COMPENSATION SERVICES
PROGRAM OVERVIEW

FOR THE

ROYAL COMMISSION ON WORKERS’ COMPENSATION
IN BRITISH COLUMBIA

June 30, 1998
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APPENDICES
1.0 INTRODUCTION

One of the BC Workers’ Compensation system’s core functions is the administration of claims. This function is currently being performed by staff in the WCB’s Rehabilitation and Compensation Services Division. As described in the WCB’s Rehabilitation Services and Claims Manual:

“…the Board has sole jurisdiction over the adjudication of claims for compensation under the [Workers’ Compensation] Act. This jurisdiction is primarily exercised through the Board’s Claims Adjudicators, Claims Officers, Disability Awards Officers and Adjudicators in Disability Awards…” (page 1 - 2)

This report comprises Step 1 of a Compensation Services research project undertaken for the Commission. It provides an overview of the Compensation Services component of the Division, briefly describing its organizational structure, budgets, staffing, objectives, claims administration processes and policies, planning, monitoring and evaluation functions as well as new initiatives.

Step 2 involves the analysis and discussion of issues of particular concern with respect to Compensation Services. Six major issue categories are being addressed in Step 2: adequacy, equity, consistency, efficiency, effectiveness and accountability.

The Rehabilitation Services component of the Division is the focus of a separate research study for the Commission.
2.0 ORGANIZATIONAL STRUCTURE

Exhibit 1 illustrates how most\(^1\) staff who administer claims were organized as of January 1998\(^2\). Claims administration is structured along three dimensions:

- benefit type (e.g., health care, short term disability, long term disability);
- geographic region (e.g., Lower Mainland, Vancouver Island, Interior); and,
- activity type (e.g., call centre, policy/training, etc).

The primary departments currently involved in administering claims are:

- **Health Care Services** - which administers financial compensation for health care expenses in the short and long term\(^3\). This department is responsible for the Medical Services Plan (MSP)/Teleplan project.

- **Compensation Services** - which administers financial compensation for the loss of wages in the short and long term.

- **Central Services** - which develops and implements policy\(^4\) and quality assurance for staff who administer claims (as well as Rehabilitation staff).

- **Divisional Controller** - which provides financial and information systems support to staff who administer claims (as well as Rehabilitation staff). This department is responsible for the E-File project.

Within **Compensation Services**, units which administer short term disability payments include:

- **Interior Operations** - which covers all the Area Offices around the province, except those in the Lower Mainland and on Vancouver Island. This unit is also responsible for the Case Management pilot (being conducted in Prince George).

- **Vancouver Island Operations** - which covers all the Area Offices on Vancouver Island (as well as Terrace).

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\(^1\) Rehabilitation staff, especially vocational rehabilitation staff, who are not included in this program description may also administer claims.

\(^2\) After the Division’s reorganization in that month. The Division was reorganized again five months later, in May 1998.

\(^3\) In addition, Health Care Services is involved with administering special allowances, arranging and paying transportation needs and liaising with medical practitioners.

\(^4\) Additional information on Central Services’ policy function is presented in Appendix A.
Insert Exhibit 1 - Rehabilitation & Compensation Services Organizational Chart
In the Lower Mainland, short term disability staff work in the:

*Call Centre* - handling the reporting of all claims in the area and making “routine” entitlement decisions.

*Entitlement Unit* - making more complex entitlement decisions for claims in the area.

*Service Delivery Region (SDR) West* - administering claims in the Service Delivery Locations (SDLs) in the Western part of the Lower Mainland.

*SDR East* - administering claims in the SDLs in the Eastern part of the Lower Mainland (including Abbotsford).

*Long-Term Disability* staff administer long term disability payments across the province. They provide financial compensation for injured workers with permanent disabilities and/or occupational diseases. Long term disability compensation is also provided to dependents of workplace fatalities. The unit has two sections:

*Disability Awards* - which administers pensions for workers and dependents.

*Occupational Disease Services* - which administers occupational disease claims other than Activity-Related Soft Tissue Disorders (ASTDs).

In addition, there are several units located in the Lower Mainland which do not actively administer claims, but (with Central Services and the Divisional Controller) support the work of others who do so. They are:

*Operations* - which deals with records management (e.g., file disclosures), CRT (claim registrations), central scanning and indexing of incoming documents, etc.

*Field Services* - which conducts field investigations into specific claims or issues, such as fraud.

*Organizational Effectiveness* - a section with responsibility for ensuring practices and procedures are being developed in a systematic way and with sufficient documentation. *(confirm)*

*Staff Development* - a section concerned with the development and implementation of training for Compensation Services staff (as well as Rehabilitation staff). *(confirm)*

Claims administration staff work in Area Offices and in Lower Mainland SDLs.

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5 In addition, Disability Awards staff administer sensitive cases such as sexual assault claims.
6 These claims have recently been devolved to the SDLs. In addition, Occupational Disease Services staff handle staff claims and interjurisdictional claims.
Area Offices are staffed by:

- Health Care Services staff (payment clerks); and,
- Compensation Services staff (client service representatives, entitlement/claims officers, claims adjudicators/case managers, case/team assistants, etc.).

They do not include Disability Awards\(^7\) or Occupational Disease Services, Operations, Field Services, Organizational Effectiveness or Staff Development, Divisional Controller or Central Service staff.

Lower Mainland Service Delivery Locations include staff from Compensation Services (client service representatives, entitlement/claims officers, claims adjudicators/case managers, case/team assistants, etc.) as well, all other Compensation Services staff work in the Lower Mainland, including:

- Disability Awards, Occupational Disease Services, Operations, Field Services, Organizational Effectiveness and Staff Development staff; and,
- all Divisional Controller and Central Service staff.

More detailed descriptions of these departments and units are presented in Appendix A.

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\(^7\) With the exception of the Victoria SDL which is staffed to allow for the evaluation of their own permanent disability claims.
3.0 BUDGETS AND STAFFING

3.1 Financial And Human Resources

Claims administration is the most expensive of the WCB’s core functions, and is performed by the largest proportion of its staff. It consumes about 30% of the WCB’s total administrative expenses and employs about 40% of its staff.

Exhibit 2 presents some of the administrative expenses incurred to administer claims, as forecast in 1997 and planned for 1998. In 1997, the WCB’s total administrative costs were forecast at approximately $200 million, of which $60 million were to be incurred by Compensation Services functions (e.g., including Central Services, but excluding Vocational Rehabilitation). Similarly, in 1997, the WCB had a forecasted total staff complement of approximately 2,500 full-time equivalents, of which 977 were working in Compensation Services functions.

The largest components of administrative expenses are staff wages and benefits. However, these expenses do not include some claims administration costs, such as the claims-related portions of the WCB’s:

- overhead/support service costs for information services, facilities and communications or other administration costs; or,
- ‘‘appeal, review board and advisor’’ (dispute resolution) costs; or,
- capital costs. (1)

In general, the proportion of administrative expenses consumed by a function is similar to the proportion of full-time equivalent (FTE) positions it represents. The two exceptions to this are the Operations area which comprises a larger proportion of FTEs than it uses in administrative expenses, and the Divisional Controller which represents more in administrative expenses than FTEs.

- In 1997, 4% of full-time equivalent staff (40.4) and 4% of total administrative expenses ($2.1 million) were incurred to administer Health Care Services. 1998 projections indicate that a similar proportion and number of FTEs (4% and 38.0 respectively) and total administrative expenses (3% and $2.1 million) will be used by this function.

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8 A more detailed breakdown of these expenses is presented in Appendix B.
9 On average, wages are lower in this area than in other areas of the Division.
10 A large component of the Divisional Controller’s administrative budget covers interdepartmental postage.
## EXHIBIT 2 - FULL-TIME EQUIVALENTS (FTE) AND ADMINISTRATION EXPENSES (ADMIN)

<table>
<thead>
<tr>
<th></th>
<th>97 Fcst FTE</th>
<th>97 Fcst ADMIN ($000)</th>
<th>98 Plan FTE</th>
<th>98 Plan ADMIN ($000)</th>
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<tr>
<td><strong>WORKERS’ COMPENSATION BOARD (1)</strong></td>
<td>2,483.0</td>
<td>$200,578.1</td>
<td>2,550.6</td>
<td>$208,404.5</td>
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<tr>
<td><strong>COMPENSATION SERVICES (2)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Care Services</td>
<td>40.4</td>
<td>4%</td>
<td>38.0</td>
<td>4%</td>
</tr>
<tr>
<td>Compensation Services</td>
<td>908.0</td>
<td>93%</td>
<td>917.7</td>
<td>93%</td>
</tr>
<tr>
<td>Short Term Disability</td>
<td>720.2</td>
<td>74%</td>
<td>707.6</td>
<td>71%</td>
</tr>
<tr>
<td>- Lower Mainland</td>
<td>347.2</td>
<td>36%</td>
<td>314.6</td>
<td>32%</td>
</tr>
<tr>
<td>- Vancouver Island</td>
<td>172.0</td>
<td>18%</td>
<td>179.0</td>
<td>18%</td>
</tr>
<tr>
<td>- Interior</td>
<td>201.0</td>
<td>21%</td>
<td>214.0</td>
<td>22%</td>
</tr>
<tr>
<td>Long Term Disability</td>
<td>96.8</td>
<td>10%</td>
<td>93.7</td>
<td>9%</td>
</tr>
<tr>
<td>Operations</td>
<td>73.3</td>
<td>8%</td>
<td>98.4</td>
<td>10%</td>
</tr>
<tr>
<td>- Field Services</td>
<td>17.7</td>
<td>2%</td>
<td>18.0</td>
<td>2%</td>
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<tr>
<td><strong>Central Services</strong></td>
<td>14.8</td>
<td>2%</td>
<td>18.0</td>
<td>2%</td>
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<tr>
<td><strong>Divisional Controller</strong></td>
<td>11.6</td>
<td>1%</td>
<td>14.0</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Other (3)</strong></td>
<td>2.3</td>
<td>0%</td>
<td>2.0</td>
<td>0%</td>
</tr>
</tbody>
</table>

(1) Including both CEO and Chair responsibilities.
(2) Excluding Vocational Rehabilitation.
(3) Other includes Vice President, Customer Survey and Case Management.

**SOURCES:** 1998 Business Plan - Summary of Resource Plans and 1998 Corporate Business Plan
• In 1997, 74% of full-time equivalent staff (720.2) and 72% of total administrative expenditures ($43.5 million) were incurred primarily to administer Short Term Disability functions. Projections for 1998 indicate that both the proportion and numbers of total Compensation Services FTEs devoted to Short Term Disability functions are expected to remain quite similar – at 71% and 707.6 FTEs respectively. The proportion of administrative expenses devoted to Short Term Disability functions is also estimated at 71%, while expenditures should increase by $.9 million to $44.4 million.

• In 1997, 10% of Compensation Services’ full-time equivalents (96.8) and 10% of its administrative expenses ($6 million) were incurred primarily for Long Term Disability claims administration. Similarly, in 1998, projections are that 9% of total FTEs (93.7) and 10% of total administrative expenses ($5.9 million) will be spent on this function.

• In 1997, 8% of full-time equivalent staff (73.3) and 6% of total administrative expenses ($3.5 million) were incurred by Operations. 1998 projections indicate that a similar proportion but larger number of FTEs (10% and 98.4) and total administrative expenses (7% and $4.3 million) will be used by this sub-function.

• In 1997, 2% of Compensation Services’ full-time equivalents (17.7) and 2% of administrative expenses ($1.4 million) were incurred by Field Services. Similarly, in 1998, projections are that 2% of total FTEs (18.0) and 2% of total administrative expenses ($1.4 million) will be spent on this unit.

• In 1997, 2% of full-time equivalent staff (14.8) and 2% of total administrative expenditures ($1.1 million) were used on Central Services’ activities. Projections for 1998 indicate that the proportion of total Compensation Services FTEs and administrative expenses devoted to Central Services is expected to remain quite similar while the number of FTEs and administrative expenditures will rise slightly – at 2% of total FTEs (18) and 2% of total administrative expenditures ($1.4 million) respectively.

• In 1997, 1% of full-time equivalent staff (11.6) and 3% of total administrative expenses ($1.6 million) were incurred by the Divisional Controller. 1998 projections indicate that a similar proportion but higher number of FTEs (1% and 14) and total administrative expenses (3% and $2.2 million) are allocated to this function.

Similar values are presented in Appendix B for the past five years (1993 to 1997). The proportions of full-time equivalents and total administrative expenses consumed by functions have remained relatively similar over this time (within 3% across all categories).\textsuperscript{11} For example, Long Term Disability administrative expenses have

\textsuperscript{11} Except in 1993 and 1994, during which one of the now Inactive Service Centres accounts for a larger proportion and short term disability costs account for a smaller proportion of total administrative expenses and full-time equivalents.
comprised between 10% (1997) and 13% (1995) of total administrative expenses each year from 1993 to 1997. Similarly, Long Term Disability FTEs have ranged between 10% (1997) and 13% (1993) during these years.

However, the dollar amount of a function’s administrative expenses may have varied quite substantially from year to year. As well, FTE counts in some areas indicate significant decreases during this five year period. For example, in real dollars, Long Term Disability administrative expenses have ranged between $5.6 million (1993) and $7.5 million (1995) each year – a $1.9 million difference. Over the same five years, Long Term Disability FTEs have decreased from 164.7 (1993) to 87.6 (1997). Other areas with large FTE decreases are Operations (from 124.2 FTEs in 1993 to 64.4 in 1997) and Health Care Services (from 68.1 FTEs in 1993 to 41.0 in 1997).

