

January 9, 2017

Caroline Read, Policy Analyst  
Workers' Compensation Board of Nova Scotia  
PO Box 1150  
Halifax, Nova Scotia  
B3J 2Y2

**Submitted by Courier**

Dear Ms. Read:

**RE: Pre-existing Conditions Draft Policy (the "Draft Policy") Review**

Please accept this submission on behalf of The Office of the Employer Advisor Nova Scotia Society (OEA NS) and the undersigned employers.

The OEA NS is an independent society that provides employers with the following services: advocacy; education programs; current issues consultation; information regarding application and administration of WCB and OHS legislation, policies, procedures and practices; assistance with rate assessments; claims management and return to work; development of WCB and occupational health and safety workplace policies; and WCB/OHS appeal support.

In the process of reviewing the proposed Draft Policy, OEA NS formed a committee composed of key employer stakeholders (the "OEA Committee") to consider the Draft Policy from the perspective of Employers. The members of this committee are:

Kate Allen, Policy Analyst, CFIB  
Jeannette Combes, Employer Advisor, OEA NS Society  
Heather Cruickshanks, President, Merit Contractors  
Dr. Colin Davey, Family Physician and former WCB Medical Advisor  
Chris Ipe, WCB Specialist, Barrister & Solicitor, Canada Post and Director, OEA NS Society  
Bernadine MacAulay, President, OEA NS Society  
Mary Morris, Executive Director, OEA NS Society

Many members of the committee have extensive experience dealing with WCB adjudication and decision making. The working group also reached out to industry sectors and individual employers and received additional feedback on this submission and the Draft Policy from the following groups:

Construction Sector  
Forestry Sector  
Health Care Sector – Long Term and Home Care  
Manufacturing Sector  
Provincial Government Sector  
Retail Sector

While employers understand the need to ensure fairness to a worker experiencing a work-related injury, they also felt it was important to ensure the Workers' Compensation system is not unfairly held responsible for injuries, earnings loss, treatment, and impairment ratings that are not "as a result of" work-related conditions. As such, any policy of the WCB, including the Draft Policy, needs to be cognizant of unintended consequences that could put an added burden on the system. Additionally, the Board must ensure that the Policy as a whole and procedures adopted under the Draft Policy address the purpose and objective of the Draft Policy.

The OEA Committee reviewed the Draft Policy in light of its stated objectives and need for this Policy. In the WCB's Program Policy Background Paper: Pre-Existing Conditions, the objectives of the Draft Policy are to provide clarity, transparency, and consistency of decision making. The concern identified for the Draft Policy is that the number of claims involving pre-existing conditions is likely to rise. The "*Issue Clarification Paper: Pre-Existing Conditions*", dated June 2016, states at p. 2:

"... as Nova Scotia's workforce ages, the likelihood a worker will have a pre-existing condition at the time of the workplace injury increases. **Claim durations in Nova Scotia are amongst the highest in Canada**, in part because pre-existing physical and psychological conditions can impact a worker's recovery and return to work."

WCB claim durations in Nova Scotia are increasing, despite the millions of dollars spent trying to improve service delivery and case management. **Compared to other Canadian jurisdictions, Nova Scotia is significantly challenged with claim durations**. Nova Scotia faces many burdens – an aging workforce; extremely high rates of cancer, cardiovascular disease, respiratory disease, diabetes; and a strained health care system. Nova Scotia also has higher rates of smoking, alcohol consumption, obesity (body mass index of 30 or higher) and elevated blood pressure than the national averages of each. With these burdens, the issue of compensability of pre-existing conditions is a sensitive issue for Nova Scotia employers and the WCB system. The effect on the employer's business includes absenteeism, loss of productivity, and economic impact. Further, there is the human impact on the workforce who are unable or reluctant to return to employment.

According to the Annual Report and Community Report of the WCB NS, claim durations are rising dramatically. Five years of WCB data identifies claim durations as steadily increasing over the past five years:

2011 – 98 days  
2012 – 99 days  
2013 – 99 days  
2014 – 102 days  
2015 – 108 days  
Second Quarter 2016 – 109 days  
2016 – Estimated to be 110 days

**Other Canadian jurisdictions are reporting an average of 68 days.**

## OVERVIEW OF EMPLOYER CONCERNS

- The Draft Policy does not meet its objective, nor does it provide a solution to the identified concern.
- The Draft Policy provides general statements rather than decision making guidelines. At times, these general statements are inconsistent with the *Act* and fetter the decision maker's discretion to adjudicate (see Appendix "A").
- The decision to limit the consultation process and identify issues "not within the scope of review" is short sighted. When considering any change and particularly policy change, the Board should not exclude factors or changes that can inform its decision making process; rather the Board should look for a cohesive package of change in order to be effective and solve the identified issues and concerns.
- To resolve the issue of "claims duration", the WCB needs more than a policy change; it needs a culture change, a belief that change is good, and tools, guidelines, and supports for the case management team to better understand how, when, and what type of compensation should be paid when a pre-existing condition exists.

## OVERVIEW OF EMPLOYER RECOMMENDATIONS

- Revise the Draft Policy to include guidelines that are consistent with the Workers' Compensation *Act*, court and WCAT decisions, and existing WCB policies.
- Provide adjudicators with effective tools that will assist their decision making throughout the adjudicative process.
- Consider making revisions to other policies in the WCB regime to assist in the adjudicative process.

