return to Work Case Plan

Date: This plan covers the time period from _____ to _____	WSIB Claim #: WSIB Adjudicator Name: WSIB Adjudicator Phone #:
Employee Name:	Employee Phone #:
Position:	
Supervisor's Name:	Supervisor's Phone #:

Health Recovery	
a) Anticipated recovery time:	
b) Treatment (scheduled of proposed):	
c) Appointment dates:	

Accommodations			
This plan is intended for (check one): ❑ Stay at Work (SAW) ❑ Return to Work (RTW)			
Objectives (select one): ❑ Pre-injury job ❑ Work Comparable[1] ❑ Pre-injury job accommodated ❑ Alternative Work[2]			
(i.e., work hardening, transitional work)	**Yes**	**No**	**Not Known**
Are the physical demands of the job within the employee's functional abilities?			
Are the essential duties[3] of the job within the employee's functional abilities?			
Does the employee have the knowledge and skills required to do the job, where applicable?			
Does the job description accurately reflect the job being done?			

[1] Work Comparable: in nature and earning to pre-injury with accommodation, if required
[2] Alternative Work: different job with accommodation, if required
[3] Essential Duties: duties necessary to achieve the actual job outcome (The job outcome is the overall objective of the job in terms of production of the final product or provision of service)

List the job tasks: (attach additional pages, if needed)

Outline required modifications to work duties: For example: technical aids, furniture, hours, productivity levels etc.)

Functional Abilities
1) Identify source(s) of functional abilities and the date(s):
2) Has a Functional Abilities Form been completed? ❑ Yes, date: _____ ❑ If no, date expected _____
3) List the precautions, if any:

Temporary	Duration	Permanent

Comments:

Develop Outcomes			
Actions: List the steps required to achieve the outcome(s)	Anticipated outcome	Assigned to	Follow up date

Outline frequency of contact and by who, if necessary, in addition to the specified follow-up dates: _____

Work Schedule		
Follow up cycle: (For example: weekly, bi-weekly etc.)		

Signatures or acknowledgement of receipt:

Employee:_____ Date: _____

Supervisor: _____ Date: _____

Union: _____ Date: _____

Human Resources: _____ Date: _____

Original copy is retained in employee file
Copies to: Employee, Supervisor, Union and Human Resources

Nipissing-Parry Sound Catholic District School Board

17.8 Return to Work Closure/Evaluation Report

Report to be completed by both the Supervisor and employee, independently, once the final outcome is achieved. Send completed forms to the WSIB Claims Administrator.

Date: _____

Employee Name: _____

Duration of Case Plan (from incident/accident report to final RTW)

_____

What was the final outcome (check all that apply).

Anticipated Outcome?	Actual Outcome?
❑ Pre-injury job	❑ Pre-injury job
❑ Pre-injury job accommodation	❑ Pre-injury job accommodation
❑ Work comparable	❑ Work comparable
❑ Alternative work	❑ Alternative work
	❑ LMR
	❑ Other
Comments	

What worked well?

What are the opportunities for improvement? (For example: If you could change one thing what would it be?)

Completed by: _____

Thank you for completing this form. Confidentiality of this information will be assured. If you have any questions, please contact the WSIB Claims Administrator.

Nipissing-Parry Sound Catholic District School Board

17.9 Return to Work Contact Log

Employee's Name:	
Work Location:	
Supervisor's Name:	
Treating Health Professionals: Doctor Physiotherapist Chiropractor Physiotherapist Other	
WSIB Claim #: **WSIB Adjudicator:**	

It is the WSIB Claims Administrator's responsibility to ensure this form is kept up-to-date and in the Claims Management file established for the employee.

Record of Contact

Date of Contact	Person Contacted	Content of Conversation Q=Question; A=Answer; C=Comment

Date of Contact	Person Contacted	Content of Conversation Q=Question; A=Answer; C=Comment

17.10 WSIB FUNCTIONAL ABILITIES FORM

Functional Abilities Form

for Planning Early and Safe Return to Work

Health Professionals, please use this form ONLY when requested by an employer or worker.

The purpose of this form is to identify your patient's overall functional abilities and work restrictions that will assist his/her return to suitable work.

Please promptly complete and return pages 2 and 3 of this form to the worker or employer to assist the workplace parties in planning an early and safe return to work.

PLEASE ENSURE YOUR BILLING INFORMATION IS NOT GIVEN TO THE WORKER OR EMPLOYER.

