ANNUAL REPORT 2010

FAIR PRACTICES OFFICE

An independent office working to promote fair practices at the Workers' Compensation Board of Saskatchewan

TABLE OF CONTENTS

Terms commonly used in this report

AD – Appeals Department

Tribunal – Board Appeal Tribunal

Board – the Board of Directors

FPO – Fair Practices Office(r)

MRP – Medical Review Panel

PFI – Permanent Functional Impairment

WCB – Saskatchewan Workers' Compensation Board

MESSAGE FROM THE FAIR PRACTICES OFFICER

It is my privilege to present the 7th Annual Report of the Fair Practices Office (FPO) for the year ending December 31, 2010.

Each year passes more quickly than the one before. It does not seem possible that I was first appointed to this position more than seven years ago. I recall a favourite saying to the effect that "time flies when you are having fun."

It may be a slight exaggeration to describe working in the FPO as "having fun." The primary objective is to receive complaints, resolve problems and provide information and advice to customers of the Saskatchewan Workers' Compensation Board (WCB). The work can be challenging, but it is also rewarding. The vast majority of our customers appreciate the help we provide. During 2010, almost 24 per cent of our contacts were from previous customers of the office.

Our customers can be new to the WCB process. It may be their first experience with a workplace injury. The FPO takes the time to listen and to then explain how the concerns can be addressed. Some customers are focused on their perception of fairness and do not always understand or believe that the decisions on their claim were reached fairly. An explanation of how a WCB policy applies can help to show that fair treatment and service were provided. Other cases may require a complete file review before an opinion on fairness can be given. A few cases require greater investigation or a recommendation from the FPO to obtain new action or a change in how a policy has been applied.

In all of our work, whether with customers or staff of the WCB, the FPO aims to treat everyone with dignity and respect. A main objective of this office is improved customer service. WCB staff share the same objective. I appreciate their cooperation when responding to the recommendations of the FPO. The effectiveness of the FPO depends upon a positive working relationship with WCB staff.

Finally, I extend my heartfelt thanks to my Intake and Inquiry Officer, for her professionalism and resourcefulness in responding to the complaints we receive.

Murray Knoll
Fair Practices Officer

OVERVIEW

Establishment of the Office

The FPO was first recommended by the James Dorsey Review of 2000. Dorsey envisioned *"the establishment of a Fair Practices Office that will assist our clients with disputes and complaints by steering them through the process to the right place. In addition, the FPO will investigate complaints and tabulate statistics that can point to the need for process and or policy changes".*

The Saskatchewan Workers' Compensation Act Committee of Review 2001 Report in referencing fairness, cited Section 21.1(1) of *The Workers' Compensation Act, 1979* (the Act) and its requirement that *"The Board shall: (a) treat workers and their dependents in a fair and reasonable manner".* The Report also referenced and supported the recommendation of the James Dorsey Review of 2000 to establish the FPO.

In September 2003, the FPO was officially established with the appointment of the first Fair Practices Officer. During its first six years, the FPO operated on the basis of a Mandate Statement provided by the WCB Board Members. The role and mandate of the FPO was more formally defined through Policy 05/2009 in September 2009. Further clarification was provided by Board Members with the approval of Policy 15/2010, which took effect on July 1, 2010. The policy confirms that the Fair Practices Officer is appointed pursuant to Section 21(1) of the Act and has the power to conduct inquiries pursuant to section 27(1) of the Act. The complete policy is available in chapter 9.5 of the WCB Policy Manual.

Role and Mandate of the FPO

The FPO has a mandate to:

- Receive, investigate and resolve complaints about unfair practices in all areas of WCB service delivery raised by workers, employers and external service providers.
- Identify complaint trends, policy matters and systemic issues and make recommendations for improvements.

If the Fair Practices Officer determines that an unfair practice has occurred, he may seek to resolve the issue at the most appropriate administrative level of the WCB. If a remedy is not implemented, he will raise the matter to senior management levels of WCB, including the Chief Executive Officer. Unresolved issues are reported to the Board Members.

The Fair Practices Officer may, on his own initiative, investigate, identify and make recommendations on systemic issues. These are issues that effect more than one file and occur on an ongoing basis. Findings and recommendations initially will be presented to senior administration within WCB, including the Chief Executive Officer, and then to the Board Members.