*The positive outcome of these three recommendations is to create a cohesive package of change to assist with and create a positive impact in case management outcomes. The WCB is currently investing millions of dollars into much needed technology upgrades. This is an opportune time to build appropriate and relevant tools, such as the AMA 6<sup>th</sup> Guidelines, revised forms 6/7 and 8/10, and to require relevant and appropriate disclosures. WCB NS's Strategic Plan places importance on leading with confidence. Therefore it is necessary to lead, to plan, and to include the appropriate tools to support any new policy. Without these changes, problem issues in case management will continue – issues that a policy cannot rescue.*

***The Draft Policy does not assist in the resolution  
of the pressing concern of claims duration***

**(1) REVISE THE DRAFT POLICY TO INCLUDE CLEAR GUIDELINES**

**(a) Definitions**

In the background materials and the Draft Policy, the definition of pre-existing condition includes degenerative changes. The employers are concerned that this broad language will lead to compensation for conditions that are not work-related. A policy that includes coverage for degenerative conditions as a blanket statement without clarification means that every worker covered by WCB has the potential to seek compensation for degenerative changes. The reality is that each and every one of us will experience degeneration of the body by age 30 years and the costs to a WCB system that casts too broad of a net is insurmountable. The Draft Policy should include a requirement that claims involving “degenerative changes” be scrutinized carefully to ensure that compensation is only paid for the injury that results from work. Such scrutiny involves objective medical evidence.

However, the definition of “Objective Medical Evidence”, on the other hand, is too narrow. It should include all types of information that would allow a physician to make a determination employing, as much as possible, the AMA 6<sup>th</sup> Guidelines, which use the international classification of functioning (“ICF”), and the Bradford Hill Criteria for determining cause and effect of a pre-existing medical condition.

**RECOMMENDATION:**

The definition of objective medical evidence should be broad enough to encompass a full assessment of the individual which includes the following:

- Documentation from all relevant practitioners that can provide guidance with regard to the pre-existing condition and/or the workplace injury (including physiotherapists, osteopaths, chiropractors, etc.), not just “physicians”
- Documentation of prior treatment(s);
- A thorough review of prior tests, procedures, and complimentary clinical examinations as a whole, rather than individual pieces of information; and
- History of functional changes.

**(b) Initial Entitlement - Determining General Entitlement**

One significantly important issue not addressed in the Draft Policy (or elsewhere in related WCB Policy) is a requirement of the worker to self-disclose a pre-existing condition. Given that the Draft Policy (and required forms/documentation) does not preclude a worker from entitlement to compensation based on a pre-existing condition, access to this knowledge early on in the process is beneficial to the adjudicator when determining entitlement or alternatively a claimant’s treatment program. The effect of earlier intervention results is a more rapid return of the worker’s health to pre-injury/illness status and or alternative function – consequently a reduction of overall financial and human costs of injury from both work injury and pre-existing conditions. Delays in treatment for conditions only declared much later on impact negatively

throughout the entire case management process.

**RECOMMENDATION:**

The Policy should:

- Require the worker to declare, through the Form 6/7 or otherwise, the existence, if any, of a pre-existing condition;
- Require the worker's treating medical practitioners to declare, through the Form 8/10 or otherwise, if worker has a pre-existing condition.

When determining General Entitlement, the Draft Policy is confusing and does not incorporate the principles set out in the General Entitlement Policy 1.2.14. For example, Section 3 (a) of the General Entitlement Policy states:

Generally, this means the accident and resulting injury must be caused by some risk related to the employment. The risk may be directly, or incidentally, related to the employment; and the injury may be the result of a single incident, or develop over a period of time. An injury, however, is not necessarily compensable simply because it happened, or symptoms occurred, at the workplace.

Given the breadth of the possible types of pre-existing conditions that may exist, adjudication in the first instance cannot be rushed. The current wording in the Draft Policy, states that the "existence of a pre-existing condition is not relevant when determining entitlement to worker's compensation". We recognize that a susceptibility to injury does not disentitle a worker to compensation because of the "thin skull" principle. However, when an entitlement determination is being made, the initial adjudication should be a full evaluation of whether or not work was a material contributing cause/factor, as well as, the severity of the pre-existing conditions, the mechanism of injury, and the risk factors (if any) in the workplace.

It is imperative that adjudicators be provided with the proper adjudication tools, training and experience to permit them to weigh all relevant evidence when considering a workers' entitlement.

For instance, consider an individual with severe coronary artery disease. These individuals may not be made aware of their condition until a heart attack is suffered. Coronary artery disease is without a doubt a personal condition and it is also one that makes a worker susceptible to injury. Simply because a heart attack happens at work does not mean that work was a culpable factor. Adjudicators should be reminded to apply the General Entitlement Policy and assess whether work activity had a material contribution to the injury. At law, the mechanism of injury has to be at least a contributing cause which means that something at work led to the heart attack. If for example, the employee was walking across the plant floor or standing at his work station, these activities would be normal every day activities in the worker's personal life and it is more likely than not that the heart attack would have occurred even if the worker was not at work.

Further, in some cases, the principles of *Ross v. Michelin* will apply. Workers with personal pre-existing conditions, such as claustrophobia, may experience disabling conditions while at work. But it is not work that causes the disablement, it is the pre-existing condition. In cases where exposure to an event, such as confined space, will cause the symptom, whether the person is at

work or not, must be considered when dealing with pre-existing conditions.

Another example is osteoporosis. Many are familiar with the saying, “Did you break your hip and fall or did you fall and break your hip?” With an aging workforce, adjudicators need to be provided with guidance and tools to evaluate these complicated questions.

