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Workplace Safety & Insurance Board
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

Head Office:
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Toronto, Ontario
Canada M5V 3J1

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200, rue Front Ouest
Bureau de la protection de la vie privée,
21ème étage
Toronto, Ontario M5V 3J1

VIA REGULAR MAIL

June 6, 2016

Injured Workers' Consultants
815 Danforth Avenue, Suite 411
Toronto, ON M4J 1L2

Attention: David Newberry

Ashleigh Burnet,
FOI Access Specialist, Privacy Office
(416) 344-4771 (416) 344-5560
TTY/ATS : 1-800-387-0050
1-800-387-0750 (ext. 4771)
www.wsib.on.ca

Dear Mr. Newberry:

RE: FIPPA Access Request #16-061
IPC Appeal PA16-239

Thank you for your letter and the cheque for $56.90 for the processing of your request.

Enclosed herein is a copy of the records responsive to items two through seven of your amended request.

As there is no single record (Item 8) that contains the names and titles of the individuals involved with the internal review, I am including a listing below.

Item 8:
Please note, some of these individuals were not involved in carrying out the internal review itself; rather, they were kept apprised of the review or were consulted at varies stages.

1) Donna Bain, Acting Chief Operating Officer
2) Tom Bell, Chief Risk Officer
3) Suzanne Bourdages, Case Manager
4) Michael Braude, Vice President, Internal Audit
5) Rabia Butt, Auditor
6) Dragos Daniel Capan, Manager & Senior Statistician
7) Corrado Cirinna, Acting Appeals Manager
8) Joe Civello, Director, Planning & Quality
9) Joanne Giannattasio, Program Quality Case Manager
10) Aaron Kember, Manager, Appels
11) Kerry Lovett, Vice President, Program Quality
12) Kevin Ma, Statistician
13) Sandi Marshall, Program Evaluation Specialist
14) Patricia Mckenna-Boot, Medical Director
15) John Mercuri, Program Evaluation Specialist
16) Freda Mroczek, Program Manager
17) Lou Nanos, Manager, Program Quality
18) Anita Patel, Director, IT & Operations Audit

19) Carmine Pugliese, Program Quality Case Manager
20) Jina Qu, Manager & Senior Statistician
21) Ian Ramroop, Program Evaluation Specialist
22) Tracy Redding, Case Manager
23) Guylaine Scavarelli, Case Manager
24) Michelle Staats, Case Manager
25) John Szkolka, Executive Director, Operations Cluster
26) Brian Tastula, Manager, Business Rules & Provider Registration
27) Marc Erick Theriault, Director, Predictive Modelling
28) Slavica Todorovic, Vice President, Appeals
29) Kathy Vukasinovic, Case Manager
30) Keith Walsh, Case Manager
31) Eugene Wen, Chief Statistician

Ongoing Access:
In your letter of March 2, 2016, you requested ongoing access for a two year period. I am interpreting this ongoing access request to be limited the amended scope, and I am proposing the below access schedule:

2016:
July 1, 2016
September 1, 2016
December 1, 2016

2017:
March 1, 2017
June 1, 2017
September 1, 2017
December 1, 2017

While I have set out the access schedule for the full two year period, as discussed during our teleconference of May 16, 2016, the Workplace Safety and Insurance Board (WSIB) anticipates that after the report is published and any remedial steps are undertaken, the WSIB will not be creating further records. Until that time, the WSIB will continue to process your ongoing access request.

Please feel free to contact me if you have any questions; however, I trust this will close the matter currently before the Office of the Information and Privacy Commissioner/Ontario.

Yours truly,

Ashleigh Burnet
cc. Lorne Swartz, Mediator, Office of the Information and Privacy Commissioner/Ontario

MC Opinion Review– Template Questions

Audit Question	Drop-down Responses	Explanation
Reviewer		• Pre-populated
Review Date	• Indicate date	• Input by Reviewer
Claim Number		• Pre-populated
Sector/Branch Office	• Government Services • Health Care/Services • Construction & Transportation • Kitchener • Industrial • Hamilton/St. Catharines • London • Ottawa • Sudbury • Thunder Bay • Windsor	• Select one
MC Type	• External • Internal	• Select one
Review Status	• To Be Reviewed • In Progress • Completed • Not reviewed — Not referred to MC	• Will default to "To Be Reviewed" • At the start of the review update to, "In Progress" • When completed save as "Completed" • Select "Not reviewed" if case was never actually referred to MC
Referring Role	• CM • EA • NC	• Select one
1. Template Primary Reason for Referral	• Compatibility - COMP • Functional abilities/ limitations - FA • Medication management- non-opioids – NON OPI • Medication management- opioids - OPI • Treatment - TX	• Select one
2. Auditor's Assessment of primary referral reason	• Agree with reason chosen • Disagree with reason chosen-if so, answer #3	• Select one

3. If auditor disagrees, provide ***reason*** that should have been selected	• Compatibility - COMP • Functional abilities/ limitations - FA • Medication management- non-opioids – NON OPI • Medication management- opioids - OPI • Treatment – TX • PEC policy application	• Select one **Note:** Compatibility-COMP" cases are to a certain extent miscoded and actually represent treatment issues. Eg is the surgery compatible under the claim or with the accepted injury. This type of question should be considered treatment not compatibility. This is for consistency in question #2 and #3. We want to get at the real reason for referral here. If referral reason doesn't fit nicely into existing codes- add new one
4. Was there more than one issue for the MC to address?	• Yes – if yes complete #5 • No – if no go directly to #6	• Select one
5. Secondary Issue(s)	• Compatibility - COMP • Functional abilities/ limitations FA • Medication management- non-opioids – NON OPI • Medication management- opioids - OPI • Treatment - TX • PEC policy application	• Select all that apply • We want to get at the real reason for referral here. If referral reason doesn't fit nicely into existing codes- add new one
6. What was the context of the case that triggered the MC referral?	• guidance on conflicting medical opinions • complex medical issue(s) beyond the CM/ARO scope of knowledge • to assist with the gathering of medical information to adjudicate • guidance on the appropriateness of treatment • guidance on determining the work relatedness of a diagnosis/condition • to support the decision makers position (i.e. leading question or statement in referral) • pressure from worker or employer/ reps	• Select all that apply
7. Was the referral for an MC file review consistent with training on when to seek an external medical opinion?	• Yes (refer to the training document) – go to 9 • No –go to question 8	• Select one
8. The MC file referral was not consistent with training because:	• Asked a leading question/made statement & asked for agreement • Issue referred was an administrative decision (ie MMR)	• Select all that apply

	• Incomplete information on file • All areas of entitlement not clearly delineated • Referral not required- Tx/Dx clearly related to injury • Requested a list of precautions • Requested an opinion on CPD	
9. What was The MC's opinion?	• Diagnosis/condition is compatible to the injury • Diagnosis/condition is not compatible to the injury • Diagnosis/condition may be compatible to the injury • Findings support worker is partially impaired • Findings support worker is totally impaired • Clinical findings support an ongoing work related impairment • Clinical findings do not support an ongoing work related impairment/worker recovered from injury • Impairment is related to the compensable injury • Impairment is related to the natural aging process or some other non-comp condition • Medication/dosage is appropriate for injury • Medication/dosage is not appropriate for injury • Medical/dosage may be appropriate for injury • Treatment is related to the injury • Treatment is not related to the injury • Treatment may be related to the injury • Ongoing treatment/coverage is not appropriate • Contact was made with the treating physician • Contact not made with the physician – letter sent • Letter sent at request of provider (dr wants request in writing) • No contact made with treating physician • Further medical investigation(s) and/ consults/exams are required ie REC,SPEC,diagnostics • File returned due to insufficient information	• Select all that apply

10. Following their review, the MC opinion was in line with:	• Family doctor/general practitioner • Specialist including Psychiatrist • REC • POC • Specialty Clinic • LBEPE • Early Expert Shoulder • Sports medicine physician • Pain management physician • Psychologist • Nurse practitioner • Physio • Chiro • Other • No other medical opinion on file	• Select all that apply Note : for cases where the MC opinion was in line with another- make note of whether it was fully or partially in line
11. Prior to the MC referral, did any of the health care providers in the case have conflicting opinions with respect to the referral reason?	• Yes-If yes answer #12 • No – if no go directly to #13	• Select one Note: the auditor is looking for conflicting opinions with respect to the issue the decision maker has referred to the MC for an opinion on
12. The care providers whose opinions were in conflict with each other were:	• Family doctor/general practitioner • Specialist including Psychiatrist • REC • POC • Specialty Clinic • LBEPE • Early Expert Shoulder • Sports medicine physician • Pain management physician • Psychologist • Nurse practitioner • Physio • Chiro • Other • No opinions were in conflict with each other	• Select all that apply Note: for this question the auditor should be focusing on conflicting opinions with respect to the issue(s) at hand e.g. the issues being considered by the MC as part of the current referral

13. Following their review, the MC opinion was contrary to:	• Family doctor/general practitioner • Specialist including Psychiatrist • REC • POC • Specialty Clinic • LBEPE • Early Expert Shoulder • Sports medicine physician • Pain management physician • Psychologist • Nurse practitioner • Physio • Chiro • Other • Agreement reached after MC discussion with physician • None of the above - no contrary opinions	• Select all that apply
14. Subsequent to the MC Opinion being provided, what was the outcome of the issue being considered that prompted the case referral?	• CM accepted opinion & granted entitlement to Tx/drugs • CM accepted opinion & denied entitlement to Tx/drugs • CM accepted opinion & ltd. entitlement to Tx/drugs • CM didn't accept opinion & granted entitlement to Tx/drugs • CM didn't accept opinion & denied entitlement to Tx/drugs • CM didn't accept opinion & limited entitlement to Tx/drugs • CM accepted opinion & granted ent. to comp benefits • CM accepted opinion & denied ent. to comp benefits • CM accepted opinion & ltd. ent. to comp benefits • CM didn't accept opinion & granted ent. to comp benefits • CM didn't accept opinion & denied ent. to comp benefits • CM didn't accept opinion & ltd. ent. to comp benefits • CM authorized further medical investigation(s) to conclusively delineate entitlement	• Select all that apply Note: the auditor should understand that further medical investigations also means referrals including for consultations or other clinical paper reviewers e.g. psychologist **This question needs to answer whether it was entitlement to compensation benefits vs. treatment or drugs which was accepted or not**
15. What was the outcome of the issue(s) under review following the CM decision?	• Worker accepted CM decision (no appeal to date) –terminate review here • Worker appealed CM decision • Worker provided additional information for reconsideration	• Select one

16. Was the decision reconsidered by the CM?	• Yes –if yes go to #17 • No • N/A- no appeal issue – terminate review here	• Select one
17. The reconsideration led to:	• Confirmation of the original denial • CM accepted non MC opinions and allowed in full • CM accepted non MC opinions and allowed in part • CM referred again for MC opinion	• Select one
18. Did the Appeal reach an ARO?	• Yes-If yes, answer question #19 • No • N/A – no appeal issue	• Select one
19. Has an ARO decision been made?	• Yes – if yes, go to #20 • No – terminate review here	• Select one
20. Did ARO accept the original MC opinion?	• Yes • No - gave more weight to the non MC opinions in the case • No - sought another opinion from external MC – if this item go to #21	• Select one
21. Did the ARO accept the new MC opinion?	• Yes – in full • Yes - in part • No	• Select one • Go to 22
22. Did the ARO decision look at the totality of the information for the issues in dispute?	• Yes • No	• Select one The auditor is looking for evidence that the ARO weighed the appropriate medical information before them and did not rely on one piece of information only. Looking for weighing of various medical opinions/reports
23. What was the outcome of the issue(s) under review following the ARO decision?	• Worker accepted ARO decision (no appeal to date) • Worker appealed ARO decision	• Select one

MC Opinion Review– Template Questions

Quality Review Question	Drop-down Responses	Explanation
Reviewer		• Pre-populated
Review Date	• Indicate date	• Input by Reviewer
Claim Number		• Pre-populated
Sector/Branch Office	• Government Services • Health Care/Services • Construction & Transportation • Kitchener • Industrial • Hamilton/St. Catharines • London • Ottawa • Sudbury • Thunder Bay • Windsor	• Select one
MC Type	• External • Internal	• Select one
Review Status	• To Be Reviewed • In Progress • Completed • Not reviewed — Not referred to MC	• Will default to "To Be Reviewed" • At the start of the review update to, "In Progress" • When completed save as "Completed" • Select "Not reviewed" if case was never actually referred to MC
Referring Role	• CM • EA • NC	• Select one
Was the opinion being requested for organic or non-organic condition?	• Organic • Non-organic • Both	• Select one
If organic, what was area of injury?	• Area of injury	• Select area of injury
If non- organic was it for CPD or Psych?	• CPD • Psych	• Select one

MC Opinion Review– Template Questions

1. Template Primary Reason for Referral	• Compatibility - COMP • Functional abilities/ limitations - FA • Medication management- non-opioids – NON OPI • Medication management- opioids - OPI • Treatment - TX	• Select one
2. Quality Reviewer's Assessment of primary referral reason	• Agree with reason chosen • Disagree with reason chosen-if so, answer #3	• Select one
3. If quality reviewer disagrees, provide ***reason*** that should have been selected	• Compatibility - COMP • Functional abilities/ limitations - FA • Medication management- non-opioids – NON OPI • Medication management- opioids - OPI • Treatment – TX • PEC policy application	• Select one **Note:** Compatibility-COMP" cases are to a certain extent miscoded and actually represent treatment issues. Eg is the surgery compatible under the claim or with the accepted injury. This type of question should be considered treatment not compatibility. This is for consistency in question #2 and #3. We want to get at the real reason for referral here. If referral reason doesn't fit nicely into existing codes- add new one
4. Was there more than one issue for the MC to address?	• Yes – if yes complete #5 • No – if no go directly to #6	• Select one
5. Secondary Issue(s)	• Compatibility - COMP • Functional abilities/ limitations FA • Medication management- non-opioids – NON OPI • Medication management- opioids - OPI • Treatment - TX • PEC policy application	• Select all that apply • We want to get at the real reason for referral here. If referral reason doesn't fit nicely into existing codes- add new one
6. What was the context of the case that triggered the MC referral?	• guidance on conflicting medical opinions • complex medical issue(s) beyond the CM/ARO scope of knowledge • to assist with the gathering of medical information to adjudicate • guidance on the appropriateness of treatment • guidance on determining the work relatedness of a diagnosis/condition • to support the decision makers position (i.e. leading question or statement in referral)	• Select all that apply