Authority of the FPO

The FPO has jurisdiction to investigate all areas of WCB service delivery including, but not limited to:

- Delays in adjudication, communication, referrals or payment.
- WCB staff conduct.
- Spoken and written communications.
- Implementation of appeal decisions.
- Employer services.
- Benefit payments.
- Wrong application of policy.

Complaints NOT Within the Authority of the FPO

A complaint is not within the jurisdiction of the FPO if it is about:

- The conduct or a decision of the Board Members.
- Changes to the Act or its regulations.
- An issue outside of the jurisdiction of WCB.
- An issue under appeal.
- An issue being handled by the Office of the Workers' Advocate, unless the Workers' Advocate requests that the FPO reviews the complaint.
- An alleged illegal or fraudulent act. Allegations of this nature are referred to the investigative unit within Internal Audit.

Reporting

The FPO reports directly to the Board Members through the WCB Chairperson. The FPO reports quarterly, or more frequently if requested by the Board Members or the FPO.

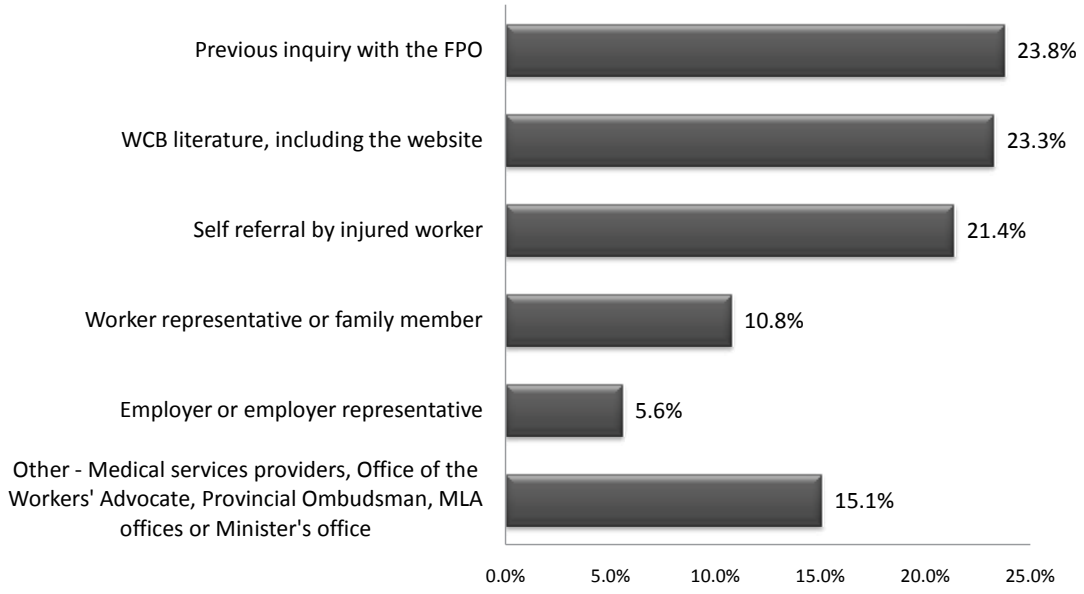
The FPO publishes an independent annual report that outlines the activities of the office. Statistics and case summaries are provided to show the type of work the office performs on a regular basis.

2010 – Activities During the Year

- Attended the WCB's Compensation Institute in Regina and hosted an information table.
- Attended the WCB Annual General Meeting in Saskatoon and Regina.
- Delivered a presentation on the role of the FPO to a workshop of the Advanced Assessment and Treatment providers in the province.
- Participated in quarterly teleconference meetings with the Fairness Working Group (counterparts in other WCBs in British Columbia, Manitoba, Ontario, Newfoundland and Labrador, and Nova Scotia).
- Participated in a meeting with the Fair Practices Advocate from Manitoba and the Fair Practices Commissioner for Ontario.

How do people find the FPO?

We continue to receive calls from people who say they only recently learned about the FPO. During 2010, we asked callers how they learned about the FPO. This is how they replied:



Common Complaints

The most common complaint received by the FPO is that someone disagrees with a WCB decision. The following list provides some examples of these complaints:

- I have not recovered from my work injury.
- My wage loss benefits have been reduced or ended.
- WCB does not agree that my medical condition is related to my work injury.
- My return to work program is not suitable.
- My wage loss benefits have been suspended.
- I don't agree with how my benefits have been calculated.
- I require additional or different medical services.
- My claim has been denied.
- The travel expenses provided are too low.
- I don't agree I've been overpaid.