In addition to administrative expenses, claim administration functions incur benefit payments or claim costs. Exhibit 3 illustrates the benefit payments administered by each of the claims administration functions (excluding vocational rehabilitation). In 1997, these functions incurred a total of $675.7 million in claim costs. Projections for 1998 are that a total of $676.8 million will be paid on similar benefits. In 1997:

- 22% ($150.6 million) of these claim costs were incurred for health care benefits. These benefits may be administered by health care or short term disability staff;
- 38% ($255.0 million) are short term disability benefits which are primarily administered by short term disability staff (who also determine claims’ entitlements to benefits); and,
- 33% are long term disability benefits and 7% are survivor benefits which are primarily administered by long term disability staff.

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12 These FTE counts are those taken as of December 31st each year. They are different from those included in annual budgets/forecasts for the year as a whole (presented in Exhibit 2).

13 As well as Rehabilitation staff including those in the Rehabilitation Centre.
EXHIBIT 3 - BENEFIT PAYMENTS/CLAIM COSTS ($000)

<table>
<thead>
<tr>
<th></th>
<th>97 Fcst</th>
<th></th>
<th>98 Plan</th>
<th></th>
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</thead>
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<tr>
<td>COMPENSATION SERVICES (1)</td>
<td>$675,650</td>
<td>100%</td>
<td>$676,800</td>
<td>100%</td>
</tr>
<tr>
<td>Health Care (2)</td>
<td>$150,650</td>
<td>22%</td>
<td>$155,800</td>
<td>23%</td>
</tr>
<tr>
<td>Compensation Services (1)</td>
<td>$525,000</td>
<td>78%</td>
<td>$521,000</td>
<td>77%</td>
</tr>
<tr>
<td>Short Term Disability</td>
<td>$255,000</td>
<td>38%</td>
<td>$240,000</td>
<td>35%</td>
</tr>
<tr>
<td>Long Term Disability</td>
<td>$225,000</td>
<td>33%</td>
<td>$240,000</td>
<td>35%</td>
</tr>
<tr>
<td>Survivor</td>
<td>$45,000</td>
<td>7%</td>
<td>$41,000</td>
<td>6%</td>
</tr>
</tbody>
</table>

(1) Excluding Vocational Rehabilitation and Widow's Project costs.
(2) Health Care benefits include Rehabilitation Centre costs of approximately $20,000.

SOURCES: 1998 Rehabilitation and Compensation Services Division Business Plan (Draft) and Workers' Compensation Board of BC Annual Report 1997
3.2 Position Descriptions

Compensation Services employs staff in numerous different positions. This section provides an overview of some of the key staff positions involved with administering claims, the main activities they are expected to undertake, as well as the qualifications and/or experience the WCB of them before they undertake these activities (according to their job descriptions). More details on these positions are presented in Appendix B. Information on staffing levels and training planned/provided by position are not available.

• Health Care Payment Officers are responsible for adjudicating and processing accounts for medical treatment, health care and income loss payments, transportation/subsistence arrangements, etc. The qualifications required for this position are a Grade 12 education and 9 to 12 months of related experience.

• Claims Officer Is or Client Service Representatives deal with short term disability claims – in particular, adjudicating simple/routine claims. CSRs also have an information gathering responsibility on non-routine claims. Claims Officer Is qualifications are a Grade 12 education and 9 to 12 months of related experience, preferably supplemented by post-secondary education in business or a related discipline. Client Service Representatives are required to have a Grade 12 education and 27 to 36 months (real time) related experience plus a 40 wpm net typing speed.

• Claims Officers IIs and Entitlement Officers adjudicate and manage short term claims. Claims Officer II qualifications are a Grade 12 education and 1 to 2 years experience, preferably supplemented by post-secondary education in a business or a related discipline. Entitlement Officer requirements are a post-secondary diploma in a related field (not specified), 1.5 to 2.3 years (real time) of experience and a typing speed of 40 words per minute.

• Case Assistants or Team Assistants provide support services to officer level staff and/or case management teams. Team Assistant qualifications are a Grade 12 education and 2.3 to 3 years (real time) of related experience.

• Claims Adjudicators or Case Managers are responsible for the adjudication and management of complex claims. Claims Adjudicators qualifications are a Grade 12 education and 3 to 4 years of related experience. However, according to an April 1997 memo from Central Services, in practice, an estimated 50% of the WCB’s Claims Adjudicators have a university degree (or equivalent) and 25% have some post-secondary education (from a few courses to a college certificate). Case Manager requirements are a university degree in a health care area or an equivalent combination of education and experience.

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14 Including those who work in Occupational Disease Services and Disability Awards.
• Junior Disability Awards Officers or Disability Awards Officers adjudicate and manage long term claims involving functional award entitlements. Junior Disability Awards Officer qualifications are a Grade 12 education and 9 to 12 months directly related experience. Disability Awards Officers require a Grade 12 education, 1 to 2 years of post-secondary education and 1 to 2 years related experience.
4.0 PURPOSE

4.1 Mandate

The WCB is *legislatively mandated* to provide compensation. Compensation payments are made to persons affected by a *work-related personal injury or occupational disease*. This may include *workers* or *their dependents*.

Many sections of the *Workers’ Compensation Act* influence claims administration, but four of its Divisions, in particular, affect the activities of compensation services staff:

- Part 1, Division 1 (Scope of this Part);
- Part 1, Division 2 (Compensation);
- Part 1, Division 3 (Scale of Compensation); and,
- Part 1, Division 5 (Procedure and Miscellaneous).

The legislative mandate for claims administration derives primarily from the following sections of the *Workers’ Compensation Act*:

- Sections 1, 2 and 17 which identify workers, employers and dependents covered by the Act;
- Sections 5, 6 (and 7) which specify the personal injury and occupational diseases covered by the Act;
- Sections 21, 22, 23, 29 and 30 which describe the types of benefits covered by the Act; and,
- Sections 53 to 56 which cover the reporting of claims.

Compensation for personal injury (including a fatal injury) or occupational disease is mandatory. Several sub-sections of the *Workers’ Compensation Act* specify that the compensation provided by the Act *must be paid*. These include sub-sections stipulating that:

5 (1) Where, in an industry within the scope of this Part, personal injury or death arising out of and in the course of the employment is caused to a worker, compensation as provided by this Part *must be paid* by the board out of the accident fund. (italics added)
6 (1) Where
(a) a worker suffers from an occupational disease and is thereby disabled
from earning full wages at the work at which the worker was employed or
the death of a worker is caused by an occupational disease; and
(b) the disease is due to the nature of any employment in which the worker
was employed, whether under one or more employments,

compensation is payable under this Part as if the disease were a personal injury
arising out of and in the course of that employment... (italics added)

The Act specifically covers mandatory payment of compensation to dependents of
workers as a result of a death in a sub-section which states that:

17 (3) Where compensation is payable as the result of the death of a worker or of
injury resulting in such death, compensation must be paid to the
dependants of the deceased worker as follows... (italics added)

Further, Section 13 of the Act specifically covers the fact that compensation cannot be
waived:

13 (1) A worker may not agree with his or her employer to waive or forego any
benefit to which the worker or the worker’s dependants are or may become
entitled under this Part and every agreement to that end is void. (italics
added)

4.2 Key Objective

The key objective of Compensation Services appears to be to provide fair (equitable)
compensation, as illustrated by the WCB’s statements below.

Fair compensation could have a number of components including:

- adequacy (in terms of level and duration);
- timeliness (such that income continuity is maintained);
- horizontal equity (across workers/dependents with similar circumstances); and,
- vertical equity (across workers/dependents in different circumstances).

The first two components provide for “income security”, the latter two relate more to
“consistency” in service delivery.
The objective of “fair compensation” has been in place at the Board at least since the early 1990s. For example, the WCB’s Mission Statement adopted by the Board of Governors in 1991 was (italics added):

Workplace safety and health is our challenge.
Quality rehabilitation and fair compensation is our commitment.
World leadership is our goal. (2)

Subsequently, in January 1995, the Compensation Services Division’s Mission Statement was:

“Together with workers and employers, the Compensation Services Division is committed to determining appropriate compensation and facilitating early and safe return to work.” (Compensation Services Management Meeting, 1995 Business Plan, Section 2, page 1)

More recently, the WCB’s 1997 Annual Report states that one of the goals the WCB is currently pursuing is:

Fair compensation for workers suffering from an occupational injury or illness. (page 1)

Fair compensation in terms of income security or income continuity is a key element of the WCB’s current Mission Statement, as outlined in its Strategic Plan, as well as in the Rehabilitation and Compensation Services Division’s 1997 and 1998 Business Plans:

“To strengthen the trust of workers and employers in the mutual insurance of safe workplaces with income security and safe return to work for injured workers.” (page 2) (italics added)

Similarly, the WCB’s 1996 Annual Report states that Compensation Services:

“…seeks to provide uninterrupted income for injured workers by processing compensation benefits quickly and fairly.” (page 21)

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15 At this time, the Division included Vocational Rehabilitation and Medical Services, but not the Rehabilitation Centre.
4.3 Critical Factors, Business Principles And Values

Equitable compensation is one of the “critical factors” outlined in the WCB’s 1996 Corporate Strategic Plan for the Board as a whole, which also include:

- superior service to injured workers and their families; and,
- a fully funded financial status.

Thus, while fairness is critical, so is client service as well as the organization’s financial stability. These critical factors can compete against each other. For example, improved service to workers in terms of faster decision-making has the potential to affect the quality and consistency (equity) of the decisions being made and the resource levels required to fund them.

These critical factors are further evidenced in the business principles which underlie the WCB’s 1996 Corporate Strategic Plan, and thus the Division, that the WCB be:

- service driven
- results focused
- cost effective
- prudent

Recently, the values which underlie the Board’s delivery of services have also been documented in the WCB’s 1997 Annual Report, as:

- service - client focused
- people - respectful, collaborative, supportive
- business - ethical, professional, prudent
- development - future-oriented, improvement-oriented, learning-oriented

4.4 Strategic Goals

The WCB’s 1997 Annual Report also outlines the Board’s strategic goals, along with their definitions and targets for the first time. These are operational goals which include an element of change (increase or decrease). Strategic goals to which Compensation Services may contribute include the Board’s intent to:

- reduce average total claim duration;
- improve timeliness of entitlement decisions to within 17 days of disablement;
- achieve income continuity for 90% of entitled claims;
- raise injured workers’ service satisfaction level;
- achieve an accident fund balance, including reserves, in the range of 110% to 115%;
- improve the work climate by 50% from current measurement; and,
- achieve a 90% accreditation level for professional officer staff.
5. CLAIM PROCESS

5.1 Reporting/Opening A Claim

The claims process starts with a work place accident or a worker suffering from an occupational disease. Either the worker, a dependent, an employer or a doctor may be the first to report the injury or disease to the WCB. They may mail or fax their forms (6, 7 or 8) to the Board (in Richmond or an Area Office). Receipt by the WCB of a form from any of the above is sufficient to open a claim. In 1997, approximately 186,000 claims were reported to the Board.

According to the Workers’ Compensation Act (Sections 53 to 56), a worker or dependent may apply to the WCB for compensation (using a Form 6). The worker may also visit a physician (if necessary) and notify their employer (if necessary). A physician (or other qualified medical practitioner) must send the WCB a report (Form 8) within three days of first attending the worker. An employer must send in their report (Form 7) within three days of the injury or disabling occupational disease and “immediately” where the worker has died. However, there appears to be no requirement for a physician or employer to notify the worker when they send in a report.

According to WCB staff, most claims are first reported by physicians (registered using Form 8s) or employers (registered using Form 7s). In the majority of cases, workers’ reports (Form 6s) are never sent in.

Before an entitlement decision is made, a worker, dependent, employer or physician may receive a call from a WCB staff member following up with them. Typically, these calls will ask them for additional information or for confirmation of information received already. However, entitlement decisions may also be made with out any direct contact with the worker.

Before E-File was implemented these calls would have been placed by Case Assistants, Claims Officers and Claims Adjudicators. With E-File they are usually placed by Client Service Representatives (CSRs) who try to gather all the required information on

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16 Claims may also be opened on the basis of other forms or a piece of correspondence. Sometimes two claims are opened because they are started on receipt of different information. These claims may subsequently be “consolidated”.

17 For example, it may not be necessary to visit a physician when the worker is reporting an accident, but not applying for health care or wage loss benefits.

18 For example, it may not be necessary to formally notify the employer if the employer is already aware of the injury or disease and is preparing or has sent in their report.

19 Or notification thereof by the worker.

20 WCB managers interviewed report that WCB staff are being encouraged to call workers when they first receive a file, to let them know they are handling their claim and provide them with a “direct line” contact number.

21 In the past, forms were received by the mail room, sent to Claims Registration which determined whether it was an existing claim (sent to an officer or adjudicator) or a new claim (sent to Claims Unit 9 to be assigned a complexity rating) and then sent to an officer or adjudicator (who worked with Case Assistants).
new claim files within five days. However, they may also be made by the individual making the entitlement decision on the claim (also the Client Service Representative, or an Entitlement Officer or a Claims Adjudicator).

Alternatively, workers (or dependents or employers – though not usually physicians) may phone in to request the status of the claim or to provide additional information. Before E-File was implemented their calls would have been directed to the Case Assistant, Claims Officer or Claims Adjudicator working on their file. With E-File their requests are usually answered by a Client Service Representative or the individual handling their claim.

• In 1997, Compensation Services piloted an Interactive Voice Response (IVR) automated telephone service enabling workers to phone the WCB to find out whether or not their claim has been accepted and/or the date and amount of their most recent compensation payment. Expansion of IVR across the province is planned for 1998. (7)

Thus, several different individuals may handle a claim and/or respond to questions from workers during this phase of the claims process – between when a claim is reported and when a decision on entitlement is made. These individuals most likely include one or more Client Service Representatives, Entitlement Officers and/or Claims Adjudicators.