The current wording of the policy suggests that existence of a pre-existing condition is not relevant when determining entitlement. While a weakness or susceptibility to injury does not disentitle a worker to compensation because of the “thin skull” principle, other factors need to be considered in determining initial entitlement.

**RECOMMENDATION:**

The Policy needs to outline factors to be considered when determining entitlement, such as:

- A full evaluation of whether work was a material contributing cause;
- The severity of the pre-existing conditions;
- The mechanism of injury;
- The risk factors, if any, in the workplace; and
- The factors leading to disablement and whether or not they are unique to the work environment.

Adjudicators should be provided with adjudication tools (see below), training, and experience that permit them to weigh all relevant evidence and approach entitlement as a practical question of fact which can best be answered by ordinary common sense.

**(c) Ongoing Adjudication – Determining Causality**

The Draft Policy refers to the “thin skull” and “crumbling skull” doctrines, which are only two of many legal principles which apply when assessing causation. As such, the Policy limits “non-compensability” to only two scenarios which is inconsistent with the *Act* and established jurisprudence.

The Draft Policy does not recognize that a pre-existing condition could be an “intervening event”. This is applicable where the pre-existing condition and the disabling symptoms associated with it are clearly personal to the individual such as diabetes, mental illness, failure to cope, osteoarthritis, etc. The Supreme Court in ***Anthey v. Leonati*** describes other categories of assessing causation in the headnote:

Separation of distinct and divisible injuries is not truly apportionment; it is simply ***making each defendant liable only for the injury he or she has caused, according to the usual rule.*** Separation is also permitted where some of the injuries have tortious causes and some have non-tortious causes. Again, such cases merely recognize that the ***defendant is not liable for injuries which were not caused by his or her negligence [the workplace injury]***. Here, the disc herniation was a *single indivisible injury* so division was neither possible nor appropriate. Any defendant found to have negligently caused or contributed to the disc herniation will be fully liable for it.

...An analogy cannot be drawn to those cases where an **unrelated event, such as a disease** or non-tortious accident, occurs after the plaintiff is injured. The plaintiff's loss is the difference between the original position the plaintiff would have been in absent the defendant's negligence and the plaintiff's position after the tort. **Where an intervening event unrelated to the tort affects the plaintiff's "original position", the net loss is not as great as it might have otherwise seemed, so damages would be reduced to reflect this.** Here, *the disc herniation was found to be the product of the accidents and not an independent intervening event.*

In the *Act* entitlement to all benefits must be "as a result of an injury" (see Appendix "B"). Throughout the entire claims process, the adjudicator must assess whether the earnings loss or medical aid is "as a result of the injury". Further, the adjudicator should continually be conscious of the fact that under the *Act*, the earnings loss benefits are to cease when the earnings loss is no longer "**as a result of the injury**".

In addition to the comments in *Anthey*, the Nova Scotia Court of Appeal has provided some guidance on the meaning of the words, "**as a result of**", in *Ferneyhough v. Workers' Compensation Board (N.S.) et al.*, 2000 NSCA 121 and *Canada Post Corp. v. Nova Scotia (Workers' Compensation Appeals Tribunal) (Nurnber)* (2004), 224 N.S.R. (2d) 276 (C.A.).

In *Ferneyhough*, in relation to whether or not a worker's death was "**as a result of**" occupational disease, the Court concluded at paragraph 20:

The correct standard by which to assess whether the required causal link has been established is that the occupational disease must be a **contributing cause** in the sense that, "**but for" the occupational disease, death would not have occurred when it did or, that the occupational disease contributed to the death in a material degree.** The term "material degree" should be understood, as it was in *McGhee* and *Athey*, to mean something beyond the *de minimis* range, that is, something that is not negligible.

The Court also reminded decision makers to apply a common-sense approach. In *Nurnber*, the Court found that WCAT had erred by applying a legal test for causation that relied solely on medical opinions, to the exclusion of all other evidence. The Court stated that decision-makers cannot simply defer to medical opinions in determining causation. Instead all relevant evidence must be considered. At paragraphs 24 and 25, the Court stated:

... While, of course, expert opinion evidence will often be of great assistance in determining questions of causation, it is neither necessary nor necessarily dispositive.

... WCAT should **weigh all relevant evidence and approach causation as a practical question of fact which can best be answered by ordinary common sense.**

In Ontario, WSIB has a Significant Contribution Factor Test that is used by adjudicators when assessing the impact of a pre-existing condition on a workers ongoing impairment. The adjudicator must determine whether the work-related injury continues to be a significant contributing factor to the impairment. To make this determination, the adjudicator is also



provided with factors to consider:

- a. Does the impairment affect the same body part as the pre-existing condition? and
- b. Does the impairment continue beyond the expected recovery time given the work-related injury?

**RECOMMENDATION:**

Adjudicators must carry out a full evaluation when assessing claims including, whether work was a material contributing cause of the injury, the existence and severity of any pre-existing condition(s), the mechanism of injury and the risk factors, if any, in the workplace.

Further to that, adjudicators must be provided with adequate adjudication tools (see below) to permit them to weigh all evidence that is relevant to a claim and to approach entitlement as a “practical question of fact which can best be answered by ordinary common sense”.

To evaluate that a full assessment and adequate adjudication has taken place, a written claim decision should be completed on all claims and not only when requested. The written claim decision guarantees that assessment, planning, implementation and evaluation of the injury and any pre-existing condition is documented.