COMPARATIVE STATISTICS

for the calendar years 2006 through 2010

Number of Complaints / Inquiries Received

	2010	2009	2008	2007	2006
Complaints received	**425**	407	434	401	365
Re-opened	**33**	25	39	43	28
Total	**458**	432	473	444	393

Source of Complaints / Inquiries (%)

	2010	2009	2008	2007	2006
Injured Workers	**93.2**	92.9	83.6	90.1	91.0
Employers	**5.9**	6.9	10.4	6.2	8.0
Other	**0.9**	0.2	6.0	3.7	1.0
Total	**100.0**	100.0	100.0	100.0	100.0

Category of Complaints / Inquiries

	2010*	2009*	2008*	2007	2006
Disagree with decision	**338**	275	332	212	178
Information requests	**131**	126	120	73	74
Timeliness & process delays	**68**	65	76	55	66
Communications/service issues	**75**	55	96	56	40
FPO issues (systemic)	**1**	2	1	2	3
Other	**0**	0	0	3	4
Total	**613**	523	625	401	365

* Beginning in 2008, two or more categories can be entered for each complaint that is registered. In prior years, only one category per complaint was entered.

Resolution (closed files)

	2010	2009	2008	2007	2006
Completed by FPO without referral	**262**	276	263	248	204
Called WCB for clarification	**52**	30	38	31	26
Referred to WCB for review	**111**	101	133	122	135
Total	**425**	407	434	401	365

Outcome of Referrals to WCB

	2010	2009	2008	2007	2006
Decision changed	**20**	23	18	13	17
New action taken	**81**	74	112	101	105
Reviewed – no change	**10**	4	3	8	13
Total	**111**	101	133	122	135

Response Time to Close (%)

	2010	2009	2008	2007	2006
0-7 days	**71.5**	75.2	75.1	69.6	63.5
8-30 days	**19.1**	16.0	18.9	20.9	20.7
Over 30 days	**9.4**	8.8	6.0	9.5	15.8
Total	**100.0**	100.0	100.0	100.0	100.0

CASE SUMMARIES

The following case summaries are examples of inquiries completed by the Fair Practices Office. Names are not provided to protect the privacy of the individuals who brought these concerns to the FPO.

CASE SUMMARY 1 – Massage treatments? Yes, but only 5

A worker called to complain that massage treatments that had been recommended by his surgeon were not approved by his case manager. The worker's surgery had gone well and he was participating in a tertiary treatment program. He had started a return to work program and his surgeon recommended five massage treatments to help with his recovery and return to work.

The case manager denied the request for five massage treatments because the worker had five earlier massage treatments in 2007 following his first surgery. Based upon the WCB procedure on massage treatments, the worker was permitted only five massage treatments in total for his injury. The worker felt massage treatments had been helpful following his first surgery and could not understand why his surgeon's request would be denied.

Massage therapy is authorized by WCB Procedure 51/2010. The procedure does limit the number of massage therapy treatments to five sessions per claim and it supports the decision to deny further massage treatments. At the same time, Section 21.1 (1) of *The Workers' Compensation Act, 1979* requires the WCB to provide medical treatment that may be required as a result of the injury. Given the obligations imposed by the Act and the request by the surgeon for five additional massage treatments, I was of the view that some discretion should be available.

I approached the Team Leader and then the Director of Operations, who agreed this situation required some discretion to meet the medical needs of this worker. The Director approved an additional five massage treatments for the worker.

The limitation of massage treatments to five per claim has been brought to the attention of my office on several occasions. The procedure is under review by the Board. My office has provided comments for the Board to consider in the course of their review.

CASE SUMMARY 2 – Hearing aids – only partial coverage?

A worker called to complain that he had purchased new hearing aids but the WCB would pay only a portion of the costs. Several of his co-workers were using the same hearing aids and they reported that WCB had paid their full cost. This seemed unfair to the worker.

Upon reviewing this file, it was learned that the case manager had only approved the costs of entry level hearing aids for this worker. The man had purchased mid-range hearing aids with an additional cost of $400 per hearing aid. The case manager was prepared to review the case if the worker provided additional documentation to support the need for the mid-range hearing aids.