5.2 Entitlement Decisions On New Claims

Most workers have their claims accepted. In 1997, 185,852 claims were reported. That year, claims equal to 1% (1,733) of those reported were rejected, while about 4% (8,358) were disallowed.²²

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²² Claims may be first paid, rejected or disallowed in a different year from that in which they are reported.
EXHIBIT 4 - CLAIM FLOWS (1997)

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total New Injuries Reported</td>
<td>185,852</td>
<td>100%</td>
</tr>
<tr>
<td>Claims Disallowed</td>
<td>8,358</td>
<td>4%</td>
</tr>
<tr>
<td>Claims Rejected</td>
<td>1,733</td>
<td>1%</td>
</tr>
<tr>
<td>Total Claims First Paid</td>
<td>148,144</td>
<td>80%</td>
</tr>
<tr>
<td>Health Care Only</td>
<td>73,020</td>
<td>39%</td>
</tr>
<tr>
<td>Short Term Disability</td>
<td>70,745</td>
<td>38%</td>
</tr>
<tr>
<td>Long Term Disability</td>
<td>4,215</td>
<td>2%</td>
</tr>
<tr>
<td>Fatal</td>
<td>164</td>
<td>0%</td>
</tr>
<tr>
<td>Difference (To Reported)</td>
<td>27,617</td>
<td>15%</td>
</tr>
</tbody>
</table>

SOURCE: WCB Data Response 2.4/2.5
However, claims equal to 15% (27,617) of those reported likely had no entitlement decisions or payments made on them. These include “suspended” claims, “phantom” claims and consolidated claims. Suspended claims are those where the claimant fails to respond to a request for information or withdraws the claim. Phantom claims are accident reports that are not claims for benefits (e.g., for exposures or information only). Claims are consolidated when two (or more) claims opened for the same injury are subsequently combined.

Most workers receive health care services and/or wage loss payments on their claims. In 1997:

- claims equal to 39% (73,020) of those reported were accepted and paid for health care services (only);
- claims equal to 40% (74,960) of those reported were accepted and paid for wage loss (38% for short term disability and 2% for long term disability)\(^{23}\); and,
- claims equal to less than 1% (164) of those reported were accepted as fatal claims and paid accordingly.

These claim flows have been changing over the past five years. For example, there are fewer claims entering the system in 1997 than in 1993. The number of new injuries reported has decreased - from 195,117 (1993) to 185,852 (1997). In particular, there are fewer \textit{unpaid} claims in the system. The difference between new injuries reported and claims with entitlement decisions/payments made on them (potential suspended/phantom/consolidated claims) appears to have decreased - from 51,688 (1993) to 27,617 (1997). At the same time, however, there are more \textit{paid} claims in the system. The number and proportion of claims first paid has increased - from 135,689 (1993) to 148,144 (1997). While their numbers have varied, the proportions of claims disallowed or rejected have remained relatively constant.

\(^{23}\) Health care services or payments may also have been provided on these claims.
EXHIBIT 5 - CLAIM FLOWS (1993 to 1997)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total New Injuries Reported</strong></td>
<td>195,117</td>
<td>197,911</td>
<td>194,280</td>
<td>189,418</td>
<td>185,852</td>
</tr>
<tr>
<td>Claims Disallowed</td>
<td>5,380</td>
<td>6,994</td>
<td>8,776</td>
<td>9,370</td>
<td>8,358</td>
</tr>
<tr>
<td>Claims Rejected</td>
<td>2,360</td>
<td>1,846</td>
<td>1,667</td>
<td>1,538</td>
<td>1,733</td>
</tr>
<tr>
<td><strong>Total Claims First Paid</strong></td>
<td>135,689</td>
<td>140,785</td>
<td>147,223</td>
<td>145,278</td>
<td>148,144</td>
</tr>
<tr>
<td>Difference (To Reported)</td>
<td>51,688</td>
<td>48,286</td>
<td>36,614</td>
<td>33,232</td>
<td>27,617</td>
</tr>
<tr>
<td><strong>Total Claims First Paid</strong></td>
<td>135,689</td>
<td>140,785</td>
<td>147,223</td>
<td>145,278</td>
<td>148,144</td>
</tr>
<tr>
<td>Health Care Only</td>
<td>56,186</td>
<td>59,297</td>
<td>68,823</td>
<td>71,438</td>
<td>73,020</td>
</tr>
<tr>
<td>Short Term Disability</td>
<td>75,601</td>
<td>77,108</td>
<td>73,762</td>
<td>69,021</td>
<td>70,745</td>
</tr>
<tr>
<td>Long Term Disability</td>
<td>3,778</td>
<td>4,228</td>
<td>4,504</td>
<td>4,667</td>
<td>4,215</td>
</tr>
<tr>
<td>Fatal</td>
<td>124</td>
<td>152</td>
<td>134</td>
<td>152</td>
<td>164</td>
</tr>
</tbody>
</table>

**SOURCE: WCB Data Response 2.4/2.5**
The composition of the claims which are first paid has also altered between 1993 and 1997. For example, the number and proportion of health care only claims grew from 56,186 (41%) in 1993 to 73,020 (49%) in 1997. Simultaneously, the number and proportion of short term disability claims decreased from 75,601 (56%) in 1993 to 70,745 (48%) in 1997. In comparison, while their numbers have varied, the proportions of long term disability and fatal claims remained relatively constant.

A worker can expect to have the Board make a decision on whether their claim has been accepted within three weeks after their injury/disablement. For example, among workers whose claims were accepted and paid for short term disability benefits (equal to approximately 38% of the claims reported in 1997):

- approximately one in five workers (17%) had short term disability payments first made on their claims up to seven days after their injury/disablement in 1997;
- almost one in two workers (48%) had short term disability payments first made on their claims up to fourteen days after their injury/disablement in 1997; and,
- almost two in three workers (66%) had short term disability payments first made on their claims up to twenty-one days after their injury/disablement in 1997.

24 Communicating these decisions may require additional time.
25 These time periods apply irrespective of when the worker reported or registered their claim – they include claims returning from the appeal system or with a delay of over 365 days (which are excluded from the timeliness statistics reported by Compensation Services).
**EXHIBIT 6 - TIME FROM DATE OF INJURY/DISABLEMENT TO FIRST SHORT TERM DISABILITY PAYMENT (ALL CLAIMS)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6-7 Days</td>
<td>3434</td>
<td>4%</td>
<td>4947</td>
<td>6%</td>
<td>5687</td>
</tr>
<tr>
<td>8-14 Days</td>
<td>16459</td>
<td>21%</td>
<td>17989</td>
<td>22%</td>
<td>18883</td>
</tr>
<tr>
<td>15-21 Days</td>
<td>17636</td>
<td>22%</td>
<td>17042</td>
<td>21%</td>
<td>15935</td>
</tr>
<tr>
<td>21-60 Days</td>
<td>32145</td>
<td>41%</td>
<td>31212</td>
<td>38%</td>
<td>27012</td>
</tr>
<tr>
<td>61+ Days</td>
<td>9463</td>
<td>12%</td>
<td>10003</td>
<td>12%</td>
<td>10371</td>
</tr>
<tr>
<td>Total Days</td>
<td>79137</td>
<td>100%</td>
<td>81193</td>
<td>100%</td>
<td>77888</td>
</tr>
</tbody>
</table>

**SOURCE:** WCB Data Response 5.2
The timeliness of these short term disability payment decisions has been improving. In 1997, twice as many workers had short term disability payments first made on their claims up to fourteen days after their injury/disablement than five years earlier. In 1997, 48% of workers’ first short term disability payments were made during this time (as reported above). In 1995, this proportion was 31%, while in 1993 it was only 25%. In contrast, the proportion of workers with short term disability payments first made on their claims between twenty-nine and sixty days after their injury/disablement decreased to 25% in 1997, from 41% in 1993.

It can take longer or shorter for an entitlement decision to be made, depending upon:

- how long it takes for all the required information to be gathered or sent in.
- how long it takes to make the entitlement decision which can vary with:
  - the complexity of the claim (e.g., M, B, C or Y).
  - the level of investigation required on it. In most cases the issues are decided based on the information in the worker’s application and the employer’s and medical reports – in a minority of cases more formal investigative procedures may be used. (8)
  - staff workloads and schedules.

The timeliness of the decisions made on other claim types, however, varies. Information on the average length of time it takes to reject or disallow new claims is not available.

- **Information on the timeliness of health care claims has been requested. These payments are generally made to health care practitioners or vendors, rather than to workers.**

On fatal claims, survivor benefits are typically paid for the first time within ninety days of a worker’s fatality. Over the last five years, between 49% and 70% of survivor benefits were first paid within ninety days (other than on reinstated pensions in 1996 and 1997). (9)

Workers’ may or may not be notified about their claim’s entitlement decision by the WCB. If their claim has been **accepted for short term disability benefits**, the worker receives a cheque at this time. However, no letter is sent to them unless there has been a protest from their employer – and no reasons are given for a claim which is accepted. If their claim has been **rejected or disallowed**, the worker may receive a letter stating why this decision has been made at this time. (10)

- **The WCB’s Assured Service initiative would ensure workers receive a phone call if their claims are not adjudicated for short term disability benefits within 17 days.**
If the claim has *no entitlement decision or payment made* on it, or is *accepted with benefits paid only to others* (e.g., physicians), the worker receives neither a cheque nor a decision letter. In 1997, claims equal to 15% of those reported likely had no entitlement decisions or payments made on them, while 39% were accepted and paid for health care only.

The worker (or dependent) may hear back about an entitlement (and first payment) decision made by:

- a Client Service Representative (on routine or health care only claims);
- a Claims/Entitlement Officer (on more complex claims);
- a Claims Adjudicator/Case Manager (on complex claims); or,
- a Disability Awards Adjudicator (on fatal claims).

All Claims are initially screened by a CSR and either kept for first payment or assigned for review by an Entitlement Officer. Some types of claims are referred to a Claims Adjudicator or Case Manager to determine entitlement (e.g., ASTDs). Routine (straightforward) traumatic claims are accepted and have the initial payment done by the CSR. If the worker is off more than five days the claim is assigned to either an Entitlement Officer or Claims Adjudicator (depending upon the issues on the claim) for ongoing payment and claims management. Some of the criteria for triaging new claims are presented in Exhibit 7. (11)
Insert Exhibit 7 - CSR Business Process - Call Centre - New Claims Triage
A worker is likely to be working at the time they hear about their entitlement decision. Only an estimated 15% to 20% of all claims reported cover persons off work for more than three weeks before they are closed for the first time. For example:

- About one-half (54%) of these workers likely continue to work while reporting their claim and awaiting an entitlement decision, including:
  - workers whose claims have no entitlement decisions or payments made on them (estimated at 15% in 1997) – who are therefore unlikely to have lost wages as a result of an injury or disease (are likely to have continued to work).
  - workers whose claims are accepted and paid for health care only payments (39% in 1997) – who are therefore unlikely to have lost wages as a result of an injury or disease (are likely to have continued to work).

- A further 24% (estimated) may not have worked for a period of days, but return to work within three weeks (i.e., receive short term disability benefits for 14 days or less). For example, in 1997, among workers who received short term disability benefits on claims which were closed for the first time in 1997 approximately 62% received short term disability benefits for 14 days or less. (12)

- For about 5% of the claims reported no information is available which can be linked to workers’ employment situations (rejected and disallowed claims) or for which it doesn’t apply (fatal claims).

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26 A full-time worker is typically (but not always) paid for five days of benefits in a calendar week.
27 Thus, 38% received short term disability benefits for more than 14 days (equal in number to 15% of those reporting claims).
### EXHIBIT 8 - ESTIMATED LENGTH OF WAGE LOSS - ALL CLAIMS REPORTED (1997)

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Wage Loss Payments</td>
<td>54%</td>
</tr>
<tr>
<td>Potential Suspended/Phantom/Consolidated Claims</td>
<td>15%</td>
</tr>
<tr>
<td>Health Care Only Claims</td>
<td>39%</td>
</tr>
<tr>
<td>STD Paid For 14 Days Or Less (New Claims)</td>
<td>24%</td>
</tr>
<tr>
<td>STD Paid For More Than 14 Days (New Claims)</td>
<td>15%</td>
</tr>
<tr>
<td>Rejected/Disallowed/Fatal/LTD Claims</td>
<td>7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**SOURCE:** WCB Data Response 2.4/2.5/5.15
The entitlement decision may be appealed by the worker or by their employer. If the employer appeals the decision, the worker may not learn about it for some time. The employer has up to 90 days to appeal the decision from the decision allowing a claim.(13)

Entitlement decisions most frequently brought to the Workers’ Compensation Review Board or to be the focus of a Manager Review are those which disallow claims. (14)

5.3 Health Care Services On New Claims

Once an entitlement decision has been made accepting the claim, eligible health care expenses can be paid. If a claim is not accepted, eligible health care expenses are not paid, even if they have already been incurred 28. (15)

Health care expenses are incurred in the following manner (other than those incurred for emergency and/or first aid treatments). 29

Workers may choose a physician (or qualified practitioner) to attend them – that is, someone who will provide or recommend health care services to them. (16) Most workers likely choose their family physicians to attend them.

There are five types of physicians or qualified practitioners workers may choose among (medical practitioners/physicians, naturopaths, chiropractors, podiatrists or dentists - as qualified by their own Acts). (17) The majority likely choose medical physicians who are members of the BC Medical Association.

Among these types of physicians/qualified practitioners – workers may choose any physician or qualified practitioner, so long as they accept the appropriate WCB fee schedule. (18) The WCB has established fee schedules with physicians (BCMA), chiropractors, and physical therapists/massage therapists. (19) Again, this is likely a majority of BCMA members/physicians in the province.

Decisions on what health care services workers need and will be provided with are made initially by their attending physician (qualified practitioner). They may include referrals to another health care provider (e.g., a physiotherapist), medical appliances/special equipment (e.g., crutches) and/or prescribed medications. (20)

- Information has been requested on the duration of health care payments. It is anticipated that they are typically paid for periods of less than eight weeks.

