Adjudicative Advice

Practice Guidelines For Adjudicating Recurrence Claims

Background

In 1999, file reviews coordinated by Quality Improvement (QI) involving Business Unit and Appeals staff determined there existed opportunities to improve consistency in the adjudication of recurrence claims.

In late 1999, a committee consisting of representatives from Small Business, Pre 1990, Medical Services and Appeals met to consider the feedback and establish guidelines aimed at improving the way we adjudicate recurrence issues.

These guidelines are a supplement to existing policy and are intended to assist all WSIB decision-makers in evaluating the merits of these challenging cases.

Principles

Worker's compensation legislation in Ontario, over the years, has never attempted to limit ongoing entitlement in a claim. Once entitlement to an injury is accepted, the WSIB need only obtain information which supports that future lost time and treatment is linked to that original injury, in order for additional benefits and services to be provided.

This approach supports a concept that, in some injury claims, future problems can occur which arise directly from the original injury. Establishing this link can be even easier if the WSIB has recognized that the original injury has caused a permanent problem.

Until the introduction of FEL/LOE benefits in 1990, a worker could claim for a recurrence right up until he/she died. While this approach continues for Pre 1990 cases, the recent legislation directs LOE benefits are fixed 72 months post accident (the FEL benefit is finalized 60 months following the first (D1) determination). The WSIB may review the LOE benefit if the worker suffers a significant deterioration in his/her work-related condition after the 72nd month. Please refer to Policy 18-03-03 for the criteria.

The option for payment of a supplement and review of the FEL after the final review also exists in cases of significant deterioration (refer to Policy 18-04-12 and 18-04-14.)

Decision Making

The challenge in adjudicating recurrence cases is that further entitlement is generally determined utilizing both medical and non-medical evidence. Historically, further entitlement in some cases has been determined strictly on medical compatibility.

Decision-makers need to be aware that the information health professionals supply is incidental to their main objective, which is restoring the health of the worker. External physicians have indicated during WSIB focus sessions that it is very difficult for them to complete the REO8. They find the patient wants them to provide 'objective evidence' but the evidence is often 'only subjective' but quite real and genuine. Consequently, a decision-maker must appreciate that the medical reports may

Notice: This document is intended to assist WSIB decision-makers in reaching consistent decisions in similar fact situations and to supplement applicable WSIB policies and guidelines as set out in the Operational Policy Manual (OPM). This document is **not a policy** and in the event of a conflict between this document and an OPM policy or guideline, the decision-maker will rely on the latter.

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not directly address the issues they are obliged to decide or the information needs required to make those decisions.

When determining the merits of a case, it is necessary for a decision-maker to consider each piece of information or evidence and determine whether it is relevant to the issue. If it is relevant, a determination of whether it is credible and what weight it should been given is needed.

This requires that contradictory or inconsistent evidence, as well as complementary evidence be considered. For example, a decision-maker's preference for a WSIB physician's view of the worker's medical condition over the worker's treating physician must be premised on a assessment of the strengths and weaknesses of the opinions expressed. It is important that decisions are not made by default, in the absence of evidence, but are made by gathering and then weighing all relevant medical and non-medical evidence.

Common Cases

Determining recurrence entitlement in cases with no permanent impairment

A common recurrence situation involves a worker who essentially recovers from the original injury, and then suffers a further period of temporary disability. Well-established continuity inquiries are made, and up to date medical information is obtained, in order to determine a link to the original injury.

There is usually a need to establish some non-medical evidence in order to satisfy a decision-maker that the further problems are likely due to the original injury rather than due to some other cause. The WSIB medical consultant can be involved to provide an opinion with respect to medical compatibility. This opinion may be of more significance in situations where other non-medical continuity evidence is scarce.

Determining recurrence entitlement in cases with a permanent impairment

Workers who have a permanent disability (PD) or permanent impairment (PI) as a result of their work injury, pose a different set of challenges when it comes to determining entitlement to a recurrence. In these cases, medical compatibility is most often demonstrated by the recognition of the PD/PI. As well, continuity evidence is often readily established: there are usually continuing complaints; ongoing need for medication; and in many instances, job change impacts.

Given the above, the key issue for consideration of ongoing benefit entitlement is whether the worker has recently become temporarily (significantly) disabled (TD). It can be helpful to consider whether the precautions/abilities are in any way different. This may point to more restricted activities and support a finding of temporary disability (TD).