The FPO met with the Team Leader and suggested further follow up with the audiologist to learn why this worker needed the more expensive hearing aids. This recommendation was implemented within a few days. The audiologist confirmed the prescribed hearing aids performed better when there is continued exposure to noisy backgrounds. As this man worked in a noisy industrial setting, the case manager agreed to pay the additional costs.

At the time of my review, I noted that this man had not been reviewed for Permanent Functional Impairment (PFI) since 1994 when his claim was first accepted. He was not wearing any hearing aids at that time and he was found to not have any rateable PFI. As recent audiograms indicated deterioration in his hearing, I suggested the file should be reviewed by a Medical Consultant to determine if this deterioration now made the man eligible for a PFI award.

The file was promptly referred to a Medical Consultant who concluded that the man now did qualify for a PFI award of 3%. This resulted in the payment of the minimum award to the worker of $2,200.00.

CASE SUMMARY 3 – The recovery is too slow

An employer called to complain that it was taking too long for his injured employee to recover from a work injury. The employer accepted that the injury occurred at work, but believed the injury was not serious and felt the worker should be recovered. The employer was concerned about the impact the duration of this claim would have on his WCB premiums. The employer stated he had received no recent information from WCB about the status of this claim, except for monthly cost statements. The employer had reported early in the claim that due to the needs of his business, he had been forced to replace this worker.

Review of this claim showed the worker was recovering from a recent surgery. The claim was likely to continue for at least another two to three months. The employer was correct; there had been little communication with him.

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Review of this employer's account with Revenue and Employer Accounts confirmed that he was in the Standard Program as his annual premiums to WCB were less than $15,000.00. In this program, it is only the number of Time Loss claims that influence the premiums he pays to WCB. As this employer had two Time Loss claims in the previous three years, he was not eligible for a discount, but he was also not being assessed a surcharge. As a result of this Time Loss claim, the employer had lost his prior discount of $268.00. However, the actual costs of this claim and the recovery time would not have any further impact on his premiums.

The employer was relieved to know that his premiums would not be subject to a large increase as a result of this claim. Meanwhile, the case manager resumed communication with the employer about the progress of the injured worker. It appears the gap in communication was inadvertent and may have been due in part to the relocation of the worker and the reassignment of the file to a new case manager.

CASE SUMMARY 4 – Medical Review Panel

An injured worker can request a medical review panel (MRP) under Section 60 of *The Workers' Compensation Act, 1979* where there is a medical question to be determined. The results of the MRP are binding on both the worker and the WCB. This worker called the FPO after he had been examined by an MRP and his benefits had been terminated. The worker did not think this was correct since the MRP had agreed he did have ongoing impairment related to his work injuries and he had previously been assessed at 15% Permanent Functional Impairment (PFI).

The Board Appeal Tribunal (Tribunal) had reviewed the certificate of the MRP and ruled that the worker had been adequately compensated and that no further benefits were warranted. Upon receipt of the Tribunal decision, the case manager decided that earnings replacement benefits and coverage for prescription medications would end immediately. The worker's eligibility for Independence Allowance also ended.

The FPO reviewed this file and had some concerns about how the Tribunal decision had been interpreted by the case manager. The FPO suggested that the Tribunal be asked to clarify their intentions, in light of the interpretation being applied by the case manager. The Tribunal subsequently explained that it was the intent of their decision that the worker did not have any "additional entitlement", beyond that which he was already receiving at the time of his MRP. As a result of this clarification, the worker's prior level of benefits was immediately reinstated, including coverage for medications and eligibility for Independence Allowance.

CASE SUMMARY 5 – Benefits reduced – no explanation

A worker called the office after her earnings replacement benefits were reduced without notice or explanation. The worker was unable to return to her previous occupation due to ongoing restrictions from her work injury, but had obtained alternate employment at a lower wage. The WCB had agreed to top up her wages to recognize the loss of earnings due to the lower salary. The hours of work in her new position were subject to seasonal variations. As a result, the WCB had agreed to consider her capable of earning $400.00 per week, on an annual basis, and her monthly payment was to be calculated on this estimate. Further review of her earnings would occur after a full year in the new position. A letter had been sent to the worker confirming this decision.