Authority to Release Information

Section 37(3) of the *Workplace Safety and Insurance Act, 1997* provides the legal authority for health professionals to give the Workplace Safety and Insurance Board (WSIB), the injured worker and the employer such information as may be prescribed concerning the worker's functional abilities.

When completing this report, please **print** in **black ink**.

Worker and/or employer should complete Sections A and B of this report. If your patient needs assistance, please help. Please submit this report even if Section A is not fully completed.

Information about your responsibilities can be found on **Page 4**.

The WSIB will pay health professionals for completing this form.

Mail to:
Workplace Safety and Insurance Board
200 Front Street West
Toronto, ON M5V 3J1

OR

Fax to:
416-344-4684
or 1-888-313-7373

WSIB ONTARIO
CSPAAT

A guide to completing this form is available at www.wsib.on.ca

WSIB / CSPAAT

Mail to:
200 Front Street West
Toronto ON M5V 3J1

or Fax to:
416 344-4684
OR 1-888-313-7373

Please PRINT in black ink

FAF

Functional Abilities Form
for Planning Early and Safe Return to Work

Claim No.

A. Section A to be completed by the employer and/or worker.

Worker's Last Name	First Name	Telephone

Address (no., street, apt.)	City/Town	Province	Postal Code

Employer's Name	Date of Birth (dd/mm/yyyy)
Full Address (No., Street, Apt.)	Date of Accident/ Awareness of Illness (dd/mm/yyyy)
City/Town / Prov. / Postal Code	Employer Telephone
	Employer Fax No.

fold

1. Type of job at time of accident (where available, please attach description of job activities)	Area(s) of injury(ies)/illness(es)
2. Have the worker and the employer discussed Return To Work ☐ yes ☐ no	If no, will be discussed on dd mm yyyy
3. Employer contact name	Position

fold

B. Worker's Signature

By signing below, I am authorizing any health professional who treats me to provide me, my employer and the Workplace Safety and Insurance Board (WSIB) with information about my functional abilities on the WSIB's "Functional Abilities for Planning Early and Safe Return to Work" form.

Signature	Date dd mm yyyy

C. Health Professional's Billing Information
For billing purposes fax or mail pages 2 and 3 to the WSIB.

Health Professional's Designation
☐ Chiropractor ☐ Physician ☐ Physiotherapist ☐ Registered Nurse (Extended Class) ☐ Other

PROVIDER BILLING INFORMATION IN THE BOLDED AREA OF SECTION C SHOULD NOT BE PROVIDED TO THE WORKER OR EMPLOYER.

Are you registered with the WSIB? ☐ yes Please enter the **WSIB Provider ID.** in the box provided ☐ no Please call **1 - 800-569-7919** to register	**WSIB Provider ID.**
Health Professional's Name (please print)	**Your Invoice Number**
Address (No. Street, Apt.)	Service Code **FAF**
City/Town / Province / Postal Code	Fax

I hereby declare that the information being submitted in Sections C, D, E and F of this form is true and complete. It is an offense to knowingly make a false or misleading statement or representation to the WSIB.

Health Professional's Signature	Telephone	Date dd mm yyyy

WSIB ONTARIO CSPAAT

Mail to:
200 Front Street West
Toronto ON M5V 3J1

or Fax to:
416 344-4684
OR 1-888-313-7373

Please PRINT in black ink

FAF

Functional Abilities Form
for Planning Early and Safe Return to Work

Worker's Last Name	First Name	Claim No.

D. The following information should be completed by the Health Professional to identify the patient's overall abilities and restrictions.

1. Date of Assessment: dd mm yyyy

2. Please check one:

- ☐ Patient is capable of returning to work with **no restrictions.**
- ☐ Patient is capable of returning to work **with restrictions.** Complete sections **E and F.**
- ☐ Patient is physically unable to return to work at this time. Complete section **F.**

E. Abilities and/or Restrictions

1. Please indicate **Abilities** that apply. Include additional details in section 3

Walking:
- ☐ Full abilities
- ☐ Up to 100 metres
- ☐ 100 - 200 metres
- ☐ Other (please specify)

Standing:
- ☐ Full abilities
- ☐ Up to 15 minutes
- ☐ 15 - 30 minutes
- ☐ Other (please specify)

Sitting:
- ☐ Full abilities
- ☐ Up to 30 minutes
- ☐ 30 minutes - 1 hour
- ☐ Other (please specify)

Lifting from floor to waist:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ Other (please specify)

Lifting from waist to shoulder:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ Other (please specify)