	• pressure from worker or employer/ reps	
7. Was the referral for an MC file review consistent with training on when to seek an external medical opinion?	• Yes (refer to the training document) – go to 9 • No –go to question 8	• Select one
8. The MC file referral was not consistent with training because:	• Asked a leading question/made statement & asked for agreement • Issue referred was an administrative decision (ie MMR) • Incomplete information on file • All areas of entitlement not clearly delineated • Referral not required- Tx/Dx clearly related to injury • Requested a list of precautions • Requested an opinion on CPD	• Select all that apply
9. What was The MC's opinion?	• Diagnosis/condition is compatible to the injury • Diagnosis/condition is not compatible to the injury • Diagnosis/condition may be compatible to the injury • Findings support worker is partially impaired • Findings support worker is totally impaired • Clinical findings support an ongoing work related impairment • Clinical findings do not support an ongoing work related impairment/worker recovered from injury • Impairment is related to the compensable injury • Impairment is related to the natural aging process or some other non-comp condition • Medication/dosage is appropriate for injury • Medication/dosage is not appropriate for injury • Medical/dosage may be appropriate for injury • Treatment is related to the injury • Treatment is not related to the injury • Treatment may be related to the injury • Ongoing treatment/coverage is not appropriate • Contact was made with the treating physician • Contact not made with the physician – letter sent • Letter sent at request of provider (dr wants request in writing) • No contact made with treating physician	• Select all that apply

	• Further medical investigation(s) and/ consults/exams are required ie REC,SPEC,diagnostics • File returned due to insufficient information	
10. Following their review, the MC opinion was in line with:	• Family doctor/general practitioner • Specialist including Psychiatrist • REC • POC • Specialty Clinic • LBEPE • Early Expert Shoulder • Sports medicine physician • Pain management physician • Psychologist • Nurse practitioner • Physio • Chiro • Other • No other medical opinion on file	• Select all that apply Note : for cases where the MC opinion was in line with another- make note of whether it was fully or partially in line
11. Prior to the MC referral, did any of the health care providers in the case have conflicting opinions with respect to the referral reason?	• Yes-If yes answer #12 • No – if no go directly to #13	• Select one Note: the quality reviewer is looking for conflicting opinions with respect to the issue the decision maker has referred to the MC for an opinion on
12. The care providers whose opinions were in conflict with each other were:	• Family doctor/general practitioner • Specialist including Psychiatrist • REC • POC • Specialty Clinic • LBEPE • Early Expert Shoulder • Sports medicine physician • Pain management physician • Psychologist • Nurse practitioner • Physio	• Select all that apply Note: for this question the quality reviewer should be focusing on conflicting opinions with respect to the issue(s) at hand e.g. the issues being considered by the MC as part of the current referral

	• Chiro • Other • No opinions were in conflict with each other	
13. Following their review, the MC opinion was contrary to:	• Family doctor/general practitioner • Specialist including Psychiatrist • REC • POC • Specialty Clinic • LBEPE • Early Expert Shoulder • Sports medicine physician • Pain management physician • Psychologist • Nurse practitioner • Physio • Chiro • Other • Agreement reached after MC discussion with physician • None of the above - no contrary opinions	• Select all that apply
14. Subsequent to the MC opinion being provided, what was the outcome of the issue being considered that prompted the case referral?	• CM accepted opinion & granted entitlement to Tx/drugs • CM accepted opinion & denied entitlement to Tx/drugs • CM accepted opinion & ltd. entitlement to Tx/drugs • CM didn't accept opinion & granted entitlement to Tx/drugs • CM didn't accept opinion & denied entitlement to Tx/drugs • CM didn't accept opinion & limited entitlement to Tx/drugs • CM accepted opinion & granted ent. to comp benefits • CM accepted opinion & denied ent. to comp benefits • CM accepted opinion & ltd. ent. to comp benefits • CM didn't accept opinion & granted ent. to comp benefits • CM didn't accept opinion & denied ent. to comp benefits • CM didn't accept opinion & ltd. ent. to comp benefits • CM authorized further medical investigation(s) to conclusively delineate entitlement	• Select all that apply Note: the quality reviewer should understand that further medical investigations also means referrals including for consultations or other clinical paper reviewers e.g. psychologist **This question needs to answer whether it was entitlement to compensation benefits vs. treatment or drugs which was accepted or not**
15. What was the outcome of the issue(s) under review	• Worker accepted CM decision (no appeal to date) –terminate review here	• Select one

following the CM decision?	• Worker appealed CM decision • Worker provided additional information for reconsideration	
16. Was the decision reconsidered by the CM?	• Yes –if yes go to #17 • No • N/A- no appeal issue – terminate review here	• Select one
17. The reconsideration led to:	• Confirmation of the original denial • CM accepted non MC opinions and allowed in full • CM accepted non MC opinions and allowed in part • CM referred again for MC opinion	• Select one
18. Did the Appeal reach an ARO?	• Yes-If yes, answer question #19 • No • N/A – no appeal issue	• Select one
19. Has an ARO decision been made?	• Yes – if yes, go to #20 • No – terminate review here	• Select one
20. Did ARO accept the original MC opinion?	• Yes • No - gave more weight to the non MC opinions in the case • No - sought another opinion from external MC – if this item go to #21	• Select one
21. Did the ARO accept the new MC opinion?	• Yes – in full • Yes - in part • No	• Select one • Go to 22
22. Did the ARO decision look at the totality of the information for the issues in dispute?	• Yes • No	• Select one The quality reviewer is looking for evidence that the ARO weighed the appropriate medical information before them and did not rely on one piece of information only. Looking for weighing of various medical opinions/reports
23. What was the outcome of the issue(s) under review following the ARO decision?	• Worker accepted ARO decision (no appeal to date) • Worker appealed ARO decision	• Select one

MC Opinion Review– Template Questions

Quality Review Question	Drop-down Responses	Explanation
Reviewer		• Pre-populated
Review Date	• Indicate date	• Input by Reviewer
Claim Number		• Pre-populated
Sector/Branch Office	• Government Services • Health Care/Services • Construction & Transportation • Kitchener • Industrial • Hamilton/St. Catharines • London • Ottawa • Sudbury • Thunder Bay • Windsor	• Select one
MC Type	• External • Internal	• Select one
Review Status	• To Be Reviewed • In Progress • Completed • Not reviewed — Not referred to MC	• Will default to "To Be Reviewed" • At the start of the review update to, "In Progress" • When completed save as "Completed" • Select "Not reviewed" if case was never actually referred to MC
Referring Role	• CM • EA • NC	• Select one
Was the opinion being requested for organic or non-organic condition?	• Organic • Non-organic • Both	• Select one
If organic, what was area of injury?	• Area of injury	• Select area of injury
If non- organic was it for CPD or Psych?	• CPD • Psych	• Select one

1. Template Primary Reason for Referral	• Compatibility - COMP • Functional abilities/ limitations - FA • Medication management- non-opioids – NON OPI • Medication management- opioids - OPI • Treatment - TX	• Select one
2. Quality Reviewer's Assessment of primary referral reason	• Agree with reason chosen • Disagree with reason chosen-if so, answer #3	• Select one
3. If quality reviewer disagrees, provide ***reason*** that should have been selected	• Compatibility - COMP • Functional abilities/ limitations - FA • Medication management- non-opioids – NON OPI • Medication management- opioids - OPI • Treatment – TX • PEC policy application	• Select one **Note:** Compatibility-COMP" cases are to a certain extent miscoded and actually represent treatment issues. Eg is the surgery compatible under the claim or with the accepted injury. This type of question should be considered treatment not compatibility. This is for consistency in question #2 and #3. We want to get at the real reason for referral here. If referral reason doesn't fit nicely into existing codes- add new one
4. Was there more than one issue for the MC to address?	• Yes – if yes complete #5 • No – if no go directly to #6	• Select one
5. Secondary Issue(s)	• Compatibility - COMP • Functional abilities/ limitations FA • Medication management- non-opioids – NON OPI • Medication management- opioids - OPI • Treatment - TX • PEC policy application	• Select all that apply • We want to get at the real reason for referral here. If referral reason doesn't fit nicely into existing codes- add new one
6. What was the context of the case that triggered the MC referral?	• guidance on conflicting medical opinions • complex medical issue(s) beyond the CM/ARO scope of knowledge • to assist with the gathering of medical information to adjudicate • guidance on the appropriateness of treatment • guidance on determining the work relatedness of a diagnosis/condition • to support the decision makers position (i.e. leading question or statement in referral)	• Select all that apply

	• pressure from worker or employer/ reps	
7. Was the referral for an MC file review consistent with training on when to seek an external medical opinion?	• Yes (refer to the training document) – go to 9 • No –go to question 8	• Select one
8. The MC file referral was not consistent with training because:	• Asked a leading question/made statement & asked for agreement • Issue referred was an administrative decision (ie MMR) • Incomplete information on file • All areas of entitlement not clearly delineated • Referral not required- Tx/Dx clearly related to injury • Requested a list of precautions • Requested an opinion on CPD	• Select all that apply
9. What was The MC's opinion?	• Diagnosis/condition is compatible to the injury • Diagnosis/condition is not compatible to the injury • Diagnosis/condition may be compatible to the injury • Findings support worker is partially impaired • Findings support worker is totally impaired • Clinical findings support an ongoing work related impairment • Clinical findings do not support an ongoing work related impairment/worker recovered from injury • Impairment is related to the compensable injury • Impairment is related to the natural aging process or some other non-comp condition • Medication/dosage is appropriate for injury • Medication/dosage is not appropriate for injury • Medical/dosage may be appropriate for injury • Treatment is related to the injury • Treatment is not related to the injury • Treatment may be related to the injury • Ongoing treatment/coverage is not appropriate • Contact was made with the treating physician • Contact not made with the physician – letter sent • Letter sent at request of provider (dr wants request in writing) • NEL has deteriorated	• Select all that apply

	• NEL has not deteriorated • PEC affecting/prolonging recovery • PEC NOT affecting/prolonging recovery • No contact made with treating physician • Further medical investigation(s) and/ consults/exams are required ie REC,SPEC,diagnostics • Outstanding medical reports should be requested & file returned for opinion	
10. Following their review, the MC opinion was in line with:	• Family doctor/general practitioner- In full or in part • Specialist including Psychiatrist – In full or in part • REC – In full or in part • POC – In full or in part • Specialty Clinic – In full or in part • LBEPE – In full or in part • Early Expert Shoulder – In full or in part • Sports medicine physician- In full or in part • Pain management physician In full or in part • Psychologist – In full or in part • Nurse practitioner – In full or in part • Physio – In full or in part • Chiro – In full or in part • Other- In Full or in part • No other medical opinion on file (for issue under review) • No opinion requested – administrative referral • MC opinion not in line with any other opinion on file • No MC opinion provided	• Select all that apply Note : for cases where the MC opinion was in line with another- make note of whether it was fully or partially in line
11. Prior to the MC referral, did any of the health care providers in the case have conflicting opinions with respect to the referral reason?	• Yes-If yes answer #12 • No – if no go directly to #13	• Select one Note: the quality reviewer is looking for conflicting opinions with respect to the issue the decision maker has referred to the MC for an opinion on
12. The care providers whose opinions were in conflict with each other were:	• Family doctor/general practitioner • Specialist including Psychiatrist • REC	• Select all that apply Note: for this question the quality reviewer should be focusing on conflicting opinions with respect to

	• POC • Specialty Clinic • LBEPE • Early Expert Shoulder • Sports medicine physician • Pain management physician • Psychologist • Nurse practitioner • Physio • Chiro • Other • No opinions were in conflict with each other	the issue(s) at hand e.g. the issues being considered by the MC as part of the current referral
13. Following their review, the MC opinion was contrary to:	• Family doctor/general practitioner – In full or in part • Specialist including Psychiatrist –In full or in part • REC – In full or in part • POC – In full or in part • Specialty Clinic – In full or in part • LBEPE – In Full or in part • Early Expert Shoulder – In full or in part • Sports medicine physician – In full or in part • Pain management physician - In full or in part • Psychologist- In full or in part • Nurse practitioner- In full or in part • Physio – In full or in part • Chiro –In full or in part • Other -In Full or in part • Agreement reached after MC discussion with physician • None of the above - no contrary opinions • No MC opinion provided	• Select all that apply
14. Subsequent to the MC opinion being provided, what was the outcome of the issue being considered that prompted the case referral?	• NC accepted opinion & granted entitlement to Tx/drugs • NC accepted opinion & denied entitlement to Tx/drugs • NC accepted opinion & ltd. entitlement to Tx/drugs • NC didn't accept opinion & granted entitlement to Tx/drugs • NC didn't accept opinion & denied entitlement to Tx/drugs • NC didn't accept opinion & limited entitlement to Tx/drugs • CM accepted opinion & granted entitlement to Tx	• Select all that apply Note: the quality reviewer should understand that further medical investigations also means referrals including for consultations or other clinical paper reviewers e.g. psychologist **This question needs to answer whether it was**

	• CM accepted opinion & denied entitlement to Tx • CM accepted opinion & ltd. entitlement to Tx • CM didn't accept opinion & granted entitlement to Tx • CM didn't accept opinion & denied entitlement to Tx • CM didn't accept opinion & limited entitlement to Tx • CM accepted opinion & granted ent. to comp benefits • CM accepted opinion & denied ent. to comp benefits • CM accepted opinion & ltd. ent. to comp benefits • CM didn't accept opinion & granted ent. to comp benefits • CM didn't accept opinion & denied ent. to comp benefits • CM didn't accept opinion & ltd. ent. to comp benefits • CM authorized further medical investigation(s) to conclusively delineate entitlement • CM requested additional medical information/prior med hx to help delineate ENT (no decision made) • Medical information received- referred for subsequent MC opinion • Medical investigations/consults/exams received- referred for subsequent MC opinion • MC followed through with administrative action • SIEF only- granted	**entitlement to compensation benefits vs. treatment or drugs which was accepted or not**
15. What was the outcome of the issue(s) under review following the CM decision?	• Worker accepted CM decision (no intent to appeal to date) – terminate review here • Worker disagrees- Intent to Object submitted – terminate review here • Worker disagrees ARF submitted- no appeal action- terminate review here • Worker disagrees appealed CM decision- answer ARO questions below • No CM decision- CM followed through with administrative action • Worker provided additional information for reconsideration • Employer accepted CM decision (no intent to appeal to date) – terminate review here	• Select one