The worker explained that she had been working extra hours during the past few weeks and questioned if this was the reason for the reduction in her payment. Inquiry by the FPO confirmed this was indeed the case. Routine verification of the worker's wages with the new employer confirmed earnings in excess of the $400.00 per week that had been estimated. As a result, her benefits had been reduced, based upon her actual earnings. This adjustment would have been correct, except for the fact that the WCB had previously agreed to continue payment for one year, before making further adjustments.

The FPO brought this problem to the attention of the Team Leader. The seasonal nature of the position and the variable hours of work were noted. The Team Leader confirmed these factors as the rationale for the earlier agreement to review this worker's earnings after one full year in the new position. The previous estimate of $400.00 weekly earnings was restored and benefits returned to their previous level. The actual earnings will be reviewed after one year and adjustments may be considered at that time.

CASE SUMMARY 6 – My surgeon says it was due to my work injury

This worker complained that the WCB had refused to accept responsibility for his recent surgery. His claim for a wrist injury had been accepted, but it was noted that he also had arthritis. The WCB had concluded that the surgery was primarily due to the arthritis and not the work injury.

Review of this file confirmed the worker had appealed the denial of responsibility for his surgery to the Appeals Department (AD), but his appeal had been denied. Detailed letters of support had been received from both his family doctor and the surgeon. However, these letters had only been received after the AD had made its decision to deny the surgery. Between the date of the AD decision and the receipt of the letters from the doctors, the Manager of the AD had left the position. The new Manager of the AD informed the doctors of the worker's right to file a further appeal with the Board Appeal Tribunal, but did not conduct any further review of the prior decision.

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In examining the letters of support from this worker's doctors, the FPO was of the view that the surgeon was not merely offering a different opinion on this case, rather, he was disagreeing with the WCB's interpretation of the medical facts. In this situation, the FPO was of the view that a WCB Medical Consultant should be asked to review the report from the surgeon and provide a further opinion.

The new Manager of the AD agreed with this recommendation and the claim was referred for review to the WCB Chief Medical Officer. This review resulted in the opinion that the surgery was due to the work injury. The AD subsequently reversed their earlier decision and the WCB accepted responsibility for the surgery and ongoing wage loss during the recovery from the surgery.

CASE SUMMARY 7 – FPO recommendation not accepted

There are a few instances each year where the recommendations of the FPO are not accepted. Here is one example.

A worker called the office after his claim for wage loss benefits was denied. He stated that he was told initially his claim would be accepted, but after some further inquiries the decision was made to deny his claim. The letter of denial indicated he did not have any coverage at the time of his injury.

Review of this file revealed a complex set of circumstances. The worker was required to travel to a worksite about three hours from his residence. The employer provided travel expenses and temporary accommodations to the worker, at no expense to the worker. The temporary accommodations were not on the worksite. The worker had fallen down some stairs while leaving his temporary accommodations and fractured a bone in his foot. His claim was denied as he was not considered to be in employment at the time of his injury.

The WCB has established policy to deal with injuries that occur while travelling to and from, or for work (Policy 12/98). Section 2 of the policy states:

(2.) "Where employment takes the worker away from the usual place of residence, and the employer pays for travel, meals, and/or lodging:

> *(c.) Injuries that occur while the worker is making reasonable and proper use of the lodgings are also compensable."*

Based upon review of this policy, the FPO was of the view that this claim should have been accepted. Meetings were held with the Supervisor and the Team Leader involved. Both stated that denial of the claim was correct and noted this policy was outdated, under review and likely to change in the near future. The FPO expressed the view that existing policy needs to be followed until it is repealed or changed.

A meeting with the Director of Operations confirmed his opinion that the worker was not “in employment” at the time of his injury. The Director suggested the worker could appeal this decision.

I advised the worker of his option of filing an appeal and advised him the Office of the Workers’ Advocate may be able to assist him with this appeal. I also told him I would pursue my concerns about his claim with the Vice President of Operations. The worker did file an appeal with the assistance of the Workers’ Advocate. The Appeals Department agreed the claim was valid and full coverage was provided for this worker.

The Vice President of Operations agreed with the FPO that existing policy must be followed until it is changed or repealed. As the file was under appeal, he was not prepared to intervene in this case. A later meeting with the Chief Executive Officer again confirmed the position that existing policy should be followed until it is changed or repealed.

At the time of preparing this report, the proposed policy change had still not been approved and Policy 12/1998 remains in effect.

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