Health care is “subject to” the direction of the WCB who may, at their discretion, limit or reverse the decisions made by workers’ attending physicians. (21) Some of the ways in which the WCB exercises its control over health care are discussed below.

28 Unless they have been incurred at the Rehabilitation Centre or for “investigative purposes”.
29 The special allowances and transportation expenses administered by Health Care Services are not included in the following discussion.
Generally, the worker may only visit one health care provider at a time. Workers may receive health care services whether or not they are working. However, if they are not working, they may return to their doctor once every two weeks for a check up, until they return to work or are considered ready to return to work. (22)

Workers may receive some treatments for a limited time only without WCB pre-approval, for example:

- physiotherapy, massage therapy, chiropractic treatments, naturopathic treatments are all limited to eight weeks; and,
- some medications (e.g., those containing a narcotic). (23)

While most treatments are approved by the WCB after they are received, some require the worker (or their physician) to request approval before they proceed, including (but not limited to):

- extensions of physiotherapy, massage therapy, chiropractic and naturopathic treatments;
- dental;
- acupuncture;
- elective surgery;
- some out of province treatment;
- some medical appliances; and,
- chronic pain agency programs. (24)

- *Health Care Services’ Program 2000 is to standardize some elements of these services through the use of standard protocols, drug benefits lists, standard allowances and preferred provider contracts.* (24a)

In addition, workers may find that their claims have been referred to WCB Medical Advisors for a wide range of reasons. Their claims are usually referred to Medical Advisors by Claims Adjudicators (though they may, in theory, be referred by attending physicians as well). They are usually referred after eight weeks, rather than immediately after an injury. Workers may or may not be aware of these referrals. (25)

Reasons for referring these claims may include whenever a Claims Adjudicator “does not understand or is confused by a medical issue” (26), as well as for specific procedural reasons such as:

- requests for treatment extensions (e.g., chiropractic, physiotherapy, massage therapy and naturopathic);
- concurrent treatments (pre or post);
- out of province treatments (pre); and,
- “delayed”/extended period without a return to work (i.e., to terminate benefits). (27)
The WCB Medical Advisor may review the file, and they may also examine the worker (at the Board) in order to provide an opinion to the Claims Adjudicator (and, theoretically, the attending physician) on the issue which prompted the referral. (28)

The worker may (also) find that they have been referred to one of the WCB Rehabilitation Centre programs by a Claims Adjudicator or Medical Advisor. Their attending physician may also refer them to these programs, but only via Board staff. (29)

Or the worker may find that they have been identified as potentially eligible for a Work Conditioning program through the EIPS program. In this case, they may receive a phone call reviewing their eligibility for work conditioning at three weeks after their injury. (29a)

Workers’ health care providers may send their invoices for payment directly to the WCB. Workers may submit out of pocket expenses to the WCB for reimbursement as well. (30)

If workers (or practitioners) submit their expenses before the entitlement decision is made, they will be paid once this decision is made. If they submit their expenses after the entitlement decision is made, their request will be processed immediately. Service providers are paid through MSP twice a month, or directly once a month. Workers’ requests are paid as they are processed throughout the month.

- *The MSP/Teleplan initiative is expected to expedite the payment of health care invoices.* (30a)

Health care payments cease:

- when the health care services are considered to be no longer necessary, including when a decision has been made that any ongoing medical problems are not compensable;
- when the worker fails to attend a medical exam; or,
- for insanitary or injurious practices/refusal to submit to medical treatment. (31)

As specified in the Rehabilitation Services and Claims Manual:

> “Coverage for necessary health care continues for as long as the worker continues to experience the effects of a compensable injury or occupational disease, notwithstanding that he or she may not be disabled from working or may be retired from the workforce.” (page 10-2)

Thus, a worker may have contact with WCB staff around health care services in the following ways:

- not at all (when payments are made only to their health care practitioners or vendors);
- with one or more health care payment clerks (e.g., around reimbursable health care expenses or special allowances);
• with one or more claims staff (e.g., Client Service Representative, Entitlement Officer and/or Claims Adjudicator for more complex reimbursable expenses, lengthier treatments and/or services which require pre-authorization); and/or,
• with other WCB staff e.g., rehabilitation staff, medical or nurse advisors and special consultants around rehabilitation, long-term or complex medical issues.

Appealable health care service issues in the Claims Adjudication Handbook include: extension of chiropractic care, physiotherapy and massage therapy. (32)

5.4 Short Term Disability Benefits On New Claims

Once an entitlement decision has been made, short term (temporary) disability (std) benefits may also be paid. Std benefits are incurred when a worker is unable to work, because they are “medically unstable”. (33)

As noted above, most workers receive three weeks or less in short term disability benefits (62% of those who received short term disability benefits on claims first closed in 1997). These workers would receive only one or two wage loss cheques before their claim is closed for the first time. (31)

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30 The WCB calculates its measure of “retrospective duration” for short term disability benefits on claims which are closed for the first time – primarily new claims and excluding re-opened claims.
31 About one-third of those receiving short term disability benefits receive more than one payment (two thirds receive a combined “first and final” payment). (confirm)
### EXHIBIT 9 - DISTRIBUTION OF DAYS DURATION (TOTAL WCB)

<table>
<thead>
<tr>
<th>Duration</th>
<th>1996</th>
<th>1997</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 7 Days</td>
<td>34607</td>
<td>35421</td>
</tr>
<tr>
<td>8 - 14 Days</td>
<td>11562</td>
<td>11465</td>
</tr>
<tr>
<td>15 - 21 Days</td>
<td>6015</td>
<td>5737</td>
</tr>
<tr>
<td>22 - 28 Days</td>
<td>3846</td>
<td>3699</td>
</tr>
<tr>
<td>29 - 60 Days</td>
<td>9474</td>
<td>9980</td>
</tr>
<tr>
<td>61 - 90 Days</td>
<td>3485</td>
<td>3620</td>
</tr>
<tr>
<td>91+ Days</td>
<td>5366</td>
<td>4966</td>
</tr>
<tr>
<td><strong>Total Days</strong></td>
<td><strong>74355</strong></td>
<td><strong>74888</strong></td>
</tr>
<tr>
<td><strong>Average Number Of Days</strong></td>
<td><strong>29.4</strong></td>
<td><strong>28.3</strong></td>
</tr>
</tbody>
</table>

**SOURCE:** WCB Data Response 5.15
On average, workers received 28 days of short term disability benefits on new claims in 1997 – though for workers with complex claims (C claims) the average was longer than this. (34)

Workers may receive short term disability benefits on new claims for several months. For example, 7% of those with short term disability claims first closed in 1997, were paid short term disability benefits for 91 days or more. Short term refers to the fact that the disability is considered to be “temporary” (is not medically stable) at this time, rather than a specific period of days, weeks or months.

During this time, the worker receives cheques from the WCB for wage loss, separately from any cheques they receive for health care expenses. In addition, the following may occur:

- **After 4 weeks (one month)**, their claim should be passed on to a Claims Adjudicator if it has not already been. Thus, their contact at the Board may change (probably for at least the second time).

- **After 8 weeks (two months)** their wage rate may be reviewed. (35)

- **After 13 weeks (more than three months)** their file may be reviewed regarding the need for medical or rehabilitation referrals, wage rate information and consideration of Sections 5(5) and 39(1)(e). (36)

- Workers may also be referred to vocational rehabilitation – if they meet the “immediate referral” criteria for these services, for example. (37)

- Workers with potential permanent disabilities may also be referred to disability awards. (38)

- **After six months** his/her file may be reviewed regarding the worker’s estimated recovery or plateau date, whether or not a rehabilitation plan is required and what information needs to be provided to the worker regarding WCB policy and procedures, according to the Claims Adjudication Handbook. A team meeting of WCB staff should also be considered at this time. (39)

Workers may or may not hear from the Board during or after the 8 and 13 week reviews or as a result of a referral to vocational rehabilitation or disability awards. They should be informed or advised of the outcomes of the six month file review.

- **Under Case Management, the short term disability benefit claims process is expected to change such that, for complex claims, workers, their attending physicians and**

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32 If a worker is actively participating in a Work Conditioning program their claim may not be passed on at this time.
Program Overview

WCB team members are more actively involved in the claims process, and from an earlier date (e.g., before six months).

Once started, workers continue to receive short term disability payments on a bi-weekly basis until:

- they return to work;
- their physician determines they are medically stable (and ready to return to work);
- the WCB deems they are medically stable and ready to return to work (based on medical reports which may contradict the workers’ physicians’ reports); or,
- they are determined to be medically stable (by their attending physician or the WCB) and not ready to return to work (see below). (40)

The WCB may hear about a return to work in the following ways:

- The worker advises the WCB when they return to work. The stub message on the WCB benefit cheque and the information pamphlet sent on filing a claim also state that workers must advise the WCB of all earnings while in receipt of WCB benefits.
- Employers advise the WCB when their worker returns to work (by phone or using a Form 9).
- Physicians, other qualified practitioners or continuum of care providers may report a return to work on their progress reports when such is the case. (40a)

As noted above, most workers (80% - 85%) are likely to be working when their entitlement decisions (if any) are made. Others will return to work after this while still receiving short term disability benefits (e.g., on a graduated return to work or “Section 30” initiative). Still others will return to work after this, but at the same time as their short term disability benefits end (the return to work will be the reason for the benefits being terminated). (41)

In practice, the WCB maintains ongoing contact with the parties and identifies the return to work or contacts the various parties for confirmation when one or another of them indicates a likelihood of a return to work.

However, a worker may be determined to be medically stable (to have “plateaued”) and not be ready to return to work if they:

- need vocational rehabilitation services; and/or,
- have a permanent disability which impairs their ability to work. (42)
It is likely that only a few workers will not have returned to work by the time their short term disability benefits are “finalled” or “terminated”\(^{33}\). These workers have three options once their short term disability benefits end:

- a WCB staff member may refer them to vocational rehabilitation. (43) If they are accepted for vocational rehabilitation, they may receive a “wage loss equivalency” allowance while they are pursuing their vocational rehabilitation plan.

- a WCB staff member may refer them for a pension assessment. (44) They may receive a “wage loss equivalency” allowance while their pension is being assessed.

- they may receive no other WCB benefits or allowances – and may need to apply to other income support programs for financial assistance:
  - while looking for work (without receiving vocational rehabilitation services);
  - while waiting for vocational rehabilitation acceptance/allowance decisions; and/or,
  - while waiting for their pension to be assessed/paid.

According to WCB data, more than one-half (52%) of those receiving functional pension awards in 1997 were awarded their pensions more than one year after it became effective (e.g., after their short term disability benefits ended\(^{34}\)). Similarly, more than three quarters (78%) of those receiving loss of earning pension awards in 1997 received their awards up more than one year after it became effective. (44a)

Once workers have returned to work or are determined to be medically stable without a return to work they may get a letter from a Claims Adjudicator stating that their short term disability benefits have been terminated. (45)

Thus, a worker may have contact with WCB staff while they are being paid (around) short term disability benefits in the following ways:

- with a CSR, EO, CA/CM or Case/Team Assistant
  - administering their payments (e.g., wage rate setting);
  - around their return to work (letting the Board know or confirming);
  - around their non-return to work (and need for other services); and,

- with vocational rehabilitation or disability award staff around the services they provide.

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\(^{33}\) The WCB does not currently capture data on return to work for all workers receiving short term disability benefits.

\(^{34}\) For claims which received no short term disability benefits (e.g., hearing loss claims) the date of injury disablesment has been used.
Workers frequently appeal short term disability benefit decisions around the termination of these benefits. (46)

5.5 Long Term Disability Benefits On New Claims

Generally, once short term (temporary) disability benefits are finished\(^{35}\), long term (permanent) disability benefits may be paid. Long term disability benefits may be paid:

- with the worker having returned to work (even if they are determined to have a 100% permanent disability for benefit purposes); or,

- without the worker returning to work. (47)

The worker may have received a letter stating that their short term benefits have been terminated and their claim referred for a pension assessment. Workers could expect to be referred to Disability Awards if it is evident they have a permanent disability based on a report from their physician or a WCB Medical Advisor. The permanent disability must be physical, but may also include a loss of earnings component. (48)

Workers are most likely to be eligible for a functional pension award. For example, in 1997, 87% of all pension awards were functional awards, while 13% were loss of earnings awards.

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\(^{35}\) In a few cases, such as those involving hearing loss, long term disability benefits are paid immediately (without short term benefits having been paid).
### EXHIBIT 10 - LONG TERM DISABILITY AWARDS (1997)

<table>
<thead>
<tr>
<th></th>
<th>FNC</th>
<th>LOE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number Of 1997 Awards</td>
<td>4545</td>
<td>698</td>
<td>5243</td>
</tr>
<tr>
<td>Percent Of Total 1997 Awards</td>
<td>87%</td>
<td>13%</td>
<td>100%</td>
</tr>
<tr>
<td>Number Of First Awards</td>
<td>3850</td>
<td>338</td>
<td>4188</td>
</tr>
<tr>
<td>Percent First Awards (of 1997 Awards)</td>
<td>85%</td>
<td>48%</td>
<td>80%</td>
</tr>
<tr>
<td>1997 Awards with 5% Or Less PFI</td>
<td>66%</td>
<td>44%</td>
<td>63%</td>
</tr>
<tr>
<td>Percent With Pension Reserves Of $50,000 Or Less</td>
<td>86%</td>
<td>20%</td>
<td>77%</td>
</tr>
<tr>
<td>Average Reserve (1997 Awards)</td>
<td>$28,385</td>
<td>$211,004</td>
<td>n/a</td>
</tr>
<tr>
<td>Referral To Implementation (Months)</td>
<td>7.1</td>
<td>12.5</td>
<td>n/a</td>
</tr>
<tr>
<td>Up To 1080 Days From Date Of Injury/Disablement To Activation Date (First Awards)</td>
<td>68%</td>
<td>32%</td>
<td>65%</td>
</tr>
<tr>
<td>Average Days From Date Of Injury/Disablement To Activation Date (First Award)</td>
<td>3.5 yrs</td>
<td>4.8 yrs</td>
<td>n/a</td>
</tr>
</tbody>
</table>

**SOURCES:** WCB Data Response 5.8/5.9/6.1/6.2/6.4/6.6/6.7 and 1998 Rehabilitation and Compensation Services Business Plan (Final)
Workers receiving functional pension awards are most likely to receive awards for permanent functional impairments of less than 5% or with pension reserves of $50,000 or less. In 1997, 4,545 functional pensions were awarded, 66% with permanent functional impairments of less than 5% and 86% were established with pension reserves of $50,000 or less. The average pension reserve established for 1997 functional awards was $28,385.