	• Employer disagrees- Intent to object submitted • Employer appealed CM decision (ARF submitted) • Employer provided additional information for reconsideration • No CM review-recent MC opinion-less than 3 business days • No CM review-recent MC opinion-greater than 3 business days • NO CM review- MC followed through with administrative action	
16. Was the decision reconsidered by the CM?	• Yes –if yes go to #17 • No • N/A- no appeal issue – terminate review here	• Select one
17. The reconsideration led to:	• Confirmation of the original denial – no Appeal • CM accepted non MC opinions and allowed in full • CM accepted non MC opinions and allowed in part • CM referred again for MC opinion • Confirmation of original denial- sent to Appeals	• Select one
18. If there was a decision letter on file, did decision maker take accountability for the decision?	• Yes • No • N/A- no decision letter	• Select one For this question the reviewer is looking for evidence that the decision maker reviewed all the medical evidence including the MC opinion and then owned the decision vs saying the MC opinion was no
19. Did the Appeal reach an ARO?	• Yes-If yes, answer question #20 • No • N/A – no appeal issue	• Select one
20. Has an ARO decision been made?	• Yes – if yes, go to #21 • No – terminate review here	• Select one
21. Did ARO accept the original MC opinion?	• Yes • No - gave more weight to the non MC opinions in the case • No - sought another opinion from external MC – if this item go to #22	• Select one

22. Did the ARO accept the new MC opinion?	• Yes – in full • Yes - in part • No	• Select one • Go to 23
23. Did the ARO decision look at the totality of the information for the issues in dispute?	• Yes • No	• Select one The quality reviewer is looking for evidence that the ARO weighed the appropriate medical information before them and did not rely on one piece of information only. Looking for weighing of various medical opinions/reports
24. What was the outcome of the issue(s) under review following the ARO decision?	• Worker accepted ARO decision (no appeal to date) • Worker appealed ARO decision • Employer accepted ARO decision (no appeals to date) • Employer appealed ARO decision	• Select one

Medical Consultant Opinion Quality Review Project Plan

REQUESTOR

Requester's Name & Title	Donna Bain, Acting Chief Operating Officer
Priority Level	☐ Urgent (<10 days) ☒ High ☐ Mid

ISSUE IDENTIFICATION

Background / Main Business Issue

The use of medical reviewers of clinical information to inform non-medical decision making is common practice across WCBs and the Insurance Industry. Medical Consultants provide an opinion with medical rationale in response to questions posed in the referral based on a review of the available medical information in the claim file, recognized medical best practices and evidenced based medical literature.

Prior to 2012 the WSIB utilized internal Medical Consultants. In 2012, a new Medical Consultant (MC) model was introduced that included outsourcing this role. WSIB entered into contracts for these services that set out expected standards such as calling the worker's treating health care professional. Specialists make up almost 40% of the roster (including Orthopedics, Ophthalmology, Internal Medicine, Respirology, Neurology, Anesthesia, Otolaryngology and Occupational Medicine).

The model has increased the timeliness and access to quality medical opinions to improve recovery and return to work outcomes for injured and ill workers and provide evidence based medical information to staff.

Some external stakeholders have alleged that the WSIB is utilizing MC opinions to contradict the treating physician's opinion leading to front line staff and appeals decision making adversely impacting worker's entitlement to benefits and services.

WSIB has undertaken a review of the use of MC file reviews in the decision-making process; including a quality review of cases referred for a MC opinion in 2014 (includes cases for psychological conditions). The use of Medical Consultant file reviews in the decision-making process is being reviewed to better understand:

1. The experience of MC opinions differing from treating practitioner's opinions.
2. Where differing opinions arise, were they consistently and appropriately reflected in decision making?
3. Any new opportunities for improvement.

Business Areas Impacted

Service Delivery, Health Services, Appeals

Main Review Question (narrow focus)

- Following the quality review, the MC opinion was in line with the following treating practitioner's
- Following the quality review, the MC opinion was contrary to the following treating practitioner's
- Subsequent to the contrary MC opinion, what was the outcome of the issue under review

DATA REQUIREMENTS

Sample Methodology	• A sample of claims was required that have 1) a medical opinion on file and 2) how the opinion was used in the decision making process. • The sample of cases to review was provided by the Chief Statisticians area to Program Quality. The Program Quality area played no role in the calculation of the sample size nor the cases selected for review. • To calculate the sample size, the Chief Statisticians area made the following considerations and assumptions: – Stratified design by referral reason – Close to proportional allocation in strata due to oversampling in a few strata of interest such as Treatment, Medication and Psychology – An apriority assumption on the proportion of contrary opinions of 0.5 (the most conservative option due to lack of prior knowledge) – A 95% confidence interval with a +/- 5% error around our estimate ▪ A total of 376 referrals were selected randomly from the total referrals in 2014 (12,347) ▪ Results need to be weighted to reflect the true allocation of each referral reason in the population
Time Frame	Quality Review Start date – November 24, 2016 Estimated Review End date – January 8, 2016 Estimated First draft – January 26, 2016
Team Lead	John Mercuri, Program Evaluation Specialist
Reviewers	Lou's Team – Joanne, Tracy, Michelle, Carmine, Kathy, Sani, Ian, John Ken's Team – Keith, Guylaine, Suzanne Appeals Team – independent review conducted by Appeals staff
Additional Calibrators	Program Quality Manager – Lou Nanos

PROJECT DELIVERABLES/ PLAN

Deliverable/ Phase	Description of Activity	Due Dates	Accountability/FTEs
Planning and Developing Quality Review Plan Phase	• Meet with business SMEs to gain understanding of issue/scope of work • Meet with Chief Statisticians team to calibrate understanding • Gather relevant material regarding process, expectations • Develop first draft of review questions and possible responses and distribute to business partners for feedback • Refine questions and responses based on feedback • Obtain agreement on final version • Shared template with Appeals for their review • Assess work effort based on finalized template • Assign quality reviewers based on work effort (expected delivery date)	• Dec. 9 - 15, 2015	• Donna, Joe, John, Patricia, Slavica • Eugene, Dragos, Marc, Joe • Joe • Joe • Joe • Donna, Patricia, Joe, Slavica • Joe, Lou • Joe, Lou
Auditing Phase	• Build Access db based on validated questions including links to resource documents and guided answer keys to certain questions • Quality Reviewers read "Considerations for Referral to Medical Consultant for Physician Case File Review (External)" document and Administrative Practice document – Weighing of Medical Evidence.	• Dec. 15-16, 2015 • Dec. 17, 2015	• John • Team

	• Team lead receives & loads sample data provided by Chief Statistician • Team lead tests template functionality • Team lead evenly distributes cases randomly • Manager led calibration session with each reviewer on all review questions • Each reviewer independently conducted a review of the same case • Manager collectively discussed responses in group to ensure consistency and understanding • Formal review initiated • Conduct recalibration debriefs with reviewers to discuss issues and challenges until review completion • Complete initial review	• Dec. 17, 2015 • Dec. 17, 2015 • Dec. 17, 2015 • Dec. 18, 2015 • Dec. 18, 2015 • Dec 18 - 24, 2015 • Dec. 24, 2015	• John • Lou, Team • Team • Lou, Team • Team • Team
Data Review/Clean Phase	• Team Lead conducts analysis and queries looking for blanks/irregularities • Identify cases requiring further review • Assign sample of cases for a secondary quality review • Complete secondary review • Team lead reviews data for consistency and corrects any inaccuracies • Team lead forwards data file to Chief Statistician for their roll up and validation • Team lead collaborates with Chief	• Jan. 4 -18, 2016	• John • John, Ian, Sandi • John • John, Dragos

	Stats area to ensure data is aligned and bucketed consistently		
Report Delivery	• Team lead receives final version of data from Chief Statisticians area and conducts final alignment • Provide high level update on 3 key questions • Deliver first draft of report to John Szkolka • Deliver final report to Donna Bain • Solicit feedback from review sponsors	• Jan. 19, 2016 • Jan 12, 2016 • Jan. 22, 2016 • Feb 2, 2016	• John, Dragos • Joe, Lou, Dragos, John • Joe • Joe, John S
Lessons Learned/Opportunities for Improvement	• Assign 2 senior reviewers from Program Evaluation Team to assess the 24 cases with denials to assess adherence to protocols • Identify any trends that may lead to improvement opportunities	• Jan. 14, 2016 to date	• Joe, Ian, Sandi • Joe, Lou

VERSION CONTROL

1. A data repository and working copies of the review template and sample are housed on a secured/dedicated S:Drive.
2. Each Program Quality Reviewer has access to a singular working copy of the ACCESS template filtered by their name to retrieve their randomly assigned cases; but the review team members may see everyone's cases and answers.
3. The Team Lead template acts as a repository for all inputted information from working copies.
4. The Team lead pulls and validates the accuracy of the completed data onto EXCEL spread sheet for analysis and creating relational pivot tables.
5. Each iteration of an edited draft report is labeled V1,V2,V3,etc until final report is delivered.
6. The versions are stored and catalogued on the S:Drive, with the template, sample and data.

Medical Consultant Opinion Quality Review Project Plan

REQUESTOR

Requester's Name & Title	Donna Bain, Acting Chief Operating Officer
Priority Level	☐ Urgent (<10 days) ☒ High ☐ Mid

ISSUE IDENTIFICATION

Background / Main Business Issue

The use of medical reviewers of clinical information to inform non-medical decision making is common practice across WCBs and the Insurance Industry. Medical Consultants provide an opinion with medical rationale in response to questions posed in the referral based on a review of the available medical information in the claim file, recognized medical best practices and evidenced based medical literature.

Prior to 2012 the WSIB utilized internal Medical Consultants. In 2012, a new Medical Consultant (MC) model was introduced that included outsourcing this role. WSIB entered into contracts for these services that set out expected standards such as calling the worker's treating health care professional. Specialists make up almost 40% of the roster (including Orthopedics, Ophthalmology, Internal Medicine, Respirology, Neurology, Anesthesia, Otolaryngology and Occupational Medicine).

The model has increased the timeliness and access to quality medical opinions to improve recovery and return to work outcomes for injured and ill workers and provide evidence based medical information to staff.

Some external stakeholders have alleged that the WSIB is utilizing MC opinions to contradict the treating physician's opinion leading to front line staff and appeals decision making adversely impacting worker's entitlement to benefits and services.

WSIB has undertaken a review of the use of MC file reviews in the decision-making process; including a quality review of cases referred for a MC opinion in 2014 (includes cases for psychological conditions). The use of Medical Consultant file reviews in the decision-making process is being reviewed to better understand:

1. The experience of MC opinions differing from treating practitioner's opinions.
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Business Areas Impacted

Service Delivery, Health Services, Appeals

Main Review Question (narrow focus)

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- Subsequent to the contrary MC opinion, what was the outcome of the issue under review

DATA REQUIREMENTS

Sample Methodology	• A sample of claims was required that have 1) a medical opinion on file and 2) how the opinion was used in the decision making process. • The sample of cases to review was provided by the Chief Statisticians area to Program Quality. The Program Quality area played no role in the calculation of the sample size nor the cases selected for review. • To calculate the sample size, the Chief Statisticians area made the following considerations and assumptions: – Stratified design by referral reason – Close to proportional allocation in strata due to oversampling in a few strata of interest such as Treatment, Medication and Psychology – An apriority assumption on the proportion of contrary opinions of 0.5 (the most conservative option due to lack of prior knowledge) – A 95% confidence interval with a +/- 5% error around our estimate ▪ A total of 376 referrals were selected randomly from the total referrals in 2014 (12,347) ▪ Results need to be weighted to reflect the true allocation of each referral reason in the population
Time Frame	Quality Review Start date – November 24, 2016 Estimated Review End date – January 8, 2016 Estimated first draft of Interim Report – January 26, 2016 Deliver final draft of Interim Report – February 1, 2016 Estimated first draft of Final Report – February 9, 2016
Team Lead	John Mercuri, Program Evaluation Specialist
Reviewers	Lou's Team – Joanne, Tracy, Michelle, Carmine, Kathy, Sani, Ian, John Ken's Team – Keith, Guylaine, Suzanne Appeals Team – independent review conducted by Appeals staff
Additional Calibrators	Program Quality Manager – Lou Nanos

PROJECT DELIVERABLES/ PLAN

Deliverable/ Phase	Description of Activity	Due Dates	Accountability/FTEs
Planning and Developing Quality Review Plan Phase	• Meet with business SMEs to gain understanding of issue/scope of work • Meet with Chief Statisticians team to calibrate understanding • Gather relevant material regarding process, expectations • Develop first draft of review questions and possible responses and distribute to business partners for feedback • Refine questions and responses based on feedback • Obtain agreement on final version • Shared template with Appeals for their review • Assess work effort based on finalized template • Assign quality reviewers based on work effort (expected delivery date)	• Dec. 9 - 15, 2015	• Donna, Joe, John, Patricia, Slavica • Eugene, Dragos, Marc, Joe • Joe • Joe • Joe • Donna, Patricia, Joe, Slavica • Joe, Lou • Joe, Lou
Auditing Phase	• Build Access db based on validated questions including links to resource documents and guided answer keys to certain questions • Quality Reviewers read "Considerations for Referral to Medical Consultant for Physician Case File Review (External)" document and Administrative Practice document – Weighing of Medical	• Dec. 15-16, 2015 • Dec. 17, 2015	• John • Team

	Evidence. • Team lead receives & loads sample data provided by Chief Statistician • Team lead tests template functionality • Team lead evenly distributes cases randomly • Manager led calibration session with each reviewer on all review questions • Each reviewer independently conducted a review of the same case • Manager collectively discussed responses in group to ensure consistency and understanding • Formal review initiated • Conduct recalibration debriefs with reviewers to discuss issues and challenges until review completion • Complete initial review	• Dec. 17, 2015 • Dec. 17, 2015 • Dec. 17, 2015 • Dec. 18, 2015 • Dec. 18, 2015 • Dec 18 - 24, 2015 • Dec. 24, 2015	• John • Lou, Team • Team • Lou, Team • Team • Team
Data Review/Clean Phase	• Team Lead conducts analysis and queries looking for blanks/irregularities • Identify cases requiring further review • Assign sample of cases for a secondary quality review • Complete secondary review • Team lead reviews data for consistency and corrects any inaccuracies • Team lead forwards data file to Chief Statistician for their roll up and validation	• Jan. 4 -18, 2016	• John • John, Ian, Sandi • John • John, Dragos