The *Act* states that earnings loss ceases when the loss is no longer “as a result of the injury”. Therefore, it is inconsistent with the *Act* to require the Worker to return to their “pre-accident state” before temporary benefits cease in cases where a pre-existing condition exists.

**RECOMMENDATION:**

The Draft Policy should set out that:

Temporary benefits cease when the Worker returns to their “pre-accident state” **OR** the “compensable injury” is no longer the material contributing cause of the earnings loss; **OR** the Worker has reached maximum medical recovery (at which time the adjudicator must determine if there is a permanent impairment “as a result of” the compensable injury, and if so whether apportionment of benefits is appropriate).

**(d) Determining Work Relatedness of Ongoing Impairment**

The Draft Policy provides:

“In cases where the pre-existing condition is not contributing to the ongoing impairment but is prolonging the recovery from the work related injury/disease, benefits continue **as long as the ongoing impairment is work related** even if recovery takes longer due to the pre-existing conditions”.

The Draft Policy provides no guidance to the adjudicator regarding how they should determine when an “ongoing impairment is work related” and **it presumes that in all cases longer durations are compensable even if the original injury no longer materially contributes to the earnings loss.** Therefore, the guideline is inconsistent with section 37(9) of the *Act* and



fetters the discretion of the adjudicator to determine entitlement based on the individual set of facts before them.

This concern is highlighted by the growing number of PTSD claims. A psychological illness claim must have a direct and objective link to the work condition or risks in order for a worker to be entitled to benefits. Currently, PTSD claims are approved simply because the condition exists, without taking into consideration the personal conditions of the claimant that cause and contribute to the psychological symptoms. Therefore, psychological and psychiatric pre-existing conditions require clear guidelines to ensure that compensation is only payable for the earnings loss and/or medical aid that is directly related to a compensable injury and/or risk associated with employment duties.

**RECOMMENDATION:**

In addition to the recommendations outlined in 1(c), the Draft Policy should have specific criteria with regard to claims involving pre-existing psychological/psychiatric issues:

- The disabling condition must meet the definition set out in the DSM-V and should be supported by a second qualified medical opinion.
- The adjudicator should be required to review the entire psychiatric history of the worker, and seek out an independent opinion from a forensic psychiatrist on the causal elements or degree of relation to the workplace.
- A psychological illness claim must have a direct and objective link to the work condition or risks in order for a worker to be entitled to benefits.

The Draft Policy continues:

In cases where the pre-existing condition **causes** the worker to be unable to commence or continue medical treatment for the compensable injuries, *Policy 1.3.2R – Interruption of Medical Treatment – Circumstances Beyond Worker’s Control* will be applied.

This guideline is unnecessary and confusing for adjudicators. It is also inconsistent with Section 84 of the *Act*. It signals to workers that if they have a pre-existing condition, they do not have to cooperate and can refuse treatment. These cases are much too complicated, with too many variables, to determine with blanket statements.

Alternatively, it provides no guidance as to how to determine “cause”. For example, a person with mental illness may not want to participate in a treatment program, but the “cause” of the inability to participate in the treatment program is the workers inability to recognize the mental illness and inability/unwillingness to receive treatment for mental illness. Under Section 84 of the *Act*, workers are required to cooperate and take all steps to eliminate earnings loss. This includes getting treatment and dealing with the impact of a pre-existing condition on their capacity to work. The American College of Occupational and Environmental Medicine emphasizes the importance of holding workers’ accountable for seeking and adhering to appropriate treatment for underlying psychiatric disorders that interfere with recovery and return to work (see Appendix “D”). Similar sentiments should apply to physical co-morbid conditions that interfere with a worker’s ability to recover and/or return to work.

**RECOMMENDATION:**

The Draft Policy should not provide a blanket statement that a pre-existing condition is a reason to refuse treatment. The Draft Policy should incorporate the principles of section 84 and require workers to take positive steps to reduce the impact of pre-existing conditions on their functional ability.

**(e) Medical Opinions**

Seeking a medical opinion with inadequate information does not assist in proper adjudication. Employer's current experience demonstrates that case managers rely on the opinion of the medical advisor when adjudicating complex issues. When medical opinions are sought, the policy should stipulate that Medical Advisors are provided with all of the relevant information, both "objective medical evidence" and other relevant information, that would allow the medical advisor to make a determination or provide an opinion, employing as much as possible the Bradford Hill Criteria for determining cause and effect of a pre-existing medical condition.

**RECOMMENDATION:**

When a case manager seeks the opinion of a medical advisor, the summary report provided to the medical advisor should provide a detailed summary of the key file material, including:

- The details of the prior medical history and pre-existing conditions
- Any demonstrated impact of the pre-existing condition
- The details of prior treatment for pre-existing injury
- The work being performed at the time of the alleged workplace injury
- The mechanism of injury;
- The risk factors, if any, in the workplace; and
- The factors leading to disablement and whether or not they are unique to the work environment

**(2) PROVIDE ADJUDICATORS WITH EFFECTIVE ASSESSMENT TOOLS**

As stated above, the Draft Policy is too broad and does not provide adjudicators with proper assessment tools to determine which part of the injury is attributed to work and what, if any, part of the injury is related to a pre-existing condition (i.e. what is risk related to employment and what is not).

**(a) The form 6/7 - Accident Report and/or the Accident Investigation**

**RECOMMENDATION:**

The Form 6/7 and/or Accident Investigation requires revisions. Pre-existing conditions impacted by injury should be reported and described at claim commencement.