Workers receiving loss of earnings pension awards are less likely to receive awards with permanent functional impairments of less than 5% or with pension reserves of $50,000 or less than those receiving functional awards. In 1997, 698 loss of earnings pensions were awarded, 44% with permanent functional impairments of less than 5% and 20% with pension reserves of $50,000 or less. The average pension reserve established for 1997 loss of earnings awards was $211,004.

Pension assessment referrals may be made either before or after short term disability benefits are terminated. Workers can expect to wait six to twelve months to receive their pension award after their claims have been referred for assessment. Functional pension awards averaged 8.3 months to determine in 1996 and 7.1 months in 1997. Pensions with a loss of earnings component took an average of 11.3 months in 1996 and 12.5 months in 1997. (49)

Workers might expect to receive their first pension award within three years of their date of injury/disablement. For example, in 1997, 68% of the functional awards which were the first awards made on a claim were activated within 1080 days after the date of injury/disablement. Where loss of earnings awards were the first made on a claim, 32% were activated up to 1080 days after the date of injury/disablement in 1997.

During the pension determination process, workers may hear from a Disability Awards Officer or Claims Adjudicator gathering information for a functional pension decision or a Vocational Rehabilitation Consultant completing an Employability Assessment for a loss of earnings pension decision. A new (third) average earnings level may be established on their claim, and it may be a deemed one. In addition, the worker may be required to have a Functional Evaluation done for pension purposes. (50)

During the time that a pension is being assessed:

“…workers who are not reemployed may find themselves temporarily without income. Some may depend upon welfare or unemployment compensation. In some cases, the WCB will allow a worker to continue to receive income replacement benefits until the permanent disability benefits begin to be paid. The payments are recaptured when the pension is capitalized.” (1996 Administrative Inventory, page 105)

Pensions may be “commuted” and the worker receive a lump sum payment or they are paid monthly - at the end of each month. (51)
Workers may be entitled to and receive benefits from other sources at the same time as they receive WCB benefits. In particular, Canada Pension Plan disability benefits may be “stacked” with WCB permanent disability benefits. (52)

A worker’s projected loss of earnings pension will be reviewed (once) after two years (or after appeal) – and may be reviewed subsequently at the discretion of the Adjudicator. (53)

Workers frequently appeal long term disability benefit decisions around the existence of a permanent disability and the amount of compensation for this disability. (54)

- Under Case Management this claims process is expected to change such that the pension assessment process, for complex claims, should begin more quickly and take less time to complete because of the earlier and ongoing involvement of vocational rehabilitation staff and those making pension award decisions – resulting in more timely pension awards being made.

- The ARCON initiative is also expected to improve the timeliness and consistency of pension awards for some functional impairments.

### 5.6 Re-Opening A Claim

Workers may request that the WCB re-open their claims for various reasons, such as medical deterioration, reinjury or an unsuccessful return to work as part of a vocational rehabilitation intervention. (55)

Workers’ claims may be re-opened for any of the types of benefits described above i.e., health care, short term disability, long term disability (or vocational rehabilitation).

An estimated 10% to 15% of new claims receiving short term disability benefits in a year are subsequently “reopened” for short term disability benefits. For example, in 1997 claims equal in number to 13% of those first paid short term disability benefits were re-opened. Most (around 90%) of these short term disability claims which are reopened are only reopened once in a year – but one or two claims each year may be reopened six or more times in that year.
### EXHIBIT 11 - SHORT TERM DISABILITY REOPENINGS (1997)

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short Term Disability Claims First Paid</td>
<td>70,745</td>
<td>100%</td>
</tr>
<tr>
<td>Short Term Disability Claims Reopened</td>
<td>9,112</td>
<td>13% 100%</td>
</tr>
<tr>
<td>Once</td>
<td>8,131</td>
<td>89%</td>
</tr>
<tr>
<td>Two Or Three Times</td>
<td>959</td>
<td>11%</td>
</tr>
<tr>
<td>Four Times Or More</td>
<td>22</td>
<td>0%</td>
</tr>
<tr>
<td>Average Duration</td>
<td>66.9</td>
<td></td>
</tr>
</tbody>
</table>

(Number Of Days From The Date Of Reopening To The Date Of Closure)

**SOURCE: WCB Data Response 8.1/8.2/8.3**
On average, the duration of short term disability claim re-openings is longer than the duration of all new claims (67 days as compared to 28 days for new short term disability claims). Total claim duration (new and re-openings) was 42 days in 1997 (“total year duration”). (55b)

An estimated 50% of the claims referred to vocational rehabilitation in a year are re-referred for vocational rehabilitation services. (56)

- **Information on the proportion of claims which are “re-opened” for health care benefits and long term disability benefits has also been requested from the WCB.**

Workers’ may apply to have their claims reopened multiple times over as many years as the injury or disease continues to affect them. Re-openings can serve as an important source of information to the WCB on the performance of its claims administration function.

Denied re-openings are among the top reasons for worker appeals. (57)

- **As a result of Case Management and EIPS re-openings one would expect re-openings to be reduced.**
6.0 POLICIES AND PROCEDURES

6.1 Health Care Benefits

Legislation

Health Care Services are mandated under Section 21 of the Workers’ Compensation Act, but are also affected by Sections 56 and 57.

Section 21 specifies what forms of health care are compensated, and provides guidance for some “exceptional circumstances”, such as:

- where a different physician, used in an emergency, is justified;
- where employers furnish health care; and,
- where workers are entitled to additional health care (due to their circumstances prior to April 1, 1972).

In addition, Section 21 specifies that the Board has ultimate control over the health care provided – in terms of what health care is used and at what level it is compensated. However, it also provides for worker choice in the selection of their physician or qualified practitioner(s).

Section 56 outlines the duties of physicians or qualified practitioners in attending or being consulted on a case of injury to a worker (e.g., reporting).

Section 57 makes it mandatory for workers to submit to examinations “required” by the Board (e.g., for adjudication purposes).

Special allowances may also be mandated under Section 21.

Policy And Procedures

There is no formal Health Care Services procedures manual. However, Chapter 10 of the Rehabilitation Services and Claims Manual outlines “Medical Assistance” policy and Section 070 of the Claims Adjudication Handbook relates to “Medical Issues”. In addition, staff access a series of reference materials on procedures including: a Payment Officer Manual and an MSP (binder). (58)

Benefits Covered

The WCB may provide a comprehensive range of health care benefits.

Health care benefits are provided on the basis that they are considered “reasonably necessary” to cure, relieve or alleviate the effects of an injury (or disease). They are available for life, and irrespective of whether or not the claimant is working. (59)
However, they are only provided if they are included in the range of services covered\textsuperscript{36} and they may be limited at the Board’s discretion (e.g., some benefits or their continuation require pre-approval or a WCB Medical Advisor examination to confirm need). According to the Rehabilitation Services and Claims Manual, health care services include:

- necessary hospitalization;
- treatment provided by recognized health care professionals;
- prescription drugs; and,
- necessary medical appliances. (60)

The levels of health care benefits are paid in accordance with:

- negotiated fee schedules, e.g., with the BCMA;
- actual costs e.g., expense based reimbursements; and,
- other scheduled rates (e.g., MSP fee schedule for fees of non-negotiated practitioners).

In addition, six allowances may be administered as health care benefits. Only the subsistence allowance is specifically mentioned in Section 21. It covers workers’ wage loss and/or accommodation/meal costs while they are receiving treatment away from their residences. (61) The other five allowances are: clothing, homemaker, independence and home maintenance, personal care or nursing, and transportation. These latter allowances are expense or flat rate based, rather than wage loss based. (62)

Health care payments are made to health care practitioners or vendors, as well as to workers/dependents.

Health care services are used for:

- medical recovery (to plateau/stabilization);
- rehabilitation (from medically stable to active at a functional level);
- long term maintenance (to maintain or support at a functional level); and,
- administrative reasons/requirements (e.g., adjudication investigations, pension assessments, long term claim case management).

A broader range of health care services are available than are accessible. Generally, whether or not a health care benefit is “reasonably necessary” is first decided upon by an attending physician or other health care practitioner chosen by the worker. The Board may then exercise its control at its discretion (if it chooses to do so). For example, a WCB Medical Advisor may examine the worker and offer an opinion on whether or not a treatment is required (or whether or not the worker is ready to return to work) – setting up Board physicians as a “second opinion”, sometimes in situations where the second

\textsuperscript{36} For example, they do not presently include acupuncture.
opinion is expected to disagree with the first. Approximately 8,000 medical exams and 39,000 medical opinions were provided by WCB Medical Advisors in 1997.\textsuperscript{57} (63)

\subsection*{6.2 Temporary (Short Term) Disability Benefits}

\textit{Legislation}

Temporary disability benefits are mandated under Sections 29 (total) and 30 (partial) of the \textit{Workers’ Compensation Act}.

Several other sections affect the provision of these benefits, including:

\begin{itemize}
  \item Section 31 \textit{(maximum compensation)};
  \item Section 32 \textit{(recurrence of disability)};
  \item Section 33 \textit{(average earnings)};
  \item Section 34 \textit{(deductions from compensation in certain cases)}; and,
  \item Section 35 \textit{(manner of payment of compensation)}.
\end{itemize}

In addition, the claim registration, reporting, and medical examination sections of Part V (e.g., Section 53 - Worker notification of injury) may affect temporary disability benefit administration.

\textit{Policy And Procedures}


\textit{Benefits Covered}

Temporary disability benefits are provided on the basis of lost employment income as a result of an unstable injury or disease. They start the day after the injury or disease occurred. They end when the worker returns to work or when his injury or disease is determined to have “stabilized” or “plateaued” medically – for a few workers this may be a period of years, but for most it is days or weeks\textsuperscript{38}. Only workers who are not working may receive temporary total benefits. However, temporary partial benefits are available to workers who have returned to work (e.g., part time or on a graduated basis). (64)

Total benefits are paid “at 75\% of the worker’s average earnings, subject to the statutory maximum or minimum benefits”. The calculations use gross (before tax) earnings and the benefits paid are tax free. Partial benefits comprise the percentage of these earnings not being received as employment income. The benefits paid may be higher than the

\textsuperscript{37} Medical opinions may be provided without a Medical Advisor seeing the worker.

\textsuperscript{38} Not including reopenings.
workers pre-injury income depending upon the levels of deductions and/or taxes which would usually apply. (65)

Short term disability benefit gross average earnings may be calculated twice - once immediately after the injury occurs, and a second time approximately eight weeks later. The first calculation uses the workers’ wage rate on the day they were injured. The second calculation uses information from the workers’ earnings over the past year or more before this day. Some of these calculations will be straight forward (e.g., workers in steady jobs for years), while others will be more complicated (e.g., workers with intermittent work patterns, casual workers and seasonal workers). For a sample of 200 workers with soft tissue injuries in the Continuum of Care, this second benefit calculation resulted in the same (50%) or a lower (40%) wage rate than the first one. Only in 10% of the cases that it was applied to did it result in a higher wage rate than the first one. (66)

Temporary disability benefits are incurred:

• during medical recovery (to plateau/stabilization). (67)

Thus, they are not to be incurred:

• during rehabilitation (from medically stable to active at a functional level);
• for long term maintenance (to maintain or support a claimant with a loss of wages/earnings in the long term) (pensions); or,
• for administrative reasons/requirements (e.g., adjudication investigations, pension assessments, long-term claim case management).

Benefits which “bridge” the time between the termination of short term disability benefits and the start of long term disability benefits are a controversial issue which will be addressed in the Commission paper on vocational rehabilitation.
6.3 Permanent (Long Term) Disability Benefits

Legislation

Permanent disability benefits are mandated under Sections 22 (total) and 23 (partial) of the *Workers’ Compensation Act*.

Several other sections affect the provision of these benefits as well. These include sections which affect temporary as well as permanent benefits, such as:

- Section 31 (maximum compensation);
- Section 32 (recurrence of disability);
- Section 33 (average earnings);
- Section 34 (deductions from compensation in certain cases);
- Section 35 (manner of payment of compensation); and,
- the claim registration, reporting, and medical examination sections of Division 5.

As well, the Act contains sections which apply only or primarily to permanent benefits, such as:

- Section 5(5) (proportionate entitlement)
- Section 24 (reconsidering benefits);
- Section 25 (adjustments in compensation);
- Section 26 (transitional benefits); and,
- Section 28 (publication of CPI changes in the Gazette).

Policy And Procedures

Chapter 6 of the Rehabilitation Services and Claims Manual outlines “Permanent Disability Awards” policy, while Claims Adjudication Handbook 080-007 covers making referrals to Disability Awards.