	• Team lead collaborates with Chief Stats area to ensure data is aligned and bucketed consistently • Chief Statistician's area provides updated weighted percentages for final report • Team lead conducts final alignment, data cleanse and validation for Final Report	• Feb 3, 2016 • Feb 5 -9, 2016	
Report Delivery	• Team lead receives final version of data from Chief Statisticians area and conducts final alignment for Interim Report • Provide high level update on 3 key questions • Deliver first draft of Interim Report to John Szkolka • Deliver Interim Report to Donna Bain and Internal Audit • Solicit feedback from review sponsors • Team lead receives weighted percentages for Final Report • Team lead commences preparation of Final report • Deliver first draft of Final Report to John Szkolka • Deliver Final Report • Solicit feedback from review sponsors	• Jan. 19, 2016 • Jan 12, 2016 • Jan. 22, 2016 • Feb 1, 2016 • Feb 3- 4, 2016 • Feb 5, 2016 • Feb 5, 2016 • Feb 9, 2016	• John, Dragos • Joe, Lou, Dragos, John • Joe • Joe, John S • John, Dragos • John • John • Joe

Lessons Learned/Opportunities for Improvement	• Assign 2 senior reviewers from Program Evaluation Team to assess the 24 cases with denials to assess adherence to protocols • Identify any trends that may lead to improvement opportunities	• Jan. 14 –Feb 1, 2016	• Joe, Ian, Sandi • Joe, Lou

VERSION CONTROL

1. A data repository and working copies of the review template and sample are housed on a secured/dedicated S:Drive.
2. Each Program Quality Reviewer has access to a singular working copy of the ACCESS template filtered by their name to retrieve their randomly assigned cases; but the review team members may see everyone's cases and answers.
3. The Team Lead template acts as a repository for all inputted information from working copies.
4. The Team lead pulls and validates the accuracy of the completed data onto EXCEL spread sheet for analysis and creating relational pivot tables.
5. Each iteration of an edited draft report is labeled V1,V2,V3,etc until final report is delivered.
6. The versions are stored and catalogued on the S:Drive, with the template, sample and data.

Medical Consultant File Reviews

January 18, 2016

Donna Bain
Tom Bell
Eugene Wen

Background

- The use of medical reviewers of clinical information to inform non-medical decision-making is common across WCBs and the Insurance Industry
  - Medical Consultants provide an opinion with medical rationale in response to the questions posed in the referral based on a review of the available medical information in the claim file, recognized medical best practices, and evidenced-based medical literature

- In 2012, the WSIB introduced a new Medical Consultant (MC) model that included outsourcing this role:
  - WSIB has entered into contracts for these services that set out expected standards such as calling the worker's treating health care professional
  - MC roster includes access to specialists as need
  - Each year about 12,000 MC file review opinions are received for all claims in the system

Protocols for Staff

- To ensure appropriate and consistent use of MC service by staff, there are two key documents:
  - *Considerations for Referral to Medical Consultant for Physician Case File Review* informs staff on the referral process and questions that could be asked including:
    - Compatibility between the mechanism of injury and diagnosis, entitlement for secondary injuries/conditions
    - Functional abilities/level of impairment
    - Ongoing treatment
    - Appropriate drug utilization
  - The Administrative Practice Document *Weighing of Medical Evidence*, posted on WSIB website, explains for staff and stakeholders how to use medical information

- There is a template for referral questions to ensure only clinical questions are asked and to avoid posing questions that suggest bias

- In cases where the Appeals Resolution Officer seeks a MC opinion, the referral question is shared in advance with all parties and they also share the response.

Purpose of Claim Review

- The use of Medical Consultant file reviews in the decision-making process is being reviewed to better understand:
  1. The experience of MC opinions differing from treating practitioner's opinions.
  2. Where differing opinions arise, were they consistently and appropriately reflected in decision making?
  3. Any new opportunities for improvement.

- Upon completion, the review will be audited, through Internal Audit, to provide independent verification of the findings

Work Completed to Date

- Our Chief Statistician provided a random sample of 376 cases, all of which have been reviewed using a standard template to gather relevant information

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- [redacted]

s.22 [

- [redacted]

Next Steps

- Complete the claim file review and identify cases for further analysis
- Develop profiles of the cases that receive this service for example, by claim duration and nature of the injury to understand utilization patterns
- In the cases where a difference between the treating practitioner and the MC review opinion led to a denial of benefits, review adherence to approved protocols
- Complete Audit Plan for verification of findings

Use of Medical Consultants Status Update

Internal Audit

January 26, 2016

For discussion purposes only

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Contents

- Interim results
- Work performed to date
- Next steps and work plan

Interim results

- Current known results
  - REDACTED: S. 22
    - [redacted]
    - [redacted]
      - [redacted]
      - [redacted]
  - Sample was independently selected by the Chief Statistician's Office
    - Statistically valid
    - Operations staff had no input over which claims were selected
  - Key documents
    - Administrative Practice Document: Weighing of Medical Evidence
    - Considerations for Referral to Medical Consultant
    - Initial Referral for Physician Case File Review

Work performed to date

- Operations
  - 376 claims have been reviewed
  - Analysis currently underway
  - Results expected within two weeks
- Chief Statistician's Office
  - Sample design and selection
    - Date of referral had to fall within 2014
    - Random selection by claim number
- Internal Audit
  - Obtained an understanding of
    - Governing documents
    - Sampling methodology
    - Interim results to date

Next steps

- Issue engagement memo
  - Review scope with Operations
- Proposed work plan
  - Process followed to conduct the review
  - Independence of the sample selection process
  - Review of key documents
    - Governing policy documents
    - Procedural guidance
    - Training over use of medical consultants
  - [redacted]
    - [redacted]
    - [redacted]
    - [redacted]
  - [redacted]
    - [redacted]
    - [redacted]
      - [redacted]
      - [redacted]

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Questions

Appeals - Requests for MC Opinion

- ARO requests for MC opinions occur in very limited circumstances where obtaining a medical opinion is considered necessary to help the ARO render a more complete decision relating to the specific issue(s) in dispute
- ARO requests for MC opinions primarily involve seeking assistance to clarify more complex issues of medical compatibility between accident histories and diagnoses (e.g. there are two types or "arthritis" in the knee following work-related knee surgery)
- In order to maintain transparency in the Appeals process, both the request memo for the MC opinion and the MC response are shared with the participating workplace parties. The parties are then invited to make further written submissions relating to the MC opinion.
- Once any further submissions have been received, the ARO issues a decision having regard for all of the available information in the file, including the MC opinion and all other medical information from the worker's health care providers
- The ARO generally places more weight on a medical opinion(s) that is supported by objective [medical] findings
- In some appeals, the workplace parties/representatives provide their own independent medical opinion, which is typically a review and opinion of the information in the claim. The ARO has regard for this information but makes a decision based on the totality of all the medical information in the file.

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W/P Ref.:			
Prepared/Updated By:	RB	Date (mm/dd/yy):	02/03/16
Reviewed By:		Date (mm/dd/yy):	

Audit Name: Medical Consultants
Subject: Meeting Minutes

Date/Time:	February 3, 2016, 1:00 pm – 2:00 pm
Attendees:	VP and Chief Statistician Eugene Wen, VP and Chief Statistician Internal Audit Anita Patel, Director Rabia Butt, Auditor
Location:	Eugene's office, 3C.06, 19/F.
Purpose:	To discuss the process of sample design and data results for medical consultants' quality review.
Next Step:	To draft the audit engagement letter and preliminary workplan for review.

1. Audit Scope
   - Limited to physician and psychologist referrals made in 2014
   - Limited to post-1990 claims as any claims prior to 1990 were paper claims and do not have an electronic file

2. Key Contacts
   - Eugene Wen, VP & Chief Statistician

3. Audit Team
   - The audit team includes Anita and Rabia

4. Background
   - The medical consultants program functions as a secondary medical opinion for workers' cases
   - In instances where there is uncertainty regarding the treating physician's initial diagnosis, a medical consultant (MC) can be forwarded the case to give their opinion
   - The MC may agree/disagree fully or partially with the initial physician

5. Sampling Process
   - 2014 was the year selected because it was the most recent full year reflective of the current policy regime, since 2015 data is not fully in yet
   - In general, treating physician tends to be more generous in their decision regarding benefits because they are not familiar with the return to work concept
   - The medical consultants used by WSIB are specialists. They are actually recruited to be aware and knowledgeable of the return to work concept. Part of their job is to communicate with

ODM, whereas psychologist referrals are not tracked in the system. Instead, June Duesburry-Porter manually inputs and tracks them in an excel file

- Brian Tastula sent a file to Dragos which contained a list of all physician referrals made in 2014 (about 12,000). The file contained items such as claim number, referral ID, date assigned, date closed, reason for referral, etc.
  Note: A claim can have more than one referral to a medical consultant
- June Duesburry-Porter provided Dragos with a list of all psychologist referrals made in 2014 (approximately 251) which contained similar information as physicians' referrals (there was a separate study done for psychologist referrals in which the entire population was selected instead of a sample)
- Dragos included the psychologist referrals to the physicians' file and cleaned up the data by removing those that did not have an initial physician's response or were missing a consultant's response
- To ensure a representative sample, Dragos decided to sample from all strata with referral reason being the stratification variable in the sample design
  Referral reasons were compatibility, functional assessment, psychologist, treatment, medical – opioids, medical – non opioids
- Sample was chosen with a 95% confidence interval assumption with a +/-5% error around the estimate, totalling 376
- Dragos used SAS to randomly select the sample by inputting parameters to ensure sample agreed to strata weight selection (i.e. 38 with functional assessment as referral reason)
- The samples were then sent to Joe Civello in an excel file with contained information such as claim number, referral reason, date assigned (to medical consultant), date closed, etc.
- Some of the initially selected sample had to be replaced for various reasons: missing information, missing opinion, pre-1990 paper claims (22 samples)
  A further 8 samples were also replaced: 1 that was the claim of a WSIB employee and 7 that were not reviewed or not referred to a medical consultant
- Sample was analyzed on criteria sent by Joe Civello's team which specified the question and list of responses to assess the sample on

6. Next steps
   - Anita to meet with Joe Civello

wsib cspaat ONTARIO

W/P Ref.:			
Prepared/Updated By:	RB	Date (mm/dd/yy):	02/01/16
Reviewed By:		Date (mm/dd/yy):	

Audit Name: Medical Consultants
Subject: Meeting Minutes

Date/Time:	February 1, 2016, 1:00 pm – 2:30 pm
Attendees:	VP and Chief Statistician Dragos Daniel Capan, Manager & Senior Statistician Internal Audit Anita Patel, Director Rabia Butt, Auditor
Location:	Dragos office, 3D.04, 19/F.
Purpose:	To discuss the process of sample design and data results for medical consultants' quality review.
Next Step:	To draft the audit engagement letter and preliminary workplan for review.

1. Audit Scope
   - Limited to physician and psychologist referrals made in 2014
   - Limited to post-1990 claims as any claims prior to 1990 were paper claims and do not have an electronic file

2. Key Contacts
   - Dragos Daniel Capan is the contact from VP and Chief Statistician
   - Joe Civello is the contact from quality review side of operations
   - Brian Tastula is the contact from Health Services
   - June Duesburry-Porter is the contact from Chief Nursing Office
   - Other key contacts to be updated later

3. Audit Team
   - The audit team includes Anita and Rabia

4. Background
   - The medical consultants program functions as a secondary medical opinion for workers' cases
   - In instances where there is uncertainty regarding the treating physician's initial diagnosis, a medical consultant (MC) can be forwarded the case to give their opinion
   - The MC may agree/disagree fully or partially with the initial physician

5. Process
   - There are two different samples drawn from two data sources; one for psychologists and one for physicians (which includes psychologists). Physician referrals are tracked electronically in

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W/P Ref.:			
Prepared/Updated By:	RB	Date (mm/dd/yy):	02/03/16
Reviewed By:		Date (mm/dd/yy):	

Audit Name: Medical Consultants
Subject: Meeting Minutes

treating physicians to discuss their recommended treatment and work out the best solution from there

- Both the treating physician and medical consultant have different objectives which can lead to difference in opinions regarding best form of treatment
  - Treating physician focuses on taking care of the patient from a purely health focus
  - Medical consultant focu8ses on the same goal, but also has knowledge and responsibility to facilitate return to work, which is the center of the WSIB program
- [redacted]

6. Next steps
   - Anita to meet with Joe Civello

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W/P Ref.:			
Prepared/Updated By:	RB	Date (mm/dd/yy):	02/08/16
Reviewed By:		Date (mm/dd/yy):	

Audit Name: Medical Consultants
Subject: Meeting Minutes

Date/Time:	February 3, 2016, 3:00 pm – 4:30 pm
Attendees:	Office of the Chief Operating Officer Joe Civello, Director, Planning & Quality John Szkolka, Executive Director, Planning & Quality Internal Audit Anita Patel, Director Rabia Butt, Auditor
Location:	Joe's office, 1A.07, 2/F.
Purpose:	To discuss the process of referring to medical consultants for workers' claims.
Next Step:	To draft the audit engagement letter and preliminary workplan for review.