If standardized questions were asked at the beginning of a claim, or as part of the investigation, the need to timely investigate, parse out, and possibly treat pre-existing conditions could be brought to the adjudicator's attention sooner. Such timeliness can drastically reduce claims duration which is a stated objective of the Draft Policy.

**(b) The form 8/10 – Physician’s Report**

**RECOMMENDATION:**

The Form 8/10 requires revisions to complement and provide objective medical information to support the Draft Policy which states that decisions will only be based on objective medical evidence. Information sought in the Form 8/10 must include objective criteria, including diagnosis, functioning, objective findings, and details regarding pre-existing conditions.

When dealing with pre-existing conditions, an objective and clear diagnosis must be based on recognized criteria, functioning, and objective findings. Experience with difficult duration cases shows, in general, that up to the first three months, limitations and restrictions are biological in origin, but after that, the inability to return to work is more psychosocial in origin (e.g., not eating, sleeping, self-medicating, narcotic use).

Further, the Draft Policy does not explain how doctor’s notes and self-reports of workers will be used in adjudication of claims given that the Draft Policy states claims will be based only on objective medical evidence.

Implementing the Draft Policy without updating the complementary tools/forms will not achieve the stated objectives of the policy, as the information necessary to carry out the objectives of the policy will not be provided.

**(c) Hazard Assessments**

**RECOMMENDATION:**

Hazard assessments should be utilized to determine whether the work environment presented a risk of injury.

Hazard assessments are especially important in situations involving claims for “repetitive” strain. Occupational Therapists and other practitioners trained in assessing the impacts of work activity can provide valuable assistance in determining whether or not work causes or contributes to an injury. Take for example a ganglion cyst. The two main causes of ganglion cysts are repetitive forceful work and arthritis. If a worker presents with arthritis, then arthritis is a possible and likely cause – unless there are risk factors in the workplace that could either cause a cyst or aggravate the arthritis. Situations like these require the completion of a detailed hazard to assess the risks in the workplace and if those risks could cause or contribute to a cyst.

**(d) AMA Guidelines.**

**RECOMMENDATION:**

AMA 6<sup>th</sup> Guidelines should be implemented in Nova Scotia.

WCB NS states that discussion of the AMA Guidelines is out of scope for this policy review to consider. However, the revised guidelines are an important tool for adjudication. PMI assessments are being carried out with the AMA 4<sup>th</sup>, based on range of motion, and physicians are not correctly applying the AMA 4<sup>th</sup> guidelines.

Further, physicians are no longer trained in how to use the AMA 4<sup>th</sup>. A worker should not

be able to receive more for a functional loss than a worker with an amputation – but they currently do. This is unfair.

The AMA 6<sup>th</sup> provides for a broader assessment based on ICF principles, where diagnosis is paramount, and range of motion is only part of the physical examination. This approach is particularly relevant in an aging population where symptoms of osteoarthritis are widespread. Using the AMA 6<sup>th</sup>, the physician looks to functional history and clinical studies that support the diagnosis which in turn provides for a more fair, balanced, and understandable assessment. Decisions that are fair and understandable are less likely to be appealed.

The majority of other jurisdictions use the AMA 6<sup>th</sup>. Given the identified issue – aging workforce and claims complicated by psychological and psychosocial issues - Nova Scotia should implement the use of the AMA 6<sup>th</sup> to provide physicians with the ability to carry out a fair assessment of each worker. A review of other jurisdictions is attached as Appendix “C”.

**(e) Early Intervention and Appropriate Treatment Planning.**

**RECOMMENDATION:**

The current claims management process needs to be re-considered. WCB should implement a triage system that is responsive to the possible complexities of each case on the basis of the individual facts presenting at the commencement of a claim.

Further, treatment plans should be proactive rather than reactive.

Currently all claims are triaged through a benefits administrator who has limited tools and direction to identify issues arising from pre-existing conditions (either symptomatic or asymptomatic). In this process, issues arising from pre-existing conditions are often not identified until the worker fails to return to work within the expected duration. Time loss should not be the determinate for intervention and escalated management of a work injury that is complicated by pre-existing or personal conditions.

Consideration should be given to the “SPICE” methodology which is based on the military's "Forward Treatment" methodology which has been reviewed and considered as claims management technique for workers' compensation by College and Johnson H.I. (2000) “S.P.I.C.E.-a model for reducing the incidence and costs of occupationally entitled claims.” *Occup Med.* 2000 Oct-Dec;15 (4):695-722, iii.

A triage system needs to be responsive to the possible complexities involved in each and every case. For example, in our health care system, the ER staff do not operate on the assumption that all patients will be okay and that one case is not more urgent than another until they demonstrate otherwise. Rather, the triage paramedics and nurses prioritize patients using the Canadian Triage and Acuity Scale and triage patients as they enter the system so that more urgent cases are seen sooner than those that are found to be less urgent. In a claims management system, triage should accomplish the same goal – complex cases should be identified on the basis of the individual facts as they present, rather than an assumption that the worker should be able to return to work within a certain number of weeks. This shift will require training for claims management staff and the development of tools that can be effectively used by the persons responsible for triaging time loss claims.