Stair climbing:
- ☐ Full abilities
- ☐ Up to 5 steps
- ☐ 5 - 10 steps
- ☐ Other (please specify)

Ladder climbing:
- ☐ Full abilities
- ☐ 1 - 3 steps
- ☐ 4 - 6 steps
- ☐ Other (please specify)

Travel to work:

Ability to use public transit	Ability to drive a car
☐ yes	☐ yes
☐ no	☐ no

2. Please indicate **Restrictions** that apply. Include additional details in section 3

- ☐ Bending/twisting repetitive movement of (please specify)
- ☐ Work at or above shoulder activity:
- ☐ Chemical exposure to:
- ☐ Environmental exposure to: (e.g. heat, cold, noise or scents)
- ☐ Limited use of hand(s):

Left		Right
☐	Gripping	☐
☐	Pinching	☐
☐	Other (please specify)	☐

- ☐ Limited pushing/pulling with:
  - ☐ Left arm
  - ☐ Right arm
  - ☐ Other (please specify)
- ☐ Operating motorized equipment: (e.g. forklift)
- ☐ Potential side effects from medications (please specify) Do not include names of medications.
- ☐ Exposure to vibration:
  - ☐ Whole body
  - ☐ Hand/Arm

3. Additional Comments on **Abilities and/or Restrictions.**

4. From the date of this assessment, the above will apply for approximately:
☐ 1 - 2 days ☐ 3 - 7 days ☐ 8 - 14 days ☐ 14 + days

5. Have you discussed return to work with your patient? ☐ yes ☐ no

6. Recommendations for work hours and start date: ☐ Regular full-time hours ☐ Modified hours ☐ Graduated hours Start Date dd mm yyyy

F. Date of Next Appointment

Recommended date of next appointment to review **Abilities and/or Restrictions.** ▶ dd mm yyyy

I have provided this completed Functional Abilities Form to: ☐ **Worker** **and/or** ☐ **Employer**

Important Information

To receive benefits, the worker must apply for benefits within six months of the date of a work-related injury or illness. When filing a claim for benefits, the worker must also consent to the disclosure of functional abilities information provided by a health professional to his or her employer for the purpose of facilitating an early and safe return to work. Failure to file a claim or provide consent for the release of the functional abilities information can result in no benefits.

If you have questions about the completion of this form please call 1-800-387-0750.

Worker's Responsibilities

- This form is to be completed by a treating health professional, who will discuss the information with you.
- Once completed, contact your employer **immediately** to review the information on the completed form. Together, you and your employer will begin to plan an early and safe return to work.

Employer's Responsibilities

- This form provides general information about this worker's functional abilities and restrictions to help you plan an early and safe return to work.
- When you provide this form to the treating health professional, ensure that you have the worker's signed consent (Section B) for the release of functional abilities information.
- Where available, also attach a description of the worker's job activities to assist the health professional in completing the form.
- The prescribed form that is available from the WSIB is a generic form developed to assist with general functional abilities information.
- The WSIB will pay the health professional to complete the prescribed WSIB form only. A charge will appear on your Accident Cost statement or Schedule 2 invoice which reflects the cost of payment for each form completed.
- If you have a form that is specific to your workplace and have the cooperation of the worker in providing consent for the release of information on your form, you may use your own form. If you create your own form, you must reimburse the health professional directly.
- Do not send a copy of the completed Functional Abilities Form for Planning Early and Safe Return to Work to the WSIB. The health professional is responsible for submission of the form.

Health Professional's Responsibilities

- The employer and worker will use this information to plan the worker's early and safe return to work.
- Their return to work plans will reflect the functional abilities and restrictions you have noted and presume that no clinical contraindications exist for other work activities, therefore it is crucial that all sections be completed in full.
- The completion of this form is based on your examination of the worker and does not require a specialized functional abilities evaluation.
- Diagnostic or confidential information **must not** be included.
- Please add specific information on the duration of temporary restrictions or maximum times or weights to be considered, in section **E3** under **abilities and/or restrictions**. If necessary, attach an additional page to this completed form to describe abilities and restrictions.
- **Completion of this form does not replace clinical reporting requirements to the WSIB .**
- **Once you have received this form, promptly complete it and give it to the worker and/or employer.**
- **For billing purposes fax or mail pages 2 and 3 to the WSIB. When faxing, do not mail a copy.**

The WSIB will pay the health professional for the completed form when pages 2 and 3 are received.

Workplace Safety and Insurance Board
200 Front Street West
Toronto ON M5V 3J1

WSIB Fax 416-344-4684
or 1-888-313-7373