1. Audit Scope
   - Limited to physician and psychologist referrals made in 2014
   - Limited to post-1990 claims as any claims prior to 1990 were paper claims and do not have an electronic file

2. Key Contacts
   - Joe Civello is the contact from quality review side of operations

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   - The medical consultants program functions as a secondary medical opinion for workers' cases
   - In instances where there is uncertainty regarding the treating physician's initial diagnosis, a medical consultant (MC) can be forwarded the case to give their opinion
   - The MC may agree/disagree fully or partially with the initial physician

5. Process
   - A MC review can be triggered at any point in the life of a claim (i.e. beginning or 20 years down the road)
     - The majority of claims from the sample were mostly referred at the latter stage of claim's life by nurse consultants or case managers, usually more than a year after the date of injury

- The average life of the sample's cases from time of injury to referral to MC is about 5.6 years, which implies that benefits were being paid on average for 5.6 years before the case was sent to a MC referral

- Eligibility adjudicator determines worker's benefits (or no benefits). If there is something in the case that does not seem right to them based on their experience, they may ask for a medical consultant's opinion
- Medical consultant can be asked to provide an opinion on medication, treatment, compatibility, and/or functional ability
  - Medication – dosage amount/level of opioids/non-opioids
  - Treatment – duration of treatment
  - Compatibility – could the reported injury have reasonably been caused at work?
  - Functional ability – an assessment of what activities the worker can do
- When a medical consultant's opinion is required, the case manager fills out the form for medical consultant. This form becomes part of the case file
- Medical consultants are external physicians (not employees) that are assigned cases. Once a case has been assigned to a medical consultant, they cannot reject it. MCs are given access to pertinent information and usually contact the treating physician (TP) to gather more details or discuss TP's recommendation
- MCs give their opinion in a timely basis; usually within a week
- The program for referral to medical consultants has existed for some time but initially, medical consultants were internal (WSIB employees). The current version of the MC referral program with external/outsourced MCs started in 2012
- The MC is provided a template to use for returning opinion. The opinion memo is received by the case manager and included in the worker's file
  - The memo usually includes a thorough analysis which explains the rationale of the MC, often quoting literature as reasoning. Essentially the MC opinion memo explains how the MC assessed the medical condition and how they reached their conclusion
  - If the MC requires further information to provide their opinion, they will ask for it or, if the MC thinks the worker needs further investigation, they will suggest that to the case manager
- After the opinion memo is received from the MC, the case manager considers the medical opinions of both MC and TP and makes a decision. The decision is first verbally communicated to the worker (workplace party)
- After the verbal communication, the worker and the employer are sent a written decision letter which outlines the case facts, relevant factors for decision, and time limits for appeal among other information

- Both the decision letter and the decision memo (case manager's memo on how they reached their decision) become part of the case file alongside the record of telephone conversation with the worker for the initial communication of decision
- WSIB case managers have a higher probability of going through all the process for decision making if there is an adverse opinion (i.e. documenting decision memo)

6. Next steps
   - Joe to provide 3 examples of actual MC referral forms and MC opinion memos
   - Joe to provide selected sample cases

wsib cspaat ONTARIO

Engagement Memorandum
Internal Audit

TO: Tom Bell, Chief Risk Officer

CC: Donna Bain, Acting Chief Operating Officer
Eugene Wen, Chief Statistician
John Szkolka, Executive Director, Operations Cluster
Anita Patel, Director, IT & Operations Audit

FROM: Michael Braude, VP Internal Audit

DATE: February 24, 2016

SUBJECT: **Medical Consultants' File Review**

BACKGROUND

In 2012, the WSIB introduced a Medical Consultant model that enables access to independent, expert and timely medial opinions. WSIB has entered into contracts with a number of firms to provide the services of medical consultants.

Under this model, WSIB is able to seek independent medical expertise and advice, related to individual injured workers, over and above that provided by the treating physician(s). Referrals are made by eligibility adjudicators, nurse consultants, case managers and appeals resolution officers when opinions are required to support recovery and return to work and for clarification of work related entitlement.

A joint review over the use of Medical Consultants was recently conducted by the Operations Cluster and the Chief Statistician's Office. Specifically, the purpose of the quality review was to:

- Determine whether, and to what extent, differences of medical opinion exist between a treating physician and medical consultant; and
- Determine, where material differences of opinion were identified, whether these were consistently and appropriately reflected in the decision making, and what the resulting outcome was.

The basis of this review was a statistically random sample of 376 injury claims selected from the total population of referrals made to medical consultant within 2014. It is our understanding that analysis and reporting of results is currently underway.

OBJECTIVE

The objective of this internal audit (IA) review is to provide an independent view on the process followed to conduct the quality review and to review procedural guidance over the Medical Consultant model, specifically to:

- Confirm adequate segregation of duties between staff involved in selecting the sample of claims that formed the basis of the quality review from those tasked with performing the review;
- Understand the scope, methodology, work performed and results of the quality review and identify additional areas that may be considered for further inquiry; and
- Determine whether the processes followed to refer a claim to a medical consultant and consider a medical consultant's opinion, in order to make subsequent decisions related to recovery and return to work, are consistent with guidance, training and procedures provided to decision-makers.

SCOPE

The scope of IA's review will be limited to the sample, work performed and results of the 376 injury claims that formed the basis of the quality review. Work performed and results from the sample of psychological referrals will also be included in the review.

APPROACH

IA will perform its work as follows:

Quality Review

- Obtain a high-level understanding of governing documents, sampling methodology and interim results from the quality review;
- Interview relevant staff involved in performing the quality review, sampling and decision-making related to recovery and return to work decisions;
- Review the method followed to select sample claims for the quality review;
- Perform sample testing of injury claims from the quality review to confirm the process followed and results reported;
- Understand the process used to measure and report the results of the quality review; and
- Review the data analysis performed and final results of the quality review.

Claim Referral Process

- Review the following key documents that govern the use of medical consultants:
  - Administrative Practice Document: Weighing of Medical Evidence;
  - Considerations for Referral to Medical Consultant; and
  - Initial Referral for Physician Case File Review.
- Understand guidance and training provided to decision-makers over the use of medical consultants; and
- Perform walk-through testing of the process followed to refer, make use of and document opinions obtained from medical consultants to confirm compliance with procedural guidance.

SCHEDULE AND DELIVERABLES

The following table outlines key milestones and target dates of this review, premised on timely availability of key contacts, required documentation and any other client resources required for engagement execution:

Milestone Activity	Target Date
Commencement of engagement planning	January 25, 2016
Commencement of fieldwork	February 8, 2016
Completion of fieldwork	March 11, 2016
Issuance of draft memo	March 25, 2016
Exit meeting(s)	April 8, 2016
Issuance of final memo	April 15, 2016

Internal Audit will prepare a summary memo to be distributed to all persons above and others as determined appropriate. A high level summary is reported to the Audit & Finance Committee quarterly.

AUDIT TEAM

The IA team will consist of Anita Patel, Director, IT & Operations Audit and Rabia Butt, Auditor.

If you have any questions regarding this engagement, please do not hesitate to contact me at 416 344 3955.

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W/P Ref.:	1.3		
Prepared/Updated By:	RB	Date (mm/dd/yy):	02/22/16
Reviewed By:		Date (mm/dd/yy):	

Audit Name: Medical Consultants Review
Subject: Contact List

Name	Title	Phone/Location	Meeting Date(s)
Planning and Quality, Operations Cluster			
Donna Bain	Acting Chief Operating Officer, Office of the Chief Operating Officer	416-344-5610 19/F, 2H.01	
John Szkolka	Executive Director, Planning & Quality	416-344-2366 19/F, 3F.02	02/03/2016
Joe Civello	Director, Planning & Quality	416-344-2636 2/F, 1A.07	02/03/2016
John Mercuri	Program Evaluation Specialist, Program Quality	416-344-5654 2/F, 3I.W09	02/23/2016
VP & Chief Statistician's Office, Operations Cluster			
Eugene Wen	VP & Chief Statistician, Predictive Modelling	416-344-4497 19/F, 3C.06	02/03/2016
Dragos Daniel Capan	Manager & Senior Statistician	416-344-3657 19/F, 3D.04	02/01/2016

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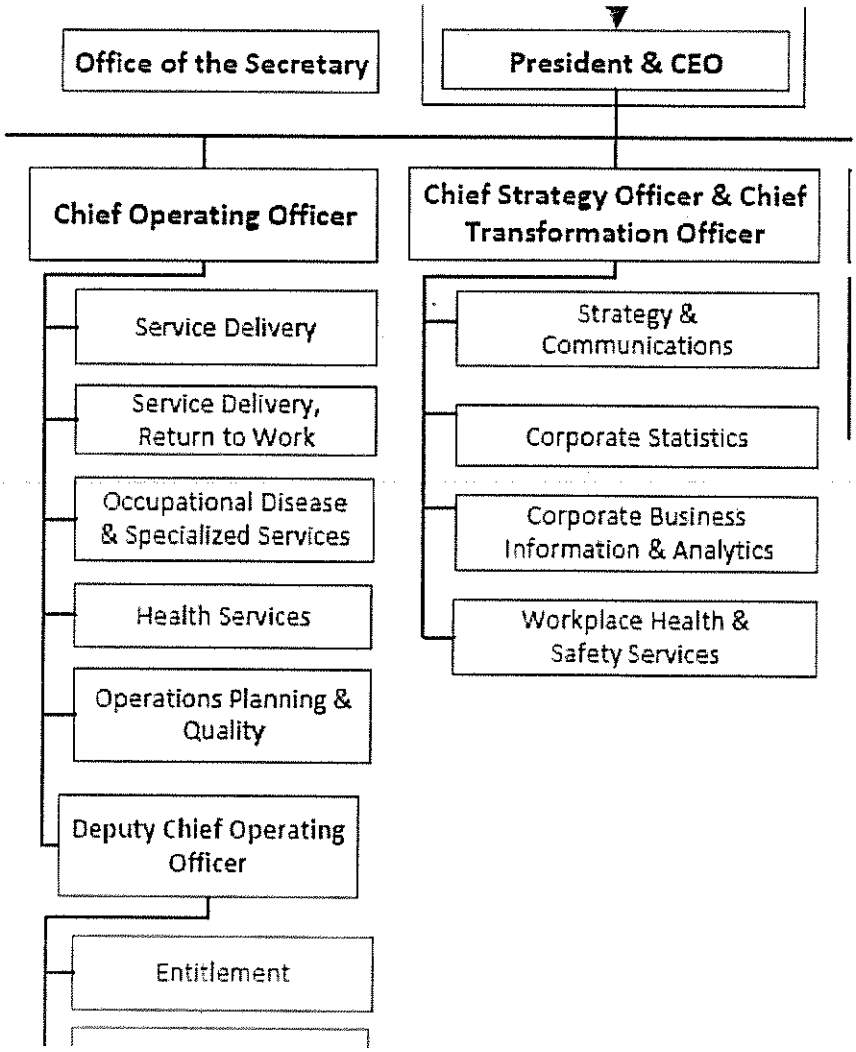
W/P Ref.:	1.5		
Prepared/Updated By:	RB	Date (mm/dd/yy):	02/23/16
Reviewed By:		Date (mm/dd/yy):	

Audit Name: Medical Consultants Review
Subject: Organization Structure

For this review, the divisions of WSIB involved are Operations Planning & Quality alongside Predictive Modelling.

The following is a snapshot of the WSIB organization chart which shows that the Acting Chief Operations Office reports to the President and CEO. Donna Bain is the acting Chief Operations Officer in charge of Operations Planning & Quality division.



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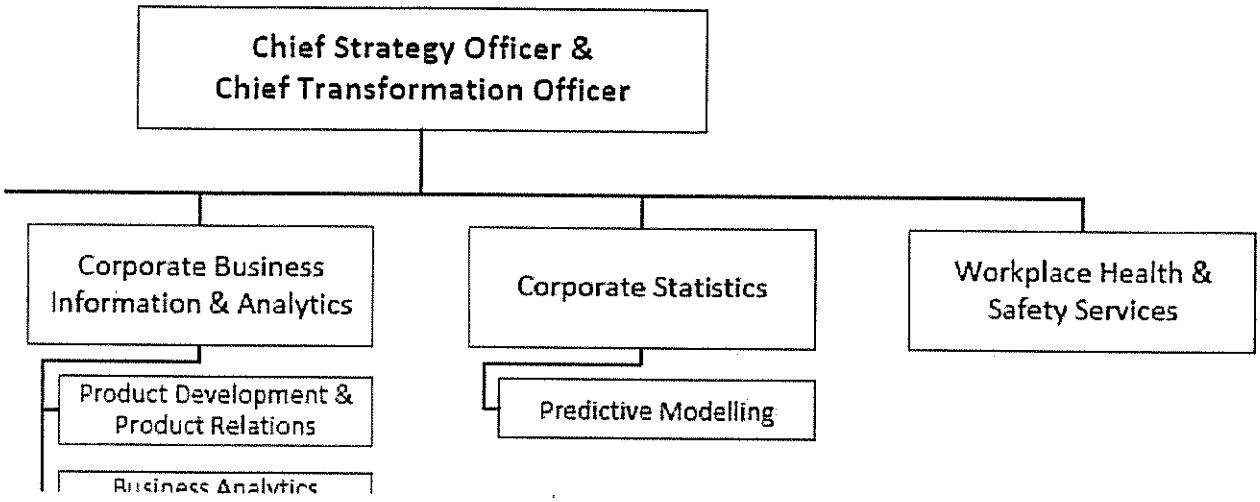
W/P Ref.:	1.5		
Prepared/Updated By:	RB	Date (mm/dd/yy):	02/23/16
Reviewed By:		Date (mm/dd/yy):	

Audit Name: Medical Consultants Review
Subject: Organization Structure

The following is a snapshot of the organization chart which shows that Predictive Modelling is under the Corporate Statistics Division. The VP & Chief Statistician of Corporate Statistics is Eugene Wen.



Medical Consultants File Review
Update – February 24, 2016

Objective: to provide an independent view on the process followed to conduct the quality review and, to review procedural guidance over the Medical Consultant (MC) model, specifically with respect to

A. Sample selection process;
B. Methodology and work performed by the Program Quality team;
C. Process followed to refer to MC's is consistent with guidance, training and procedures.

Status – Engagement letter finalized and to be issued today.

A. Sample Selection

- The sample of 376 files was statistically weighted by Chief Statistician's group.
- There was adequate segregation between Ops and Statistician's group as the sample was selected randomly by Statisticians and claim numbers provided to Ops.

Status - There were some minor adjustments and we are still confirming that Statisticians group provided the replacements.

B. Scope, Methodology of Work Performed by Program Quality Team

Scope - the 376 files were all referrals made to MCs in 2014.

Status - The decisions on those files could reflect policy from 2014 and even prior years due to the lag effect of policy changes on case decisions. Age of files at time of MC referral being followed up.

Work Performed by Program Quality - Sample review of 25 claims (includes psych files).

Status - Follow up observations with Operations/Program Quality - 50% (13/25) of the sample requires further analysis and review to understand classification reported.