Further, treatment plans should be proactive rather than reactive. The proper triaging of claims will allow workers to receive more appropriate treatment sooner in the process. For example, workers with pre-existing and undiagnosed anxiety and depression could be treated immediately rather than sending them to Tier 1 physiotherapy which, given their personal situation, is unlikely to address their problem and therefore unlikely to lead to a return to work. Likewise, with Tier 3, some workers have personal conditions that are impacting their ability to participate in treatment. Therefore, it should be a prerequisite that these workers have any personal conditions treated and resolved before entering the program. In particular, workers entering Tier 3 should be mentally stable because the worker is pushed to return to work.

The impact of psychiatric disorders on return to work is well documented and early screening, diagnosis, intervention, and treatment is a necessary solution. (See Appendix “D”).

**(f) Data and Being Informed by Data.**

**RECOMMENDATION:**

WCB should be required to maintain data on injuries where a pre-existing condition is compensated. This data should be available within MyAccount. This data should be reported in the WCB’s Annual Report.

In order to identify and prioritize the changes that are need to policies, procedures, methods, and tools, the financial and human impact of pre-existing injuries needs to be documented and objectively analyzed. Objective data can inform those impacted by the change about the need and importance of change. Therefore objective data will assist in the change management process.

**(3) CONSIDERATION OF OTHER POLICY CHANGES THAT MAY BE REQUIRED**

The OEA Committee expressed concern on behalf of employers regarding other WCB policies that require consideration. One of these is the demerit system.

The Program Policy Background Paper: Pre-Existing conditions states at page 6 that “cost recovery” is beyond the scope of the current review. However, employers have expressed that in order to have business success in Nova Scotia, they should have a comparable cost recovery system to that which is available to employers in other provinces.

The Workers’ Compensation system is based on the *Meredith Principles* which include the following:

- 1. NO FAULT COMPENSATION:** workers are paid benefits regardless of how the injury occurred. The worker and employer waive the right to sue. ***There is no argument over responsibility or liability for an injury.***
- 2. SECURITY OF BENEFITS:** a fund is established to guarantee funds exist to pay benefits to workers.
- 3. COLLECTIVE LIABILITY:** all employers share liability for workplace injury insurance. The total cost of the compensation system is shared by all employers. All employers

contribute to a common fund. Financial liability becomes their collective responsibility.

The WCB Assessment Policy is inconsistent with the “no fault” compensation because it uses a “demerit” system to penalize an employer who has high costs. The rationalization for this approach was to encourage and incent employers to take steps to avoid injuries at work. If employers are “at fault” they are penalized by receiving higher assessments and demerits. Certain claim costs are exempt, such as occupational disease. However, an employer has no ability to control a worker’s susceptibility to injury due to a pre-existing condition. Consequently, it is unreasonable to penalize an employer for events, circumstances, and consequences that are not within the employer’s control or the employer’s ‘fault’.

**RECOMMENDATION:**

WCB should consider amending the Assessment Policy to allow for costs related to pre-existing injury to be removed from the experience rating.
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**CONCLUSION**

In summary, the essence of the suggestions provided by employers amount to a necessity for a DETAILED, OBJECTIVE, and INDEPENDENT review of any and all pre-existing conditions that are found. Such review must consider the potential impact of the pre-existing condition at each stage of adjudication - recognition, necessary medical aid, ongoing earnings loss, and permanent impairments. The detailed, objective, and independent review cannot be simply be a note or an opinion from a family physician; rather it must encompass a full review of all aspects related to the worker’s injury. Any significant pre-existing condition, regardless if it occurs before, during, or after the accident must be thoroughly investigated objectively and independently.

In addition, developing a new policy for adjudicating claims where pre-existing conditions are present must be accompanied by a review and revamp of the tools used by adjudicators to support effective claims management.

Finally, the OEA Committee and undersigned employers believe revisions are needed to other related policies, including the Assessment Policy, to complement the implementation of a new policy on pre-existing conditions.

We welcome the opportunity to meet with you to further discuss the recommendations contained. Please contact the OEA at 902.442.9364 for any questions or to schedule further discussions with employers.

Yours truly,

**OEACOMMITTEE**

## APPENDIX A

Draft	Issue	Recommendation
<p>“Entitlement for a personal injury by accident arising out of and in the course of employment <b>will not be denied</b> due to the existence of a pre-existing condition. <b>Once</b> initial entitlement is established, the decision-maker considers the impact, if any, of pre-existing conditions on the worker’s ongoing impairment.” (Preamble, p. 1)</p>	<p>This wording presumes that all claims involving pre-existing condition will be approved. As such it does or can fetter the discretion of the decision maker.</p>	<p>Delete entire paragraph</p>
<p>Definitions:</p>		
<p>“pre-existing condition”</p>	<p>Definition is too broad</p>	<p>Reword</p>
<p>“disability”</p>	<p>Defined, but not used again in the Policy</p>	<p>Unnecessary - remove</p>
<p>“objective medical evidence”</p>	<p>Definition is too narrow</p>	<p>Reword</p>
<p>“worsening”</p>	<p>Use of “worsening” in the policy is too limiting</p>	<p>Remove</p>
<p>“thin skull” and “crumbling skull”</p>	<p>References should be removed because too limiting, legalistic, and confusing to decision makers.</p>	<p>Remove</p>
<p>“...In such cases, workers are compensated for the work-related injury/disease and the claim is not denied due to the existence of a pre-existing condition.” (Initial Entitlement, p. 2)</p>	<p>Presumes that pre-existing condition is not severe enough to impact entitlement and as such it does or can fetter the discretion of the decision maker and ignore the requirements of other areas of the <i>Act</i>, other policies, and case law.</p>	<p>Entitlement should be made using the guidelines set out in the General Entitlement Policy along with Guides</p>
<p>“When objective medical evidence supports that the pre-existing condition was impacted by the compensable accident, the <b>WCB provides medical aid and benefits that are necessary to treat</b> the compensable injury, including the</p>	<p>To access medical aid, the adjudicator should always use the test as to whether or not the medical aid is “necessary and expedient” <b>AND</b> “as a result of” the injury. There may be occasions in the claim</p>	<p>Re-word</p>