Benefits Covered

Permanent disability benefits are also provided on the basis of lost employment income as a result of injury or disease. They are intended to compensate the worker for the long term earnings loss which has resulted (if any). (68)

Permanent disability benefits are paid as soon as a pension is assessed (though they may be paid retroactively to the date the temporary disability ended). They are provided, in part or in full, for life (though this may be estimated and a lump sum provided). (69)

Workers may receive these benefits whether or not they are working – even if they are receiving a pension for a total/100% permanent disability. (70)

A majority of the pensions are partial, rather than total disability awards.
“Some examples of permanent total disability are paraplegia, quadriplegia, hemiplegia, total blindness, and severe loss of cerebral powers. Combinations of permanent partial physical impairments can also become permanent total disabilities, such as bilateral amputations of arms and legs.” (Rehabilitation Services and Claims Manual, page 6-1)

Total benefits are paid at 75% of the worker’s average earnings, subject to the statutory maximum or minimum benefits. The calculations use gross (before tax) earnings and the benefits paid are tax free. Partial benefits comprise a percentage of these earnings. The benefits paid may be higher than the workers pre-injury income depending upon the levels of deductions and/or taxes which would usually apply. (71)

Disability Award adjudicators determine the pension payment level using two methods:

- loss of function/permanent physical impairment assessments; and, (72)
- projected loss of earnings assessments. (73)

Both pension award types are limited to “compensable” conditions. Non-compensable conditions may include pre-existing disabilities which are covered by Section 5(5) of the Workers’ Compensation Act on proportionate entitlement. (74)

Permanent functional impairment pension awards are determined on the basis of physical condition, and may include consideration of subjective complaints. They may be scheduled or non-scheduled. Scheduled permanent functional impairment awards may be decreased or increased using age adaptability factors, enhancement factors and devaluations. Disability Award adjudicators have discretion over some factors which may or may not be considered in the assessment of pension awards, such as the variables to be used relating to the degree of physical impairment and the consideration of subjective complaints. (75)

Projected loss of earnings pension awards are determined using employability assessments. Permanent disability benefits may be calculated using “deemed” earnings (from suitable or reasonably available occupations), rather than actual earnings. Four conditions under which deeming could occur are when:

- the worker does not have a job but is considered employable;
- the worker has a job but it does not maximize long-term earnings;
- the worker, for personal reasons, decides to withdraw from the labour force; and,
- the worker fails to cooperate with a Vocational Rehabilitation Consultant.

Some of the factors that may affect the level at which loss of earnings pensions are calculated include workers’ efforts to maximize their earnings, their potential for future progress, their medical fitness, the long term availability of positions identified and the distance of jobs from the worker’s home. In addition, a worker’s age may be used to adjust the duration of the loss of earnings pension awarded. (76)
Permanent disability benefits are incurred:

- for long term maintenance (to maintain or support a claimant with a loss of wages/earnings in the long term).

These benefits are not usually incurred:

- during medical recovery (to plateau/stabilization); (77)
- during rehabilitation (from medically stable to active at a functional level); or,
- for administrative reasons/requirements (e.g., adjudication investigations, pension assessments, long-term claim case management).
7. PLANNING, MONITORING AND EVALUATION

The units or sections involved in the planning, monitoring and evaluation of claims administration are primarily under the Divisional Controller. However, managers and directors are also responsible for these activities in their areas. The Field Investigation and Quality Management units undertake examination of specific delivery issues. As well, corporate functions, such as the Policy Development Bureau, Corporate Planning, Controller and Internal Audit may be actively involved.

7.1 Planning

Strategic Plan

The strategic plan under which claims administration functions is corporate, rather than divisional or departmental. The 1996 Corporate Strategic Plan provides the basis for the administration of health care, compensation and other functions, as well as a strategic vision, mission and objectives for the organization. This plan dates from 1996; it is monitored by Corporate Planning.

There are more explicit linkages between the strategic plan and the Division’s business plans in 1996 than in 1998. As well, some strategic planning (e.g., environmental scanning) activities are now being done through the annual business planning process.

Business Plan

Divisional business plans are produced once a year (at least since 1996), by the Divisional Controller. The Divisional business plan is based on departmental/unit business plans and is “rolled” into the Corporate business plan for that year.

The Divisional business plan covers:

- estimated administration and claim cost budgets;
- planned activities and estimated transaction levels;
- a brief environmental scan; and,
- “new initiative” descriptions/action plan.

The Divisional Controller monitors the business plan as it is being implemented.

Departmental business plans vary in format and content. Some departmental plans are limited to financial information. Others include descriptive overviews of the departments’ activities, objectives and performance measures. Sometimes differences between previously budgeted, forecasted and planned expenditures are also explained.
Project Planning

Project planning varies by project, but may include:

- proposals (to senior Executive Committee management and/or the Panel of Administrators); and,
- “cost-benefit” analyses for new initiatives.

As well, the Divisional business plan includes an “overview table” of cost-benefit forecasts for some projects.

7.2 Monitoring

For the purposes of this paper, the parameters being used to define monitoring and evaluation are outlined first in each section.

Monitoring of performance typically tracks levels of pre-specified indicators on a regular basis. It tends to measure performance at a “current point in time” and usually involves the collection and analysis of secondary data, such as that in management information systems. Analysis of these data is set up to be repeated on a regular basis. Monitoring activities tend to address issues of:

- Objectives Achievement; and,
- Impacts & Effects.

Monitoring of performance can include:

- Activity/transaction monitoring;
- Outcome monitoring;
- Financial monitoring; and,
- Compliance monitoring.

The WCB is primarily conducting activities/transactions (e.g., claim volumes) and financial monitoring (e.g., claim costs). In terms of outcome monitoring it focuses on timeliness and client satisfaction. Some compliance monitoring may be conducted (e.g., by managers), but is not being reported at aggregate levels.

Monitoring information on claims administration is being reported by the WCB in many ways including:

- Monthly through Compensation Services performance reports and client survey reports.
- Quarterly through operating reports submitted to the Panel of Administrators.
• Annually through the WCB’s annual reports (outcomes and financial) and business plans (“performance measures” and outcomes).

• Periodically through the administrative inventories and potentially through strategic plan updates (e.g., on progress towards “client service objectives”). The strategic plan set targets, but did not report baseline values for these targets.

7.3 Evaluation

Evaluative research typically includes analysis of “why” indicators are at the level they are and to what extent they can be attributed to programs. It tends to be backward looking as well as “point in time”, and usually involves primary data collection methods such as in person interviews as well as secondary data methods. It can also involve more in-depth analyses that are not regularly repeated. Evaluation activities address issues of:

• Rationale;
• Objectives Achievement;
• Impacts & Effects; and,
• Alternatives.

Evaluative research on WCB claims administration has included:

• the Program Evaluation and Research Unit evaluation studies (to the extent that they cover claims administration as well as rehabilitation activities and outcomes);
• “special backgrounders” prepared by Angus Reid on specific issues or areas of interest;
• special research studies on specific issues (e.g., an analysis of rising health care costs conducted in 1994); and,
• evaluations of new initiatives or pilot projects, such as E-File and Case Management.
8. NEW INITIATIVES

The 1998 Rehabilitation & Compensation Services, 1998 Business Plan (DRAFT) outlines 34 initiatives that are ongoing or planned under five divisional “strategies” (see Appendix D):

- Client Service
- Case Management
- Operational Effectiveness
- Refine Policy and Training
- Diversity

Of these 34 initiatives, 18 appear to be the responsibility of Health Care Services, Compensation Services, Central Services or the Divisional Controller staff. Two other initiatives (Performance Management and Diversity) are the responsibility of the Division’s Vice President as division wide initiatives – thus also directly affecting these staff. The remaining 14 initiatives are the responsibility of Vocational Rehabilitation, the Rehabilitation Centre, Medical Services or Psychology staff, but may (at least) indirectly affect these staff as well.

In 1998, a Claims Adjudicator in the Lower Mainland could expect to be directly affected by at least 10 of the initiatives, and indirectly by many more.

Each initiative has planned activities for 1998 associated with it. While some of the activities outlined in the initiatives are ongoing, most are “new” or “planned” - and add to existing workloads.

Rationale:

These initiatives are undertaken in response to problems identified with current operations by external stakeholders as well as through internal processes.

Timing:

Most of the 1998 initiatives have existed in some form or other for at least the last three years.

Intended Impacts:

Generally, the initiatives are intended to improve the timeliness (efficiency) or quality (effectiveness) – or both – of claims administration at the WCB through out the claims process.

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39 Alone or in conjunction with Rehabilitation Services staff.
### Rehabilitation & Compensation Services, 1998 Business Plan Initiatives

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CS = Client Service
CM = Case Management
OE = Operational Effectiveness
RPT = Refine Policy and Training
DIV = Diversity
For example, new initiatives which affect:

- entitlement decisions on all claims - are intended to speed up decision time (without affecting quality).

- administration of health care benefits - are intended to speed up decision and payment processing times. Some new initiatives are also aimed at improving service quality (in terms of the appropriateness of the health care/benefits provided).

- administration of short term disability benefits on routine claims - are intended to speed up decision and payment processing times (without affecting quality).

- administration of complex claims - are intended to improve both service quality and speed. In particular, they are expected to result in earlier and more comprehensive service interventions, characterized by fewer staff “hand offs” and be less adversarial than previously. In addition, some initiatives are specifically aimed at improving the quality and timeliness of the administration of pensions and occupational disease claims.

New initiatives are also being undertaken in areas which support the administration of claims in terms of:

- training and policy; and,
- performance management.

*Legislation/Policy/Practice:*

The new initiatives always affect practices and may affect policy (if they are significant enough), but never affect the legislation. All new initiatives operate within the WCB’s given legislative mandate. For example, there is no experimentation with “pilot” benefit levels (of 90% of net income or benefit stacking).

*Technology/Business Processes:*

Most of the new initiatives include technology changes or are changes in business processes supported by new technologies. Very few do not include or are not influenced by new technologies at all.
References

(2) 1996 Administrative Inventory, page 22
(3) 1996 Administrative Inventory, pages 39, 40 and 55; WCB Data Response 2.4/2.5
(4) Adjudication & Appeals, note 5 and note 6; Workers’ Compensation Act page 40-42
(5) 1996 Administrative Inventory, page 40 and Claims Adjudication Handbook 040-002
(6) 1991 Administrative Inventory, page 26
(7) 1997 Annual Report, page 18
(8) Adjudication & Appeals, note 11
(9) WCB Data Response 5.12
(10) Adjudication & Appeals, note 13; Rehabilitation Services and Claims Manual, page 12-48; Claims Adjudication Handbook 030-005
(11) WCB Data Response 5.0
(12) WCB Data Response 5.15
(13) Adjudication & Appeals, note 14
(14) 1995 WCRB Annual Report, page 1; 1991 Administrative Inventory; Manager Reviews Discussion Paper, Draft 1.0
(15) Rehabilitation Services and Claims Manual, page 10-1
(16) Rehabilitation Services and Claims Manual, page 10-9
(17) Rehabilitation Services and Claims Manual, pages 10-3 and 10-10
(18) Rehabilitation Services and Claims Manual, pages 10-9/10
(19) March 2 presentation to the Royal Commission on Workers’ Compensation
(20) Health Care and You pages 3, 4, 7 & 8; Rehabilitation Services and Claims Manual and Claims Adjudication Handbook
(21) Rehabilitation Services and Claims Manual, page 10-22
(22) Health Care and You, page 4; Rehabilitation Services and Claims Manual page 10-11; Claims Adjudication Handbook 070-016 and 070-027
(23) Health Care and You, page 4&8; Rehabilitation Services and Claims Manual, pages 10-5/9/13; Claims Adjudication Handbook 070-022
(24a) Transforming Health Care Delivery To Injured Workers, page 9
(25) Claims Adjudication Handbook 070-001/002
(26) Claims Adjudication Handbook 070-001/002
(27) Claims Adjudication Handbook 070-001/002
(28) Claims Adjudication Handbook 070-001/002
(29a) Practice Directive 12 (Claims Management and the Continuum of Care)
(30) Health Care and You, page 4
(30a) Rydberg Levy Performance Management Report for the Period Apr 95 to Dec 96, page 12
(32) Claims Adjudication Handbook 070-017
(33) Rehabilitation Services and Claims Manual, pages 5-1&5-2
(34) Compensation Services Performance Report, December 1997, Section 1, pages 1 - 5
(35) 1996 Administrative Inventory, page 96; 8-week Rate Review Discussion Paper
(36) Claims Adjudication Handbook 060-005
(37) Claims Adjudication Handbook 060-004
(38) Claims Adjudication Handbook 080-007
(39) Claims Adjudication Handbook 060-019/024
(40) 1996 Administrative Inventory, pages 43&44; Rehabilitation Services and Claims Manual, pages 5-13&5-14; Claims Adjudication Handbook 080-001/008
(40a) WCB Data Response 5.17
(41) Rehabilitation Services and Claims Manual, pages 5-2&5-9; Claims Adjudication Handbook 080-009/010; 1996 Administrative Inventory, p. 43
(42) Claims Adjudication Handbook 080-008
(43) Claims Adjudication Handbook 060-004
(44) Claims Adjudication Handbook 080-001
(44a) WCB Data Response 5.11
(45) Claims Adjudication Handbook 080-001
(46) 1995 WCRB Annual Report, p. 1; 1991 Administrative Inventory; Manager Reviews Discussion Paper, Draft 1.0
(47) Rehabilitation Services and Claims Manual, page 6-3
(48) Claims Adjudication Handbook 080-007, Rehabilitation Services and Claims Manual page 6-21
(49) 1997 Rehabilitation and Compensation Services Business Plan, page 8
(50) 1996 Administrative Inventory, pages 104 and 105; Rehabilitation Services and Claims Manual, page 6-24
(51) Rehabilitation Services and Claims Manual, pages 6-55 & 6-2
(52) WCB Benefit Stacking and Integration Briefing Paper, page 2
(53) Rehabilitation Services and Claims Manual, page 6-30
(54) 1995 WCRB Annual Report, page 1; 1991 Administrative Inventory; Manager Reviews Discussion Paper, Draft 1.0
(55) Claims Adjudication Handbook 040-008; Rehabilitation Services and Claims Manual page 6-36
(55a) WCB Data Response 8.1/8.2/8.3
(55b) 1997 Annual Report, page 2
(56) Vocational Rehabilitation Interventions Evaluation Study, Appendix A, page 2
(57) 1995 WCRB Annual Report, page 1; 1991 Administrative Inventory; Manager Reviews Discussion Paper, Draft 1.0
(58) Memo from Jillian McCabe, March 21, 1997, page 1
(59) Workers’ Compensation Act, Section 21; Rehabilitation Services and Claims Manual, page 10-2
(60) Rehabilitation Services and Claims Manual, page 10-1
(61) Rehabilitation Services and Claims Manual, pages 10-43 to 10-46
(62) Rehabilitation Services and Claims Manual, pages 10-32 to 10-42
(63) Rehabilitation and Compensation Services 1998 Business Plan, page 34
(64) Rehabilitation Services and Claims Manual, pages 5-2/5-5/13/5-15
(65) 1996 Administrative Inventory, pages 102&103; Compensation Rate Briefing Paper, pages 21&22; Rehabilitation Services and Claims Manual pages 5-4&9-18
(66) Rehabilitation Services and Claims Manual pages 9-2&9-14; 8-week Rate Review Discussion Paper, page 2; WCB Presentation to the Royal Commission on Compensation Services
(67) Rehabilitation Services and Claims Manual, page 5-2
(68) Rehabilitation Services and Claims Manual, page 6-26; Permanent Disability Pensions Briefing Paper, page 5
(69) Rehabilitation Services and Claims Manual, pages 6-32/6-34/6-55
(70) Rehabilitation Services and Claims Manual, page 6-3
(71) 1996 Administrative Inventory, pages 104-110
(72) Rehabilitation Services and Claims Manual, pages 6-3, 6-4
(73) Rehabilitation Services and Claims Manual, page 6-4
(74) Rehabilitation Services and Claims Manual, pages 6-51 to 6-54
(75) Rehabilitation Services and Claims Manual, pages 6-5/6-7 to 6-9
(76) Rehabilitation Services and Claims Manual, pages 6-25 to 6-28; WCB presentation to the Royal Commission on Disability Awards
(77) Rehabilitation Services and Claims Manual, page 5-2
APPENDIX A - ORGANIZATIONAL STRUCTURE