C. PROCESS FOLLOWED TO REFER TO MC'S

- Decisions to refer to MC's seem to follow relevant procedure, based on file review.

Status - Meetings with case managers (to be scheduled) to walkthrough training and procedural guidance (case managers have been selected). Training guidance to be reviewed.

Overall

[redacted]

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W/P Ref.:			
Prepared/Updated By:	RB	Date (mm/dd/yy):	03/08/16
Reviewed By:		Date (mm/dd/yy):	

Audit Name: Medical Consultants
Subject: Meeting Minutes

Date/Time:	February 29, 2016, 11:00 am – 2:00 pm
Attendees:	Program Quality John Mercuri, Program Evaluation Specialist Internal Audit Anita Patel, Director Rabia Butt, Auditor
Location:	John's desk, 3I.W09, 2/F.
Purpose:	To discuss the quality review process and address flagged samples and questions on them.
Next Step:	To complete fieldwork and finish off working papers.

1. Audit Scope
   - Limited to physician and psychologist referrals made in 2014
   - Limited to post-1990 claims as any claims prior to 1990 were paper claims and do not have an electronic file
   - Refer to engagement memo for full scope details

2. Key Contacts
   - Joe Civello is the contact from quality review side of operations

3. Audit Team
   - The audit team includes Anita and Rabia

4. Background
   - The medical consultants program functions as a secondary medical opinion for workers' cases
   - In instances where there is uncertainty regarding the treating physician's initial diagnosis, a medical consultant (MC) can be forwarded the case to give their opinion
   - The MC may agree/disagree fully or partially with the initial physician

5. Meeting Notes
   - A list of questions was sent to John Mercuri prior to the meeting, saved as "Sample Questions for John Mercuri" in the fieldwork folder of audit working papers

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W/P Ref.:			
Prepared/Updated By:	RB	Date (mm/dd/yy):	03/08/16
Reviewed By:		Date (mm/dd/yy):	

Audit Name: Medical Consultants
Subject: Meeting Minutes

I. In cases where there is no official treating/initial physician's (TP) opinion, how is level of agreement between medical consultant (MC) and TP determined?

In case files, there is a treating physician opinion included. This specific opinion memo was not provided to IA in the printouts of samples. In most cases, the question being asked by MC can imply what the TP opinion is, i.e. if medication question, the TP opinion would be the prescription.

Requested John to provide TP opinion memo for specified cases where there is flags for level of agreement between TP and MC.

II. If there is an accepted injury but a proposed treatment is denied, what steps are taken regarding benefit payments, other treatments, etc.? Please refer to case # [redacted] for reference re: PRP injections.]s.21

[redacted]]s.21

III. In some cases, decision letter indicates that MC opinion was accepted but classification from interim report indicates that MC opinion was rejected. Could you please explain how the classification of MC opinion acceptance/rejection was determined? Please refer to case # [redacted] for reference.]s.21

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Audit Name: Medical Consultants
Subject: Meeting Minutes

In many cases of sample, case file included multiple MC opinions for the same case, some in the same 2014 year. It is possible that some of the decision letters provided were referencing a different MC opinion than the one that sample classification from Dragos references.

Requested John to provide decision letters for specified cases where there is a flag for MC opinion acceptance/rejection.

IV. What is the policy for how CM/NC phrases their questions to MC? Is there a policy for phrasing questions in a way that does now show which way the CM/NC may be leaning towards in their entitlement decision?

The official policy is that there should not be any leading questions. In their quality review, they did find some that had leading questions which are pointed out in the interim report. However, they were not excluded from the sample of 376 or from IA sample of 25.

V. Is there an opioid policy that case workers or nurse consultants refer to? If there is, could we please get a copy?

John provided some guidelines from Connex Q &As and provided helpful links for reference.

VI. Case # [redacted]

[redacted]

s.2

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Reviewed By:		Date (mm/dd/yy):	

Audit Name: Medical Consultants
Subject: Meeting Minutes

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Requested John to check on LOE benefits and its impact.

Quality review only looked at whether CM accepted responsibility of decision and whether the request for opinion was correct, not whether the individual in question made the "right" decision. But generally, our policy is that benefits should have been given based on aggravation basis injury.

In quality review classification, when something is put in the "denial" of entitlement bucket, it is classified as such relative to the question asked of the MC and not necessarily denial of benefits to the whole case for the IW. It would be that one specific aspect is denied (i.e. labral tear) but there are benefits (i.e. LOE for shoulder injury).

VII. Case #[redacted] – [redacted] s.21

VIII. Case #[redacted] – [redacted] s.2

For case #[redacted], [redacted] s.21

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Audit Name: Medical Consultants
Subject: Meeting Minutes

IX. Case # [redacted] – [redacted]

[redacted]

5.2

X. Case # [redacted] – [redacted]

[redacted]

John to provide aging of cases; from duration of cases to MC review

5.2

XI. Case # [redacted] – [redacted]

5.21

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W/P Ref.:			
Prepared/Updated By:	RB	Date (mm/dd/yy):	03/08/16
Reviewed By:		Date (mm/dd/yy):	

Audit Name: Medical Consultants
Subject: Meeting Minutes

[redacted]

s.2

XII. Case # [redacted] –

[redacted]

s.2

Note: While speaking with John, it was discovered that some workers do not put their opioid/drugs prescriptions through WSIB, but through private insurance coverers (i.e. Manulife). This allows IW more control over their medication as private insurers do not ask questions about dosage or opioid management, and put payments through as long as coverage exists. WSIB, on the other hand, has NCs and MCs who initiate action for drug usage management. Many times, WSIB has no idea what drugs an IW may be using in these cases because there is no communication between WSIB and private insurer. Per legislation, WSIB has priority over drug payments when it comes to IWs, not private or employer insurers.

Suggestion: There should be an information sharing plan (similar to the one between CRA and WSIB re: MOU) with private insurance companies to ensure that WSIB is aware of what drugs/opioids workers are taking for workplace injury.

6. Next steps
   - Complete working papers
   - Meet with CMs and NCs to discuss training and MC process

To: FILE
From: [redacted]
Worker's Name:

Memo #:
Claim:
Date: 18-Jan-16

Initial Referral For Physician Case File Review

Referral Type: Choose an item. **Referral Business Area:** Choose an item.
Claim Type:

Referral Reason: Choose an item. **Language:** Choose an item.		
Referral questions: Click here to enter text.		
Accepted Accident/Illness history: Click here to enter text.		
Areas of injury/diagnosis(es) allowed under the case Click here to enter text.	**Areas of injury/diagnosis(es) denied under the case** Click here to enter text.	
For upper extremity cases – hand dominance: Choose an item.		
Prior, pertinent, similar, subsequent or related cases: Click here to enter text.		
Occupation/Job Title: Click here to enter text. **Worker's Age:**		
Work Status: Choose an item. **If returned to modified work:** Choose an item. **Return to Work Date:**		
Work available: Choose an item. **Description of work available:** Click here to enter text.		
Medical Investigations Completed: Click here to enter text.	**Medical Investigations Pending:** Click here to enter text.	

Treatment Accepted/Allowed	Treatment Start Date	Discharged
Click here to enter text.		Choose an item.
Click here to enter text.		Choose an item.
Click here to enter text.		Choose an item.
Click here to enter text.		Choose an item.
Click here to enter text.		Choose an item.

Medications accepted/allowed (Name, dose, duration): Click here to enter text.	
Attendance at POC, REC or Specialty Clinic	**Date**
Choose an item.	
Choose an item.	
Choose an item.	
Has a NEL/PD been granted in this case? Choose an item. **If "yes", last NEL/PD Date:** **NEL/PD Quantum(s):** Click here to enter text.	

Prior NEL/PD

Claim #	PI/PD Granted For	NEL or PD	NEL/PD Date	Quantum

Click here to enter text.	Click here to enter text.	Choose an item.		Click here to enter text.
Click here to enter text.	Click here to enter text.	Choose an item.		Click here to enter text.
Click here to enter text.	Click here to enter text.	Choose an item.		Click here to enter text.
Click here to enter text.	Click here to enter text.	Choose an item.		Click here to enter text.
Click here to enter text.	Click here to enter text.	Choose an item.		Click here to enter text.
Click here to enter text.	Click here to enter text.	Choose an item.		Click here to enter text.

Additional relevant information (include co-morbidities, concerns)
Click here to enter text.

Treating Physician(s) Name and Contact Information:
Click here to enter text.
Treating Physician Type: Choose an item.
Health Professional's Name and Contact Information:
Click here to enter text.
Health Professional Type: Choose an item.

Contact Information		
Case Manager's Name	**Case Manager's Phone Number**	**Case Manager's Desk #**
Nurse Consultant's Name Click here to enter text.	**Nurse Consultant's Phone Number** Click here to enter text.	**Nurse Consultant's Desk #** Click here to enter text.

In case of questions regarding this referral, please contact:
Choose an item.

Title: Considerations for Referral to Medical Consultant for Physician Case File Review (External)

Roles: Advanced Practice Nurse (APN), Case Manager (CM), Eligibility Adjudicator (EA), Nurse Consultant (NC)

Reason for Referral

A referral is made to a Medical Consultant (external) when an intervention is required to remove a return to work (RTW) or recovery obstacle; seize an opportunity to move the plan forward towards the goals; or for medication management (Opioid and non-Opioid). A medical opinion may also be required regarding compatibility of:

- Diagnosis to accident history
- Proposed surgery to compensable condition or pre-existing condition
- Current deterioration to compensable condition or natural aging/degeneration
- Occupational Disease

Staff Physician referrals (Internal) are covered in a separate document. Staff Physician referrals are reserved for issues that require an immediate response that cannot wait 48 hours (e.g. an urgent medication review or a priority request from senior management). Staff physicians also focus on providing value-added services such as staff education, and interaction with the medical community. Staff Physicians also may be accessed to facilitate Escalation of Obtaining Outstanding Medical Information.

Role of the Medical Consultant (MC)

The MCs are an expert resource available to the CM or NC to leverage their clinical expertise in achieving RTW and recovery goals. The MCs review initial or subsequent referrals to determine what intervention is required or opinion is requested. If required, they contact the treating physician to discuss obstacle or obtain/clarify medical information.

The MCs review case documents and form an opinion to respond to the referral reason. They document the response in the 'Physician Case File Review Memo' document on professional letterhead, send it to file electronically using the PBAS system and refer the case back to the case owner via WLST.

The MCs receive cases based on their eligibility for a particular referral type and language designation. There is no limit to the number of cases which can be requested. The number will only be limited by the number of cases in the queue, which may vary day-to-day. Cases are assigned on a first in, first out basis (the oldest case in the queue first). If no referrals are available, an error message will be shown. External contracted physicians cannot decline a case once it has been requested. They also have the ability to search for cases already assigned to them.

The MCs access the case file documents saved on the WSIB network, using a network ID and security key, leveraging PBAS technology. This process adheres to requirements regarding privacy of worker information under the *Workplace Safety and Insurance Act, 1997* (WSIA). The application has the same stringent encryption levels as online banking sites. File referral turnaround time is usually within four days or less

Position Case for Referral

Critically examine the case and case conference with NC and/or Manager, if appropriate, and define the issue(s) requiring the MC's intervention or opinion. Delineate all areas of entitlement and update the JCKT. Ensure all relevant medical information is on file including:

- Specialist reports
- Operative reports
- X-ray, CT scan, or MRI reports
- Exposure or surveillance screening history for OD
- Physiotherapy reports
- Regional Evaluation Centre (REC) reports if relevant

The MCs are provided with access to copies of the case file documents from the following sections: APP, COR, FOR, INV, MED, MEM, NMD, NMO, VRS and SYN. The MED section of any prior claims noted in the referral will be made available for physician review. They have no access to the TBF section, so documents must be filed in the correct section. Ensure relevant prior claim are summarized:

- Complete the Summary of Prior or Subsequent Claim Form and file it in the SYN section of claim
- Move a copy of all NEL Medical Assessments from the prior claim into the SYN section of your claim
- Scan and file all PD information into the SYN section for prior paper claims

Include the referral to MC for a Physician Case File Review, in the most recent case plan document (e.g. Case Assessment & Plan (CAP) or Review and Monitor Action Memo) and advise the workplace parties (WPPs), when appropriate, of referral as part of case planning conversation. Complete separate referral memos if there is more than one referral type, but ask multiple questions on one referral for a single referral type.

If the referring role is not the case owner, the referring role may put the review on their hold list at the time of referral and then look for the report within about one week.

Documents Received Subsequent to the Referral

Documents that come to file after the referral will not be available to the MC. If the referring role believes the new document is critical to the review, a call is placed to Ann Howes, Medical Secretary Health Services, for assistance in copying it as a separate document for access on the K-Drive. MCs do not have access to RHST notes. Any information pertinent to the case should be included in the referral memo.

Drug Inquiry Tool

The MCs do not have direct access to the Drug Inquiry Tool. Any concerns identified as a result of NC or CM review of the Drug Inquiry Tool info may be articulated on the referral memo in the medication section as well as in the additional relevant information section. Drug Inquiry Tool information can be put on file by choosing MODI print. The referring role can make reference to this information on the referral memo.

Surveillance Videos

All surveillance videos must go Regulatory Services Division (RSD) for validation prior to a referral. Once validated, refer the case to desk T 1498 and the video to Anne Howes, Medical Secretary Health Services.