Draft	Issue	Recommendation
<p><b>worsening of the pre-existing condition</b> by the compensable workplace injury.” (Determining Causality, p. 2)</p>	<p>process that the injury is no longer a material contributing factor to the need for and expediency of the medical aid.</p>	
<p>The WCB has fulfilled its responsibilities when:</p> <ul style="list-style-type: none"> <li>■ The temporary worsening of the pre-existing condition has returned to its pre-accident state;</li> <li>or,</li> <li>■ The permanent worsening of the pre-existing condition has been treated, and the effect on the injured worker’s loss of earnings is established (Determining Causality, p. 2)</li> </ul>	<p>Fetters discretion by eliminating the situation where the earning loss is not “as a result of” the injury which may occur before the worker has returned to pre-accident state</p>	<p>Reword</p>
<p>“In cases where the pre-existing condition is not contributing to the ongoing impairment but is prolonging the recovery from the work related injury/disease, benefits continue as long as the ongoing impairment is work related even if recovery takes longer due to the pre-existing conditions” (Determining work-relatedness, p. 3)</p>	<p>This guideline is inconsistent with section 37(9) of the Act and fetters the discretion of the adjudicator to decide entitlement based on the individual facts before the adjudicator.</p>	<p>Remove</p>
<p>In cases where the pre-existing condition <b>causes</b> the worker to be unable to commence or continue medical treatment for the compensable injuries, <i>Policy 1.3.2R – Interruption of Medical Treatment – Circumstances Beyond Worker’s Control</i> will be applied” (Determining work-relatedness, p. 3)</p>	<p>Unnecessary and confusing</p>	<p>Remove</p>
<p>Medical Opinion</p>	<p>Policy doesn’t guide the criteria for the opinion.</p>	<p>Reword</p>

## Appendix “B” Relevant Legislation

### Permanent-impairment benefit

34 (1) Where a permanent impairment **results from an injury**, the Board shall pay the worker a permanent-impairment benefit.

### Earnings-replacement benefit

37 (1) Where a loss of earnings **results from an injury**, an earnings replacement benefit is payable to the worker in accordance with this Section.

37 (9) Subject to subsection (10) and Sections 72 and 73, earnings replacement benefits are payable until the earlier of

- (a) the date the Board determines that the loss of earnings has ended or **no longer results from the injury**; and
- (b) the date the worker attains the age of sixty-five years.

### Medical aid

102 (1) The Board may provide for any worker entitled to compensation pursuant to this Part, or any worker who would have been entitled to compensation had the worker suffered a loss of earnings equivalent to the amount determined pursuant to subsection 37(4), any medical aid the Board considers necessary or expedient **as a result of the injury**.

“medical aid” includes (i) any health care service, product or device that may be authorized by the Board and is provided to a worker **as a result of a compensable injury**, including those forms and reports required by the Board respecting the aid or services, and (ii) reasonable expenses, authorized by the Board, incurred by a worker in order to obtain medical aid;

### Board may deny or reduce compensation

81 The Board may deny a claim for compensation or reduce the amount of compensation payable to a worker where

- (a) the worker previously made a claim for an injury of the same nature as the injury in respect of which the claim is made;
- (b) the worker has a medical condition that, in the opinion of the Board, requires the worker to be removed temporarily or permanently from working at a particular type of employment because the medical condition could result in an injury of the same nature as the injury in respect of which the claim is made;
- (c) the worker’s claim is made after the Board requested the worker to discontinue working at the particular type of employment in order to avoid injuries of the same nature as the injury in respect of which the claim is made;
- (d) the Board has offered to provide the worker with the rehabilitation assistance the Board considers necessary to enable the worker to become employable in another class of employment; and
- (e) the worker continues or returns to employment at the particular type of employment without the approval of the Board. 1994-95, c. 10, s. 81.

## **Duty to mitigate and co-operate**

84 (1) Every worker shall

- (a) take all reasonable steps to reduce or eliminate any permanent impairment and loss of earnings resulting from an injury;
  - (b) seek out and co-operate in any medical aid or treatment that, in the opinion of the Board, promotes the worker's recovery;
  - (c) take all reasonable steps to provide to the Board full and accurate information on any matter relevant to a claim for compensation; and
  - (d) notify the Board immediately of any change in circumstances that affects or may affect the worker's initial or continuing entitlement to compensation.
- (2) The Board may suspend, reduce or terminate any compensation otherwise payable to a worker pursuant to this Part where the worker fails to comply with subsection (1). 1994-95, c. 10, s. 84.