Health Care Services

Health Care Services’ main responsibility is the payment of medical bills for all WCB claimants. To this end, it processes payments to medical practitioners and workers for health care expenses. However, it also:

- liaises and supports negotiations with medical practitioners;
- helps to administer the claims of seriously disabled workers (for special allowances and equipment needs); and,
- arranges and pays for some of the transportation requirements of some claimants (e.g., long distance).

According to a briefing document on this department prepared for the Royal Commission in 1996, the Health Care Services department:

- processes payments to a varied range of health care providers;
- processes payments to injured workers for out-of-pocket expenses;
- liaises with medical practitioners to educate and promote improved interaction and working relationships;
- participates in various fee for service negotiations with professional groups such as the BC Medical Association, the Physiotherapists’ Association, the Chiropractors’ Association and the Audiologists’ Association;
- administers two special allowances for the seriously disabled for: a) Independence and Home Maintenance, and b) Personal Care;
- arranges special equipment for the seriously disabled based on individual needs; and,
- arranges/pays for appropriate transportation for injured workers for claims inquiries, vocational training programmes and medical appointments away from the worker’s home area.

The Health Care Services department’s internal clients include: claims adjudicators, Medical Services and the Rehabilitation Centre. The department’s external clients include: medical practitioners, hospitals, various institutions, other health care professionals and injured workers. (References: Compensation Management Meeting proceedings (January 1995); March 2, 1998 Presentation to the Royal Commission on Workers Compensation)
Most Health Care Services staff work in the Lower Mainland, though some payment officers work in the Area Offices. As described in the Compensation Management Meeting proceedings (January 1995):

“Area Office Health Care accounts are handled by Payment Officers assigned to each location. Lower Mainland accounts and a number of specialized services are handled by a centralized Health Care Benefits Section.” (page 9)
Compensation Services

Interior Operations

Interior Operations consists of compensation services staff in the Kamloops, Vernon, Kelowna, Cranbrook, Nelson and Prince George Area Offices. (Jan 29/98 Organizational Chart)

These staff are primarily responsible for the administration of short term disability claims. To this end they undertake:

- call centre (Kelowna), client service and entitlement activities
- the administration of temporary disability benefit payments
- the administration of health care benefit payments (mostly on short term disability claims)

(Reference: WCB Data Response 14.0)

However, compensation services staff in these offices may also administer or support the administration of:

- health care benefit payments on health care only and long term disability claims
- occupational disease claims (i.e., ASTDs)
- vocational rehabilitation services
- medical rehabilitation services

At the beginning of 1995, Area Office service delivery locations were structured to include (see Exhibit 2):

- client service managers (supported by administrative assistants, and compensation services managers at some locations)
- claims staff (adjudicators, officer Is and officer IIs)
- case assistants
- office assistants I - IV
- payment clerks

- other divisional staff:
  - medical secretaries
  - vocational rehabilitation consultants
  - vocational rehabilitation coordinators
Insert Exhibit A1 - Structure Of An Area Office Service Deliver Location (SDL)
In addition, staff from other divisions were located in Area Offices, including:

- medical advisors
- prevention staff
- assessment staff

(Reference: Jan 1995 Compensation Services Management Meeting)

Under Case Management, Area Office service delivery locations are to be structured to include:

- regional/operations managers
  - compensation services managers
  - administrative assistants
- case managers
- team assistants
- entitlement officers
- client service representatives
- office assistants

- other divisional staff such as:
  - medical advisors
  - nurse advisors
  - medical secretaries
  - vocational rehabilitation managers
  - vocational rehabilitation consultants

(References: Prince George Area Office Case Management Pilot Staffing Package and derived from Proposed Vancouver Centre/North SDL in Service Delivery Strategies Key Initiatives 1998 - Staff Information Package, December 5, 1997)

_Vancouver Island Operations_

Vancouver Island Operations consists of compensation services staff in Victoria, Nanaimo, Courtenay Area Offices on Vancouver Island, as well as the Terrace Area Office on the mainland. (Jan 29/98 Organizational Chart)

The activities and structure of these staff are similar to those in the Interior Operations Area Offices.
**Call Centre**

The CSR Call Centre provides services throughout the Lower Mainland. It’s role is to:

- gather information
- answer enquiries
- routine claims entitlement

(Reference: SDS Key Initiatives 1998)

As described in its 1998 Business Plan:

“The Call Centre is the first point of contact for injured workers in the Lower Mainland. Client Service Representatives working in the Call Centre are responsible for answering incoming phone calls, making timely decisions on routine claims and gathering information from workers, employers and the medical community on their own routine claims as well as claims being routed to a further level of claims management.”

The Call Centre opened in Mar 24, 1997 with 14 CSRs (serving Burnaby and Coquitlam). By the end of 1997, it was expected to comprise 43 CSRs (serving all LM SDLs and the Entitlement Unit). (Call Centre 1998 Business Plan)

**Entitlement Unit**

The Entitlement Unit also provides services throughout the Lower Mainland. It’s role is to:

- manage claims through to the end of work conditioning
- complex claims entitlement

(Reference: SDS Key Initiatives 1998)

To this end, it undertakes the adjudication and ongoing management of some routine and complex files – EIPS program referral staff also report to the Manager of the Entitlement Unit. (Entitlement Unit 1998 Business Plan)

The Entitlement Unit is staffed by Entitlement Officers, a new position in 1997. As of April 1, 1998, the unit is expected to comprise 33 FTEs. (Entitlement Unit 1998 Business Plan)
**SDR West**

SDR West consists of compensation services staff for Vancouver Centre North, Vancouver South and Richmond. (Jan 29/98 Organizational Chart)

These staff are primarily responsible for the administration of complex *short term disability* claims. To this end, they undertake:

- entitlement decisions on some complex claims
- the administration of temporary disability benefit payments on complex claims
- the administration of health care benefit payments (on complex claims)

However, compensation services staff in these offices may also administer or support the administration of:

- occupational disease claims (i.e., ASTDs)
- vocational rehabilitation services on complex claims
- medical rehabilitation services on complex claims

They are not typically involved with: health care only claims, “routine” short term disability claims, long term disability claims and occupational disease claims other than ASTDs.

At the beginning of 1995, Lower Mainland service delivery locations were structured to include (see Exhibit 3):

- client service managers (supported by administrative assistants, and compensation services managers at some locations)
- claims staff (adjudicators, officer Is and officer IIs)
- case assistants
- phone controls
- file clerks
- word processors
- other divisional staff:
  - vocational rehabilitation consultants
  - vocational rehabilitation coordinators

(Reference: Jan 1995 Compensation Services Management Meeting)
Insert Exhibit A2 - Structure Of A Lower Mainland Service Delivery Location (SDL)
Under Case Management, Lower Mainland service delivery locations may be structured to include:

- regional/operations managers
  - compensation services managers
  - administrative assistants
- case managers
- team assistants
- office assistants
- other divisional staff such as:
  - medical advisors
  - nurse advisors
  - medical secretaries
  - vocational rehabilitation managers
  - vocational rehabilitation consultants
  - access to a psychologist (Richmond) and a field officer (Richmond)

(Reference: Service Delivery Strategies Key Initiatives 1998 - Staff Information Package, December 5, 1997)

SDR East

SDR East consists of compensation services staff for Abbotsford, Surrey, Coquitlam and Burnaby. (Jan 29/98 Organizational Chart)

The activities and structure of these staff are similar to those for SDR West.
**Disability Awards**

The main responsibility of Disability Awards staff is the adjudication and administration of all fatal and permanent disability claims. (Operational Status Report, p. 5) To this end, they undertake:

- entitlement decisions on fatal claims
- the administration of all permanent disability benefit payments made to workers and dependents

However, Disability Awards staff may also administer or support the administration of sensitive claims, such as sexual assault claims.

**Occupational Disease Services**

The main responsibility of Occupational Disease Services (ODS) staff is the adjudication and administration of ODS claims. (Operational Status Report, p. 5) To this end, they undertake:

- entitlement decisions on ODS claims
- the administration of all benefit payments made on these claims

Recently, Activity-Related Soft Tissue Disorders of the Limbs (ASTDs) have been distributed to the Service Delivery Locations - with the ODS left to handle the remaining disease claims. (Operational Status Report, page 7) Occupational Disease Services staff also administer:

- staff claims
- interjurisdictional claims

**Operations**

The Operations department is comprised of: Claims Registration, the Mailroom, the Central Scan and Index area and Records Management. (1998 Business Plan, p. 2)

As described in the WCB’s Operational Status Report (1996):

“The Claims Registration (CRT) department maintains central clerical support services, including sorting the incoming mail, assigning claim numbers, routing the file to the appropriate Service Delivery Location, etc.” (Operational Status Report, page 7)

The Records Management area provides “disclosure of claim files to workers, employer and dependents involved in the appeal process”, as well as a microfilm function. (Operational Status Report, page 8)
Field Services

The Field Services department:

“…conducts investigations of claims, takes statements under oath and liaises with Crown Counsel when fraud charges are being considered against workers, employers or service providers. Field Officers complete about 1900 investigations a year.” (Operational Status Report, page 7)

Organizational Effectiveness

Organizational Effectiveness has responsibility for ensuring practices and procedures are being developed in a systematic way and with sufficient documentation. The unit serves as an oversight body for the full range of new initiatives. It is primarily involved with coordinating the consultation process with the union around the organizational and technological changes that are being implemented.

Staff Development

Staff Development is concerned with the development and implementation of training for Compensation Services staff (as well as Rehabilitation staff). The unit is concerned with identifying training needs, coordinating the Division’s responses to these needs and job mapping/career planning. It includes a Learning Centre where Division staff are able to pursue training on their own. It also covers the Business Process Office which is mapping ASIS business processes as a basis for making changes in the future. Its current priorities are: training to support new initiatives, “soft skills” training and technical/line operations training.
Divisional Controller

The Divisional Controller is described in the Operational Status Report as follows.

The Divisional Controller has responsibility for the controller functions for the division and manages the Finance and Compensation Systems sections.

*Finance* has the following functions:

- prepares annual administrative and claims benefit budget and reviews it over the course of the year
- monitors projects costs
- tracks and analyzes performance and activity statistics
- prepares divisional business plan and monitors it through the year
- acts as an ad hoc information resource

The *Compensation Systems* section has the following functions:

- maintains the automated wage loss system and the claims registration system
- provides expertise in statistical and information reporting for the Division
- acts as a special projects resource

This document also notes that the Compensation Systems section supports:

- the health care benefits and file tracking systems
- system issues such as security, LAN admin and desktop publishing
- the MSP and E-File projects

The section currently has responsibility for the E-File project.

The Divisional Controller serves as the point of contact for the Corporate Controller regarding the Division’s financial matters. These primarily concern the Division’s business planning and financial reporting activities. For example, the Divisional Controller is responsible for budgeting, tracking and reporting on the Division’s finances to the Corporate Controller. In particular, the Divisional Controller monitors the costs and

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1 Including the production of the performance indicators reports (Reference: Nov 1997 Performance Indicator report footer).
benefits of major new initiatives such as e-file and case management, reporting them to the Corporate Controller every three months. The interactions also work the other way. The Corporate Controller may disseminate information to the Division through the Divisional Controller on financial procedures, business planning, reporting, etc.
Central Services

Central Services was created in late 1996. It was reorganized approximately one year later, in January 1998. It currently has two sections: Policy and Quality Management.