How to Pose Questions to the MC

The role of the Medical Consultant is to provide clinical advice therefore ensure your questions are clinical in nature and not adjudicative questions. To ensure you get your question appropriately answered, consider the following when crafting questions:

- Before you start communication, take a moment to figure out what you want to say and why
- Don't waste your time conveying information that isn't necessary
- You are responsible for asking a question that is clear, concise and directly related to the desired outcome in the case
- Refrain from asking questions that are more administrative decisions, such as asking for the MMR date
- Refrain from making a statement and then asking for agreement, and try not to ask leading questions
  - Example: "My review of the medical information supports the worker is totally impaired, do you agree?"
- Ask open ended questions that start with "What, When, Why" to allow the MC to provide you with their opinion
  - Example "How is the planned surgery related to the compensable condition?"
- If you request physician to physician contact, be specific about the desired outcome of that conversation – spend time articulating the barrier to allow the MC to appropriately manage the conversation
  - Example "The treating practitioner continues to support the worker remain off work without providing detailed findings. Please contact the practitioner to discuss RTW opportunity and determine if there are other factors driving his/ her decision to continue to authorize the worker off work "

Referral to MC Regarding RTW Obstacles

You may need to solicit a medical opinion/ intervention to address a RTW obstacle in cases where recovery expectations are not consistent with a RTW goal and plan. Examples of RTW obstacles:

FA - The treating Physician continues to support the worker remain off work despite availability of modified work (MC to Physician contact may be indicated here)

FA - Physician report is incomplete and worker's abilities are not documented

Referring a case to the MC to list precautions is not appropriate. Do not use "standard restrictions" as these should be based on medical information in the file, review of evidenced-based medical research (e.g. Official Disability Guidelines (ODG)), and collaborative discussion with WPPs. Do not put the whole case on hold while awaiting the MC opinion, proceed with other planned RTW activities that can continue concurrently

Referral to MC Regarding Recovery Obstacles

You may need to solicit a medical opinion or intervention to address a recovery obstacle such as clarification of a treatment plan and/or the need for further health care. Examples of recovery obstacles:

TX - Physician recommends further assessments without rationale yet findings support recovery

TX - Physician proposing a treatment plan that CM and NC question the relatedness to the injury

O/S REQ - Outstanding clinical information is required to assist with recovery and decision making

Referring a case to the MC for a maximum medical recovery (MMR) date is not appropriate. Normally a CM should be able to make a decision on MMR and permanent impairment without a medical opinion.

Referral to MC to Clarify Entitlement

Referring a case to the MC to approve surgery that is clearly related to the injury is not appropriate. Examples of entitlement or compatibility (COMP) issues include:

COMP - Eligibility Adjudicator questions if the diagnosis is related to the accident history

COMP - After conferencing with the Manager and NC, the CM questions if the proposed surgery is related to the compensable injury or a pre-existing condition

COMP - Is the current deterioration related to the compensable condition or natural aging/degeneration

Referral to MC to Clarify Ongoing Entitlement when Pre-existing Condition is Evident

COMP – CM questions if the ongoing impairment is work-related, when pre-existing condition to the same area or system of the body is evident

The following are the required questions to the MC:

The accepted mechanism of workplace injury that occurred on __(date of injury)__ was the following: __(detailed accident history)__. The worker has received various treatments, consultations and therapies. There appears to be ongoing impairment. Considering the worker's pre-existing conditions, namely __(specifics of pre-existing condition)__, and clinical evidence on file, please provide your opinion as follows.

(1) Do the clinical findings support a continued work-related impairment?

(2) Do the clinical findings demonstrate that the pre-existing condition is contributing to ongoing impairment?

(3) If so, is the contribution of the pre-existing condition so great that it has rendered the compensable work-related impairment insignificant?

Psychological / Chronic Pain Disability

Chronic Pain Disability (CPD) decisions do not require a medical opinion. For psychological or psychiatric requests, refer to desk T1400 and if specifically making a request for a psychiatrist review, the referral reason should indicate 'Psych MD'.

Ophthalmology Cases

For ophthalmology cases, follow referral process by completing initial or subsequent referral template. Select referral type 'occupational disease' under the field 'Referral Questions', indicate in capital letters OPHTHALMOLOGY REFERRAL, then type in the question posed. Make the referral to the appropriate desk as in the referral process, then immediately call Ann Howes (Health Services Contact) at 416-344-2927 to advise of the referral and provide the claim number.

Paper Files

In the case of paper files, the file will electronically scanned to a network drive to enable it to be reviewed. Please ensure the jacket is marked up with the appropriate direction as follows:

PBS referrals- JCKT should read "External Physician Referral"

Relative Claims – JCKT should read "External Physician Referral – Security (Relative Claim)"

BEC claims – JCKT should read "External Physician – BEC"

OD Paper claim – JCKT should read "External Physician Referral – OD"

The notification process for completed MC reviews on paper files is slightly different. Please check with Permanent Benefits Services (PBS) Manager if there are any questions.

Standard Forms and Letters

Summary of Prior or Subsequent Claim Form

Initial Physician Referral (D2I)

Subsequent Physician Referral (D2I)

Considerations

Considerations for Referral to Staff Physician

Process

How to Refer to Medical Consultant for Physician Case File Review (external)

How to Refer to Staff Physician

How to Escalate Requests for Outstanding Medical Information

Reference

Official Disability Guidelines

Administrative Practice Document – Pre-Existing Conditions (WSIB Website)

Title: How to Refer to Medical Consultant for Physician Case File Review (External)

Roles: Advanced Practice Nurse (APN), Case Manager (CM), Eligibility Adjudicator (EA), Nurse Consultant (NC)

How: Step-by-Step

Step	Role	Activities
(1)	Referring Role	Select the memo template located on D2I, 'Initial Referral For Physician Case File Review' or 'Subsequent Referral For Physician Case File Review'. Complete the mandatory fields including the Referral Type, Referral Business Area, Claim Type and Referral Reason. Without this information, the referral cannot be processed. Choose one referral type from the drop down list: Hearing Loss Musculoskeletal Occupational Disease Serious Injury Services Surveillance Choose one referral reason from the drop down list: Functional Abilities/Limitations - FA Treatment – TX Medication Management – OPI/NON OPI Lack of Physician Response – O/S REQ Compatibility – COMP If there are documents within a prior claim relevant to the current issue, note the specific claim number(s) within the "Prior Claims" section of the referral template.
(2)	Referring Role	File the completed template memo in the MEM section of the case file.
(3)	Referring Role	For imaged files refer via the WLST to the following desk #: Initial and subsequent referrals – desk # T1498 Board Employee Cases (BEC) – desk # T1499 For the referral code, use the same referral reason selected in the template. Note: If documents are stored in the optical library (identified by asterisks (*) in FLDR), set a CREV on the claim file which will retrieve the file from the optical library overnight. This would also apply to any relevant prior claims listed on the referral. A note should be made in the referral that a CREV has been set. The case may be returned without a review if documents are stored in the optical library. For paper files, flag sections of the file to be copied and take the file to Records to scan selected sections into the K-Drive.
(4)	Referring Role	The Medical Consultant's (MC) response will be documented in the 'Physician Case File Review Memo' and placed in the MEM section. Locate the memo and update the FLDR description with the correct memo number and make no other changes to the FLDR description. Note: The case file will be returned to the case owner; therefore, if the referral was made by someone else, the case owner must refer the case to the Referring Role. For Appeals refer to desk T 8000. For others (e.g. NC), check the referral history and refer to the desk # of the person who requested the opinion.

(5)	Referring Role	Assess the impact of the medical opinion and take action as appropriate. Note: Speak with your Manager if clarification of the opinion is required. If you still require clarification, send an e-mail to Ann Howes, Medical Secretary Health Services, outlining issue for clarification and referral to the appropriate party for follow-up. It is not appropriate to contact the external Medical Consultant unless they called you directly with a question. If they do call you with a question, it is expected that you return their call within 24 hours.

Standard Forms and Letters

Summary of Prior or Subsequent Claim Form 0947A
Initial Physician Referral (D2I)
Subsequent Physician Referral (D2I)
Physician Case File Review Memo

Considerations

Considerations for Referral to Medical Consultant for a Physician Case File Review (External)

Process

How to Refer to Staff Physician
How to Refer for Ophthalmology Review

Administrative Practice Document

Weighing of Medical Evidence

Note: This is not a policy; it is a supplementary document to illustrate how the WSIB will administer the *Workplace Safety and Insurance Act, 1997*, (WSIA) and Policy 11-01-02, Decision-Making in practice. If there is a conflict between this Administrative Practice Document and the WSIA and/or WSIB policy, the decision maker will rely on the WSIA and/or WSIB policy, as the case may be.

wsib
ONTARIO

March, 2015

Weighing of Medical Evidence

INTRODUCTION

Decision-makers at the Workplace Safety and Insurance Board (WSIB) must decide a worker's entitlement to benefits and services under the *Workplace Safety and Insurance Act* (WSIA). It must be established that the worker's injury resulted from an accident that arose out of and in the course of employment, or that the worker suffers from an occupational disease that occurred due to the nature of employment.

Decision-makers continuously collect information and weigh the evidence to make adjudicative decisions, including initial entitlement, throughout the life of the claim. While the specific information needed in a claim will vary based on the circumstances of the case, medical information about the worker's injury/disease, treatment and ongoing impairment is monitored and continuously evaluated.

Medical information may be received from a number of health care professionals. While the clinical findings are usually comparable, the interpretation of those findings among the health care professionals involved in the worker's case may vary. This can lead to a difference of opinion on diagnosis, prognosis, treatment, causation, and the worker's functional abilities or physical precautions. The challenge for the decision-maker is to take all of this information and weigh it appropriately.

As many of the decisions made at the WSIB are influenced by the way medical information is interpreted and weighed, this document focuses on the weighing of medical evidence in the decision-making process.

KEY PRINCIPLES

- Adjudication is the process used to determine entitlement to benefits and services under the WSIA.
- A decision-maker is the person who makes decisions regarding entitlement.
- Decision-makers will gather relevant information and weigh evidence in order to make adjudicative decisions.
- Workers are entitled to receive benefits for injuries and diseases that result from accidents that arise out of and in the course of employment.
- Work-relatedness is established when determining initial entitlement. Decision-makers continue to evaluate the work-relatedness of a worker's ongoing impairment and treatment throughout the life of a claim.
- The WSIB makes its decisions based on the merits and justice of each case.
- When the evidence for and against an issue relating to a worker's claim are equal, the benefit of doubt is given to the worker.

Decision-making

Decision-makers must gather all of the information that is available and relevant to a case in order to make entitlement and case management decisions. Wherever possible, information is gathered by telephone and medical reports are obtained from the health care professionals involved in the worker's case. All reasonable attempts must be made to obtain any missing information so that relevant information is available to the decision-maker throughout the adjudicative process.

As directed by legislation, a worker is entitled to WSIB benefits and services for a work-related injury or disease. Decision-makers are responsible for collecting the information needed to address and decide all issues that have a bearing on the worker's ongoing entitlement. Issues that may arise during the life of a claim that require an adjudicative decision include, but are not limited to:

- a change in the diagnosis of the work-related injury/disease,
- new area of injury,
- secondary conditions,
- recurrence,
- disputes about job suitability, or
- treatment required.

Decisions relating to medical issues should be based primarily on the information and opinions received from the treating health care professional(s). These health care professionals include, but are not limited to, physicians, surgeons, physiotherapists, chiropractors and registered nurses (extended class). When medical information is submitted to the WSIB, the decision-maker must review it for completeness and clarity, within the context of the claim file. The decision-maker continuously assesses the medical information received to monitor the worker's recovery and ongoing work-related impairment.

Determining Relevancy of Evidence

Generally, the information and medical reports received in a worker's claim are about the work-related injury/disease starting from the date of injury. Occasionally, the WSIB receives information about the worker or the worker's medical condition(s) that are not directly related to the work-related injury/disease and impairment. The relevancy of such information is dependent on the issue under consideration by the decision-maker at the time.

There are also situations where decision-makers request pre-accident clinical records for adjudicative decisions. For example, pre-accident clinical records or chart notes are required when determining entitlement for

- psychotraumatic disability or chronic pain disability,
- ongoing impairment when a pre-existing condition affecting the same area of the body or system as the work-related injury/disease may be contributing to the worker's ongoing impairment.

A worker's privacy is a key priority at the WSIB and therefore decision-makers must determine the need to request any particular medical information as well the relevance of all information as it is received in a claim. Information is relevant to the claim when it has value in weighing the evidence to establish a matter of fact in a case, i.e. it has a bearing on the decision-making process. Where a document contains both relevant and non-relevant information, the non-relevant information is edited (blacked out) from the document.

Once the decision-maker determines the information has a bearing on decision-making, it is considered relevant. Relevancy does not speak to the weight that is given to that information in the decision-making process. All relevant information is considered and weighed in order to reach a decision. Information that is determined to be relevant to any decision in the claim is retained in the file records.

Health Care Programs

WSIB has established health care programs to provide workers with expedited access to specialized health care to support the worker's primary health care professional and WSIB decision-makers with respect to

Weighing of Medical Evidence

diagnosis, causation, and treatment recommendations. The objective of these programs is to provide quality care and assist the workers in their recovery from the work-related injury or disease. These programs include:

Programs of Care (POC) – Programs of Care are evidence-based health care delivery plans that describe treatment modalities shown to be effective for specific injuries and illnesses.

Low Back Expert Physician Examiner Services (LBEPE) – LBEPEs provide early and comprehensive low back assessments and recommendations to the worker, the worker's primary health care professional and the WSIB with respect to diagnosis, investigations, treatment and return to work. Direct contact with the treating health care professional is an important part of the service. The physicians providing this service are community-based family physicians who have completed a formal education program, developed and delivered specifically for this service by pre-eminent orthopedic specialists.

Regional Evaluation Centres (REC) – The REC physicians are medical experts in the field of musculoskeletal injuries. They perform a comprehensive medical assessment and contact the worker's primary health care professional to discuss the assessment findings, health recovery plan and the worker's capabilities to return to work. The work capacity liaison assists the worker to understand the implications of the REC physician's medical assessment for return to work planning.

Specialty Clinic Services – These services are especially designed to provide workers with more complex injuries and diseases quick access to health professionals with specialized knowledge and clinical expertise, for both assessment and treatment services. An integral aspect is the pharmacological review and screening of the worker's drug therapy, conducted by a pharmacist.

The above programs provide a worker with faster access to specialized and integrated health care that

Physician's Role

The CMA Policy called *The Treating Physician's Role in Helping Patients to Return to Work after an Illness or Injury*, available on the WSIB website, outlines the role of the physician including:

> "The treating physician's role is to diagnose and treat the illness or injury, to advise and support the patient, to provide and communicate appropriate information to the patient and the employer, and to work closely with other involved health care professionals to facilitate the patient's safe and timely return to the most productive employment possible. Fulfilling this role requires the treating physician to understand the patient's roles in the family and the workplace. Furthermore, it requires the treating physician to recognize and support the employee-employer relationship and the primary importance of this relationship in the return to work. Finally, it requires the treating physician to have a good understanding of the potential roles of a return-to-work coordinator and of other health care professionals and employment personnel in assisting and promoting the return to work."

Further clarification of the role of the physician in return to work is included in the same document.