## Appendix “C”

### AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition

Province	Edition	Comment
Alberta	6 <sup>th</sup> Edition (Published in 2009)	
British Columbia	6 <sup>th</sup> Edition (Published in 2009)	5 <sup>th</sup> & 6 <sup>th</sup> edition. Currently under review for using only 6 <sup>th</sup> edition
Manitoba	6 <sup>th</sup> Edition (Published 2009)	The establishment of permanent hearing impairment is modeled on the most recent edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. (October 1, 2013)
New Brunswick	6 <sup>th</sup> Edition (Published 2009)	PMI directive – effective date - May 16, 2016.
Newfoundland	Has a 24 paged document on line regarding Permanent Functional Impairment Rating Schedule	The American Medical Association (AMA) Guides may also be used to evaluate the extent of functional impairment. As many cases do not fit neatly into the rating schedule, it is a guide and the examining physician will use his or her judgment to estimate the percentage of total body impairment.
Nova Scotia	4 <sup>th</sup> Edition (Published 1993)	
Nunavut	6 <sup>th</sup> Edition (Published 2009)	The WSCC pays compensation to a worker who suffers a Permanent Partial Disability (PPD) based on 90% of the Worker's Net Monthly Remuneration multiplied by the percentage of their reduction in physical and mental abilities. The WSCC determines this percentage using the <i>American Medical Association Guide to the Evaluation of Permanent Impairment</i> (AMA). Policy 06.03
Ontario	DSM III (Published 1980)	Ontario does not use the AMA (DSM IV is the most current published 2013).
PEI	6 <sup>th</sup> Edition (Published 2009)	Based on expert medical advice and a review of medical literature, the Workers Compensation Board has determined the <i>American Medical Association Guides to the Evaluation of Permanent Impairment</i> , Sixth Edition shall be used to assess the worker's level of impairment. Policy: POL-98 Section 2. February 16, 2011
Saskatchewan	6 <sup>th</sup> Edition (Published 2009)	Medical Services will provide PFI evaluations based on the most current edition of <i>The American Medical Association Guides to the Evaluation of Permanent Impairment</i> (AMAGuides). Policy: 4.4.4 Permanent Functional Impairment (PFI) – General (PRO 23/2010)
NWT (same as Nunavut)	6 <sup>th</sup> Edition (Published 2009)	The WSCC pays compensation to a worker who suffers a Permanent Partial Disability (PPD) based on 90% of the Worker's Net Monthly Remuneration

Province	Edition	Comment
		multiplied by the percentage of their reduction in physical and mental abilities. The WSCC determines this percentage using the <i>American Medical Association Guide to the Evaluation of Permanent Impairment</i> (AMA). Policy 06.03
Yukon	6 <sup>th</sup> Edition (Published 2009)	

## Appendix “D”

Excerpt from “Preventing Needless Work Disability by Helping People Stay Employed”  
American College of Occupational and Environmental Medicine  
Published in September 2006 JOEM  
(online at <https://www.acoem.org/PreventingNeedlessWorkDisability.aspx>)

### 5. Find a Way to Effectively Address Psychiatric Conditions

When a person with underlying psychiatric illness incurs a potentially disabling physical illness or injury, the risk of permanent disability increases unless the psychiatric problem is treated. A significant psychiatric disorder becomes symptomatic during a period of serious medical illness in more than 50 percent of cases, especially those with a history of a major psychiatric disorder. Many more previously undiagnosed workers also are vulnerable to developing their first episode of anxiety or depression when sick or injured. In these cases, the physical illness or injury precipitates the psychiatric episode.

Mental health treatment is required for these cases because the patient’s mental condition significantly affects his reaction to the illness, adherence to medical treatment, the course of illness, its impact on function, and functional recovery from the physical condition. Psychiatric factors can contribute significantly to permanent disability unless treatment is active and effective. However, the current SAW/RTW process often ignores or doesn’t detect or address psychiatric issues. The reluctance of treating physicians to make a psychiatric diagnosis comes primarily from lack of awareness and stigma. Patients often do not want these diagnoses.

**Even when a psychiatric diagnosis is made, treatment is often inadequate or inappropriate.** Limited benefits coverage and shortages of skilled mental health professionals often mean that expert treatment is unavailable. And, although all health care professionals understand the need to protect and foster role functioning in personal relationships, they often overlook the importance of role functioning at work. Faced with a patient who describes stress due to difficulties at work, leaving work is often seen as the solution.

Dramatic improvements in psychiatric diagnosis and treatment have occurred during the past 15 years. Although some employers know that psychiatric treatments are potentially cost effective, they also have spent considerable sums on ineffective, expensive therapy. They correctly believe that many mental health providers do not focus on functional recovery but continue with treatments that show no apparent benefit. **Payers have not conditioned access and payment on providers’ adherence to current treatment principles.** As with other chronic conditions, psychiatric disorders may require **intermittent intensive early treatment of new episodes as well as long-term, low-level treatment to prevent recurrence.**

*Recommendation:* Adopt effective means to acknowledge and treat psychiatric co-morbidities; teach SAW/RTW participants about the interaction of psychiatric and physical problems and better prepare them to deal with these problems; perform psychiatric assessments of people with slower-than-expected recoveries routine; make payment for psychiatric treatment dependent on evidence-based, cost-effective treatments of demonstrated effectiveness.

*Current Initiatives/Best Practices:* The Washington State Department of Labor and Industries pioneered an innovative program that provides psychiatric services to injured workers. The agency handles all workers’ compensation claims and pays all benefits for the state’s insured employers. The agency reached agreement with the state medical association to pay for up to 90 days of psychiatric treatment “as an aid to cure” a physical work-related injury **if the initial evaluation, treatment plan, and progress report notes meet certain specifications.** Showing a clear connection between the diagnosis

and specific barriers to resume working is essential, as is a connection between the treatment plan and removal of those barriers. As long progress is documented, payment continues for up to 90 days.