It is important to note that the deterioration of a worker's PD/PI does not always lead to confirmation the worker has suffered a recurrence. Evidence of a wage loss needs to be established. The WSIB can arrange for a review of the PD/PI based on medical information supporting a permanent worsening of that impairment.

If a worker is requesting further benefits, in addition to his/her permanent pension benefit or non-economic loss (NEL) benefit, a basic question that must be addressed is whether there is evidence of TD.

worker employed

If the worker had been working and is now off work, a medical report with objective evidence supporting TD may be sufficient to allow the recurrence. There should be some reference to further treatment, which in turn necessitates the lost time. As noted above, workers with a PD/PI will have ongoing pain/complaints, particularly if their impairment is at least moderate.

NOTE: While a worker may feel justified in taking a day off from work here and there, this quite often is not indicative of a recurrence. A further period of active treatment, however short, does tend to confirm TD.

worker not employed

Many workers with PD/PI are not working when a recurrence is claimed. In the absence of further lost time, the WSIB must decide if the worker's condition has truly deteriorated to the point of TD.

The same requirements mentioned above are evident here as well. Where medical information does not provide a clear picture, decision-makers may need to find out what active treatment is being recommended. And if treatment is started, whether this is needed to improve the worker's condition.

Committee Observations

An ongoing challenge for WSIB staff in dealing with recurrence cases involves the establishment of objective evidence to support TD. A complaint of increased pain/discomfort, particularly with PD/PI cases, may not be confirmed with an identified increase in physical findings. If objective evidence cannot be reasonably demonstrated, then the case for allowing a recurrence is weakened. The absence of any active treatment also works against allowing a recurrence. In these situations the extent and weight assigned to the non-medical information becomes most important.

The committee recognized and discussed the longstanding adjudication practice, in PD/PI senarios, for significant weight to be assigned to the Medical consultants deterioration/ impairment comment. It is important to reinforce with decision-makers that the completeness and quality of the information provided to the consultant should be carefully considered when weighing the opinion. For example, when the medical reporting is inconclusive/ incomplete, solely relying on the consultant opinion is discouraged. In these situations, decision-makers are encouraged to undertake a more comprehensive review of the non-medical information.

A decision template has been prepared, to assist WSIB decision-makers in selecting an appropriate case resolution process. The template notes situations in which decision-makers may utilize support resources to collect/analyze information. The template information and forthcoming case studies, are designed to enhance decision-makers' knowledge of recurrence decision-making. Case conferencing and peer/manager discussions continue to be the recommended approach for the most complex cases.

Claims Quality Loop
May 2000
(revised April 2005)

Authority References

15-03-01Recurrences

18-04-12 Supplement following significant deterioration

11-01-05 determining MMR

18-06-03 Definitions for Adjudicating Pre-1998 claims

18-04-11 Supplement for LMR & ESRTW programs & LMR plans before & after 24 mths.

RECURRENCE DECISION MAKING TEMPLATE

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15-03-01Recurrences
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Notification recurrence claim (REO)

Adjudicator – review file(s)
Coordinates gathering of medical and non medical information

Update ACCD screen REO 'p'

Medical Information Complete

Yes

No

Medical complete:
Provides some or all physical findings:
ROM (range of movement),
SLR (straight leg raising),
swelling/tenderness/ spasm
abnormal neurological findings
change in the precautions/abilities

Medical reporting incomplete:
- Insufficient (no findings)
- Incomplete (reports/tests outstanding)
- Contradictory (conflicting opinions compatability extent of disability)

question

advice

NCM Assistance
-clarify existing info.
-identify if info. complete
-suggest further assessments/ consultation

>1 year since last benefit or RTW
Refer Investigation
<1 year &/or PD/PI
- telephone
- forms
- combination

Non – medical information compared with medical reporting
- Aspects of job having difficulty doing
- Site/degree of pain
- Condition outside of work: activities/change in lifestyle
- Employer/coworker statements
- Specifics recent onset (new accident)
- Frequency of medical attention

complex

opinion

Medical Consultant
-adj. highlights history & weight of non-medical info
-advisor comments on quality info. compatability & impairment precautions/abilities

Decision-maker reviews all evidence:
- Determines relevance
- Assesses credibility of information/source
- Indicates weight/significance of information/opinions
- Concludes totality of evidence supports/doesn't support compatability/disability
- Case conference/manager review as required

DECISION
PARTIES ADVISED/PAYMENT PROCESSED/WRITTEN NOTICE

May, 2000