It was created to coordinate policy initiatives, practice directives, training and quality assurance in conjunction with line departments - as well as the 39 (1) (e) Historical Relief project. (Operational Status Report, pp. 8-9)

Policy

According to the Rehabilitation and Compensation Services 1998 Business Plan (Draft), recent Policy activities have included:

- making available on-line the Act, policy and procedures (in support of E-File)
- reviewing and revising the Vocational Rehabilitation Handbook

In the future, Policy activities may also include:

- a review and update manual to separate policy from practice, in response to a variety of internal and external change requests
- policy changes as required to support major divisional initiatives
- respond to Royal Commission requirements and recommendations throughout 1998

1998 policy priorities are to be jointly developed by Division and Bureau for approval by the Panel of Administrators.

(Reference: Rehabilitation and Compensation Services 1998 Business Plan (Draft), p. 56)

Central Services are the divisional or technical experts that work with the Policy Bureau to review, develop and clarify policies which affect the Division. For example, Central Services may receive requests from line departments for policy development or clarification. It will assess these requests and send some over to the Policy Bureau as proposals for policy change on behalf of the Division. Other requests the unit may respond to itself e.g., through practice directives or more informally.

Interactions also work the other way. The Policy Bureau may bring an issue raised by workers or employers, for example, to the Division. If the Policy Bureau is planning to take to it the Panel of Administrators, they will consult with Central Services as representatives of Compensation Services. Central Services will involve other staff e.g., from Disability Awards or Vocational Rehabilitation as necessary and act as the “centre point” for responding to these requests.

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2 Central Services used to include training – which became a separate project called Staff Development in January 1998.
**Quality Management**

Quality Management is defined in the Rehabilitation and Compensation Services 1998 Business Plan as a primary measure currently being used in the Division, which is:

“A review process that confirms that the Board’s policies and procedures are being adhered to on a consistent basis, while applying appropriate discretion to the individual circumstances of each case. Quality includes maintenance of concise and timely information on a claim record.” (page 6)

According to the Initiatives, Strategies, Action Plan section of the Rehabilitation and Compensation Services 1998 Business Plan, Quality Management Reviews are:

“…to ensure consistent application of policy, procedures and practice guidelines.” (page 51)

According to the Division’s 1998 First Quarter Operating Report a draft quality Management Discussion Paper has been completed but its implementation has been delayed. In the meantime, the Division continues to:

- distribute regular policy/practice minutes to Client Service Managers to ensure greater consistency of application
- build quality into new business processes (through incorporating a quality management program for each phase of the new compensation business model)
- increase training and hold policy/practice discussions with staff
- update various user manuals to ensure quality maintained and consistency of application
- review appellate trends
- continue case conferencing on an ongoing basis
- refer all soft tissue claims to Early Intervention
- do 85 day and aged claim reviews
- ensure hands-on review of selected claim files through a triage function and supervisory positions
- do back end checks such as CADA and DAC reviews, ASTD reviews and periodic disallow file reviews

However, Central Services is only responsible for setting out a template for quality management. Line management has responsibility for implementing this template within their areas or regions. According to interviews conducted as part of this study, the present focus of these activities is on building quality management into new processes, rather than on assuring the quality of the processes which are becoming obsolete. Client Service Managers bear responsibility for ensuring that quality of the administration of claims while this transition takes place.
APPENDIX B - BUDGETS & STAFFING

Insert Exhibit B1 - Administration Expenses (ADMIN) and Full-Time Equivalents (FTES)
Insert Exhibit B2 - Administration Expenses ($000)
Insert Exhibit B3 - Full-Time Equivalents (at December 31)
Staff - Position Descriptions

Health Care Payment Officer (June 1994)

Function: The Health Care Payment Officer is responsible for receiving, adjudicating and processing accounts for all treatment expenses associated with claims; processing a variety of health care and income loss payments on the Automated Wage Loss System; for authorizing and arranging all provisions for transportation and subsistence; for the custody and control of payment cards; and for a variety of associated duties as assigned.

Qualifications: Grade 12 and 9 - 12 months of related experience.

Claims Officer I (January 1991)

Function: The Claims Officer I is responsible for the adjudication, management and disposition of no wage loss claims and routine short term wage loss claims including calculations, investigation, follow-up and maintenance of an assigned caseload; for responding to questions and concerns of workers, worker advocates and employers and for reviewing and prefixing all unnumbered wage-loss and no wage-loss forms.

Qualifications: Grade 12 and 9 - 12 months (2 - 3 years real time) directly related experience, preferably supplemented by post-secondary education in business or a related discipline.

Client Service Representative (May 1997)

Function: The Client Services Representative (CSR) normally acts as the first point of contact injured workers, employers, the medical community and advocates have with the WCB. Duties include answering claims related telephone enquiries; addressing clients questions and concerns by providing related information; reviewing all new claims to the Service Delivery Location (SDL); ensuring that missing or conflicting information is collected and documented on the claims file; assuming responsibility for the entitlement decision regarding no wage loss claims, routine short term disability claims and the first payment of short term disability benefits; performing a variety of general duties associated with the management of their caseload and performing other related duties as assigned.

Qualifications: Grade 12 and 27 - 36 months (real time) related experience plus 40 wpm net typing speed.

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3 All information in this section is from the job descriptions for each position.
Claims Officer II (June 1992)

Function: The Claims Officer II is responsible for the adjudication, management and disposition of short term to intermediate (5 months) wage loss and no wage loss claims including calculations, communication, investigation, follow-up and maintenance of assigned claims. The Claims Officer II is required to administer an assigned caseload and to respond to the questions and concerns of workers, worker advocates, employers and physicians.

Qualifications: Completion of Grade 12 and 1 - 2 years related experience, preferably supplemented by post-secondary education in business or a related discipline.

Entitlement Officer (April 1997)

Function: The Entitlement Officer is responsible for being the first point of contact for clients on non-routine and routine claims and providing timely customer services; making entitlement decisions on these claims; managing short-term non-routine and routine claims; addressing client questions regarding claims decisions and related matters; and for performing other related duties as assigned.

Qualifications: A post-secondary Diploma in a related field and 18 - 27 months (real time) of related experience, supplemented by 40 wpm net typing.

Case Assistant (July 1992)

Function: The Case Assistant is responsible for providing a range of support services to officer level staff in the Compensation Services area including assistance in obtaining and documenting claim information; scheduling appointments; preparing routine correspondence; processing payments; maintaining statistics; and performing other clerical duties as required.

Qualifications: n/a
Team Assistant (February 1998)

Function: The Team Assistant is responsible for providing a range of support services and assistance to the case management team(s) such as obtaining and documenting claims related information; preparing individual client budgets; scheduling appointments; maintaining statistics; preparing routine correspondence and performing other related clerical and support duties as required.

Qualifications: Grade 12 and 27 - 36 months (real time) related experience.

Claims Adjudicator (April 1993)

Function: The Claims Adjudicator is responsible for the adjudication, management and disposition of long-term complex (including complex permanent disabilities) and short/medium-term problematic wage-loss claims, and for all calculations, communication, investigation, follow-up and maintenance of assigned claims. The Claims Adjudicator is also responsible for training new and existing staff and for undertaking quality educational reviews with Claims. The Claims Adjudicator functions in an environment characterized by changing law, policy and caseload, and to respond to the expectations of both workers/worker advocates and employers/employer advocates within varying time constraints.

Qualifications: Grade 12 and 3 - 4 years related experience.

Case Manager (February 1998)

Function: The Case Manager is responsible for directing, integrating, implementing and evaluating case management claim files, with a primary focus on an early and safe return to work for the injured worker; coordinating the efforts of the employer and service providers in the return to work plan; maintaining a comprehensive knowledge of claims adjudication procedures, policies and directives; overseeing the management of all assigned active cases; performing a variety of functions required in the adjudication of wage-loss claims including verifying and authorizing cost allocation and calculation of benefits; reviewing decisions on the basis of new information and altering decisions where appropriate; assuming responsibility for all team decisions regarding the disposition of a case and performing other related duties as assigned.

Qualifications: A university degree in Physiotherapy, Occupational Therapy or Nursing (specializing in Occupational Health) and 3 years (real time) experience or an equivalent combination of education and experience.
**Junior Disability Awards Officer (April 1994)**

**Function:** The Junior Disability Awards Officer manages and adjudicates disability awards claims of limited complexity involving functional award entitlement for permanent partial disabilities. Responsibilities include reviewing and assessing file information and evidence; determining the potential existence of loss of earnings; adjudicating or status changing claims as deemed appropriate based on established guidelines; communicating acceptance of awards to claimants; and handling concerns from claimants, employers and their advocates.

**Qualifications:** Grade 12 and 9 - 12 months of directly related experience.

**Disability Awards Officer (August 1993)**

**Function:** The Disability Awards Officer manages and adjudicates claims involving functional award entitlement for partial and total disabilities. Responsibilities include reviewing and assessing file information and evidence; (conducting investigations where required), determining the potential existence of loss of earnings; adjudicating or status changing claims as necessary; reassessing and adjusting established pensions as required; communicating pension award decisions to claimants and handing concerns from claimants, employers and their advocates.

**Qualifications:** Grade 12, plus 1 - 2 years of post-secondary education and 1 - 2 years of directly related experience.
APPENDIX C - PURPOSE - Health Care Services

Health Care Services’ Business Purpose, as identified by Project 2000 and presented to the Royal Commission on March 2, 1998:

- To supervise and administer, directly and indirectly, the utilization and quality of health care services provided to injured workers.
- To establish and maintain professional business relationships with health care service providers.
- To provide support and advice with respect to health care services to WCB line departments, external providers, physicians and other practitioners.
- To procure and pay health care related goods and services.

Key Outcomes as outlined at the Compensation Services Management Meeting in January 1995:

- Timely processing of health care accounts
- Quality adjudication
- Cost effective
APPENDIX D - NEW INITIATIVES

Source: Rehabilitation and Compensation Services 1998 Business Plan (Draft)

Rehabilitation & Compensation Services Division:

Operational Effectiveness

Performance Management (Internal/External)

• define objective measures of performance and train management staff to use standards developed as tool to improve divisional performance in key result areas (page 50)

Diversity

Diversity Program

• create a work climate that promotes diversity within the division (overcome language barriers, provide work experience for people with disabilities, employee sensitivity training, encourage participation in Multiculturalism Week celebrations and multicultural projects) (page 58)

Health Care Services

Operational Effectiveness

WCB/MSP Teleplan

• establish electronic means of filing claim-related health care expenses utilizing the MSP’s Teleplan network (page 51)

Program 2000

• 1. Electronic data interchange with practitioners and hospitals
   2. Automated health care only claims adjudication
   3. Pharmaceutical Management System
   4. Common purchasing and payment system (with Controllers) (page 52)
Other Operational Initiatives

- BCMA/WCB agreement, audit recommendations, review Chapter 10 of policy manual, streamline payment processes for WCB Clinic services, review role of specialized health care services, key provider/medical professional strategies, “quick hitters” implementation (page 53)

Health Care Management

- initiate means to improve Health Care outcomes - negotiations with BCMA, distribution of attending Physicians’ handbook, expand surgical access, implement electronic data transmission (page 55)

Compensation Services

Client Service

E-File

- to convert claims processing to an electronic, automated process; and,
- to evaluate and modify business processes in conjunction with work flow technology

CSR Position

- establish Client Service Representative position that will provide a client relationship between the claimant and the WCB enabled by E-File and case management initiatives (page 45)

Client Satisfaction Initiatives (survey and comment cards)

- establish means to measure client satisfaction with current practices and new strategies, as well as to identify areas for potential improvement
  - initiate a monthly survey process
  - distribute “Tell Us What You Think” comment cards (page 46)

Teleclaim

- establish a system to allow claimants and small businesses to register a claim by phone through the new CSR position and the extended service hours from 7am to 7pm (page 46)
Assured Service

• initiate a process to ensure that claimants who do not receive an entitlement within 17 days are contacted and informed of the delay (page 46)

Case Management

Case Management Project

• establish prototype site in PG to develop and test model, as well as to define Case Management organizational structure (page 47)

Operational Effectiveness

Front-End Claims Processing

• develop a system to attract form info from all sources electronically (e.g., automated registration, automated adjudication, form transmission initiatives) (page 53)

Dictation Project

• investigate feasibility of improving the dictation process within the division (page 53)

Disability Awards Initiatives

• 1. MIS & REP system - completed
  2. Performance & Productivity - ongoing
  3. Assessment System (ARCON) - ongoing
  4. Quality Control - performance management feedback & file review - ongoing
  5. Other - retroactive reactivation of widows’ pensions project, roll out of E-File, incorporation into Case Management, integration of E-File with ARCON and Pension systems (page 54)

Refine Policy & Training

Comprehensive Staff Development Program

• comprehensive training plan supporting: Client Service, E-File, Case Management, Disability Management, Health Care, Operational Effectiveness, Ongoing Core Staff Development, Policy/Practice Implementation (page 56)
Central Services

Operational Effectiveness

Quality Management Reviews

- develop a quality assurance process to ensure consistent application of policy, procedures and practice guidelines (page 51)

Refine Policy & Training

Revise Policy

- review and update manual to separate policy from practice, in response to a variety of internal and external change requests (page 56)
- policy changes as required to support major divisional initiatives (page 56)

Divisional Controller

Case Management

Financial Reserves/Case Plans

- introduce financial reserves structure and case plan as part of the CM initiative to ensure all parties (i.e., case manager, injured worker and employer) are committed to a Disability Management plan (page 48)

Operational Effectiveness

Fraud Control

- enhance fraud control and reduce risk of fraud and misrepresentation e.g., interdivisional team meetings (ongoing), exchange of data with EI (new), acquire fraud control detection software (June 1998) (page 51)