> "The CMA recognizes the importance of a patient returning to all possible functional activities relevant to his or her life as soon as possible after an injury or illness. Prolonged absence from one's normal roles, including absence from the workplace, is detrimental to a person's mental, physical and social well-being. The treating physician should therefore encourage a patient's return to function and work as soon as possible after an illness or injury, provided that a return to work does not endanger the patient, his or her co-workers or society. A safe and timely return to work benefits the patient/employee and his or her family by enhancing recovery and reducing disability."

The role of other health care professionals, such as chiropractors and physiotherapists are similar. It is the role of the decision-maker to use the functional information provided to make decisions about the worker's ability to work.

incorporates return to work planning and enhanced communication among participants, which may include the worker, employer, primary health care professional, and the WSIB. This ensures a common understanding of the recommendations, and enables the WSIB to provide the worker and employer with timely benefits and services.

Weighing of Medical Information

Medical information about the worker's injury or disease is integral to decision-making at the WSIB. Medical Information relating to the worker's case may be received from a variety of health care professionals, including the services noted above.

Where there is a conflict in the medical information or opinions between the health care professionals, the decision-maker is expected to assess and weigh each report in order to reach a decision. The decision-maker may case conference with the nurse consultant who can explain pathology, or request a clinical opinion from a medical consultant (MC).

While decision-makers acquire medical knowledge as part of claims training and through exposure to claim files, this does not equate to the expertise of physicians. Therefore, the decision-maker may call on a MC to assist with

- issues of causation, mechanism of injury, pathology, or interpretation of medical information,
- clarification of the relationship between a diagnosis and the accident history, work environment or employment circumstances,
- the effects of pre-existing conditions or other non-work-related conditions on the work-related impairment.
- advice when there is a need for clarification of medical opinions on file. For example, the primary health care professional's treatment plan or list of functional abilities (or precautions) that may be different or contrary to the discharge recommendations from a Program of Care or REC.

When referring a file to an MC, the decision-maker must outline to the MC the facts of the case, such as the accepted accident history or mechanics of the work that may be responsible for the injury/disease or the accepted diagnosis. The decision-maker must also determine the issues he/she requires assistance with, and frame their questions to the MC in an objective and unbiased way.

The MC is responsible for reviewing the medical reports in order to provide an opinion in response to the questions posed. Any opinion offered by the MC should provide a full explanation and rationale based on the available clinical evidence. Entitlement decisions are beyond the scope of the MC.

It should be noted that the WSIB can provide timely access to assessment, and in some cases to treatment, via the various programs offered. These programs provide valuable services and information that can assist the decision-maker. Where there are conflicting opinions or conflicting medical information, the treating health care professional(s) may be contacted in order to reconcile those differences, where feasible. To do so, decision-makers may request the assistance of a MC for these conversations. In cases where conflicting

medical information or opinions exist, decision-makers may seek an additional assessment by an external expert (including REC and Specialty Clinic programs).

The following is a list of some points the decision-maker may consider when weighing medical evidence and opinions:

- Did the health professional have all the relevant medical records, including diagnostic and radiological reports, available to review in order to obtain a complete "picture" of the worker's condition, a full understanding of the worker's relevant medical history, and the injury process involved?
- What is the timeliness of the medical examination in relation to the issue at hand?
- What is the degree of the health professional's knowledge of the worker's past and present medical history? How does this impact the weight of the medical opinion at issue?
- What is the extent of the health professional's knowledge and understanding of the nature of the worker's work or employment environment in relation to ongoing impairment?
- What is the expertise of those offering an opinion, relative to the issue? Is reference made to relevant medical literature to support the opinion and recommendations, where appropriate?
- Is the evidence/opinion provided based on an examination of the worker? Does it include the evaluation of the worker's complaints and symptoms relative to the clinical findings?
- Is the opinion well explained and the conclusion logical? Are clinical findings provided? Do the clinical findings support the opinion?

The relative significance of the factors noted above is dependent on the issue under consideration by the decision-maker. Even after weighing the medical evidence, based on the considerations noted above, there may still be opposing opinions that the decision-maker determines to be of equal weight. In these cases, the equally-weighed medical opinions are assessed together with all other relevant and weighed evidence to make a decision.

The "Benefit of Doubt" is an adjudicative principle outlined in s.119(2) of the WSIA. This principle is employed only where the evidence for or against a particular result is approximately equal in weight, with the benefit of doubt given to the worker.

It is important to note that the benefit of doubt principle is not applied to the weighing of the medical evidence itself or to conflicting medical opinions of equal weight in order to give greater weight to the opinion that favours the worker. It is only used when the body of all of the evidence for and against a particular outcome is approximately equal in weight. Therefore, a benefit of doubt ruling is always made by the decision-maker, never the MC.

Weighing of Medical Evidence

Communication of Decisions

All adjudicative decisions should be communicated verbally to the workplace parties, wherever possible, and then confirmed in writing. The decision letter should

- identify the issue decided,
- provide a summary of the facts of the case,
- provide the entitlement rules that apply to the issue (legislative and/or policy criteria, or standards),
- provide the rationale for the decision reached, explaining how the entitlement rules were or were not met,
- reference only evidence that is relevant to the decision, and
- include the timeframe for appealing the decision for all adverse decisions.

Every effort is made to communicate decisions in plain language to ensure the decision and reasons for the decision are fully understood by the worker and employer. The rationale should outline the evidence that was considered relevant to decision-making on the identified issue. Where the decision-maker must weigh conflicting or differing information/medical opinions, the decision letter should include an explanation of the decision-maker's assessment of the relative weight of the evidence. The explanation should indicate whether the evidence/opinion was accepted or not, and the reasons the evidence/opinion was given more or less weight.

Conclusion

All decisions should be based on the information relevant to the issue being decided. Where medical information is relevant to the decision, the decision should be based on information received from the treating health care professionals of the worker as well as all other sources of medical information, such as the REC or Specialty Clinic programs.

Decisions should not be made in the absence of pertinent information – such as medical reports from all health care professionals and operative reports unless all reasonable attempts to get the missing documents have failed. Where there is differing or conflicting medical information/opinions, every effort should be made to reconcile those differences which may include telephone contact with the health care professional or obtaining the assistance of a medical consultant to do so. In some cases, a decision-maker may conclude that it is necessary to seek an additional external medical assessment.

Ultimately, the decision-maker must make decisions having regard for the medical information on file and the opinions offered, including those of the health care professionals who have assessed and/or treated the worker and, in certain situations, a medical consultant.

Medical evidence should be assessed bearing in mind the points outlined earlier in this document, and then weighed. Evidence or opinions that are not accepted or are given less weight should always be identified and the reasons for the decision-maker's assessment of their relative weight should be explained.

Document History:

March 2015 – replaces Best Approaches Guide, Weighing of Medical Evidence, October 2005.

Scheduled Review: March 2020

Sample size calculation for the Medical Consultant review audit

Survey main questions:

1. Is the Medical Consultant's opinion in line with/contrary to the treating physician opinion?
2. What is the Case Manager's /Nurse consultant's decision following the Medical Consultant's review?

Referral population

The population consists in all referrals to medical consultants in 2014. Referrals to physician medical consultants can be found in ODM and an extract for those that occurred in 2014 were sent to us by Brian Tastula. The database records the reason for the referral. Below is the distribution for the 2014 referrals:

Referral_Reason1				
Referral_Reason1	Frequency	Percent	Cumulative Frequency	Cumulative Percent
	6	0.05	6	0.05
COM	8244	66.42	8250	66.47
FA	1242	10.01	9492	76.48
LPR	309	2.49	9801	78.97
MEDN	400	3.22	10201	82.19
MEDO	1610	12.97	11811	95.17
TR	600	4.83	12411	100.00

LPR (Lack of Physician Response) was excluded as it is not a category of interest for this study.

Referrals for psychological issues are tracked separately and do not exist into a database. June D provided us with an excel file containing referrals for psychological reasons.

After including the referrals for psychological issues and considered 'psych' as the reason for the referral the distribution for the 2014 referrals was:

Referral_Reason1				
Referral_Reason1	Frequency	Percent	Cumulative Frequency	Cumulative Percent
COM	8244	66.77	8244	66.77

Referral_Reason1				
Referral_Reason1	Frequency	Percent	Cumulative Frequency	Cumulative Percent
FA	1242	10.06	9486	76.83
MEDN	400	3.24	9886	80.07
MEDO	1610	13.04	11496	93.11
Psych	251	2.03	11747	95.14
TR	600	4.86	12347	100.00

Sample size calculation

A random sample representative of the population of interest needs to be drawn to answer the main questions. We considered the population to be stratified based on the referral reason and hence constructed a stratified sample. We considered strata sample sizes proportional to the population. However, some of the strata like MEDO, TR, MEDN, PSYCH with a lower proportion of referrals are of more interest than others (e.g. COM). To increase precision in those strata of interest we oversampled (increased the proportion sampled compared to the proportion in the population). To keep the total sample the same we sampled less in the strata of less interest (that had a higher proportion in the population).

When aggregating the results we will weigh each referral based on the its reason to reflect its proportion in the population.

To calculate the sample size we made the following assumptions:

1. Stratified design (in case the response to the question of interest differs with reason of referral)
    a. Stratification variable: referral reason
2. An apriority assumption of the proportion of interest of 0.5 (the most conservative option due to lack of prior knowledge)
3. A 95% confidence interval with a +/- 5% error around our estimate

With the above assumptions and with a total known population of 12,347referrals the sample size needed was calculated to be 376 referrals.

Below is the number of referrals reviewed from each stratum.

Template Reason Referral				
Template_Reason_Referral	Frequency	Percent	Cumulative Frequency	Cumulative Percent
COM	142	37.77	142	37.77
FA	38	10.11	180	47.87
MEDN	25	6.65	205	54.52
MEDO	104	27.66	309	82.18

Template Reason Referral				
Template_Reason_Referral	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Psych	26	6.91	335	89.10
TR	41	10.90	376	100.00

In the sampling process we had to replace some of the referrals randomly picked the first time due to:

a) Claims had accident date before 1990 and they could not be reviewed (no electronic records)
b) Claims were deemed security files (WSIB employees)
c) Not reviewed/ not referred to MC

The referrals added to the original sample were also randomly chosen from the remaining (un-sampled yet) referrals. The Appendix contains mode details on the actual sampling process.

Analysis considerations:

Percentages need to be weighted in order to account for the true distribution of the referral reasons in the total referral population. **The sample size is not designed to have the same margin of error for any subsample analysis.**

Psychology referrals sample

Based on a population of 251 referrals to a psychologist a statistical sample of 153 was initially calculated under the same assumptions used for the overall referrals.

Since many of the referrals selected either could not be reviewed (pre 1990 claims, no MC on file) or the reason for the referral was to clarify the diagnosis and translate it to DSM a decision was made to have ALL left eligible referrals reviewed.

In the end a total of 222 referrals were included in the analysis.

Analysis considerations:

Since there is no stratification variable the results do not need to be weighted. No confidence intervals are needed if we state the results to reflect post 1990 claims.

Appendix:

Sampling process

We used the PROC SURVEYSELECT procedure in SAS to select the 376 referrals. As mentioned we departed from the proportional allocation in each stratum to sampling more referrals from a few strata.

The table below outlines the allocation in the strata and the percentages of each stratum within the sample.

Stratum	Proportional Allocation	Oversampled initial allocation	Referrals reviewed
Compatibility	249 (66.2)	140 (37.2)	142 (37.8)
Functional Abilities	38 (10.1)	38 (10.1)	38 (10.1)
Medical Non-Opioids	13 (3.5)	26 (6.9)	25 (6.6)
Medical Opioids	49 (13.0)	100 (26.6)	104 (27.7)
Psychological	8 (2.1)	32 (8.5)	26 (6.9)
Treatment	19 (5.1)	40 (10.6)	41 (10.9)

Step 1 sample selection – initial sample:

```
proc surveyselect data=referrals
 SAMPSIZE= (140 38 26 100 32 40)
 seed=453492  out=Sample_referrals;
 strata Referral_Reason1;
 title 'Number surveyed in each strata - oversampled as per the
agreement in some strata';
run;
```

The following is the SAS output from the above procedure as well as a frequency procedure on the resulting sample:

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Number surveyed in each strata - oversampled as per the agreement in some strata

The SURVEYSELECT Procedure

Selection Method	Simple Random Sampling
Strata Variable	Referral_Reason1

Input Data Set	REFERRALS
Random Number Seed	453492
Number of Strata	6
Total Sample Size	376
Output Data Set	SAMPLE_REFERRALS

Page Break

Number surveyed in each strata - oversampled as per the agreement in some strata

The FREQ Procedure

Referral_Reason1				
Referral_Reason1	Frequency	Percent	Cumulative Frequency	Cumulative Percent
COM	140	37.23	140	37.23
FA	38	10.11	178	47.34
MEDN	26	6.91	204	54.26
MEDO	100	26.60	304	80.85
Psych	32	8.51	336	89.36
TR	40	10.64	376	100.00

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Step 2 – sample selection – replacement 1

The following list of claims (22) in the original sample needed to be replaced as the team could not review pre-1990 claims.

s.21

[redacted]

To replace the above claims the following steps were taken:

1. From the total population exclude all pre-1990 claims and also the claims sampled the first time
2. Determine the strata the 22 referrals come from
3. Use PROC SURVEYSELECT to randomly select 22 referrals
4. Once sample is selected confirm strata allocation

Pre-90 cases by strata from innitial sample that need to be replaced

The FREQ Procedure

Table of replace by Referral_Reason1

		Referral_Reason1(Referral_Reason1)						
		COM	FA	MEDN	MEDO	Psych	TR	Total
replace								
0	Frequency	136	36	22	90	31	39	354
	Percent	36.17	9.57	5.85	23.94	8.24	10.37	94.15
	Row Pct	38.42	10.17	6.21	25.42	8.76	11.02	
	Col Pct	97.14	94.74	84.62	90.00	96.88	97.50	
1	Frequency	4	2	4	10	1	1	22
	Percent	1.06	0.53	1.06	2.66	0.27	0.27	5.85
	Row Pct	18.18	9.09	18.18	45.45	4.55	4.55	
	Col Pct	2.86	5.26	15.38	10.00	3.13	2.50	
Total	Frequency	140	38	26	100	32	40	376
	Percent	37.23	10.11	6.91	26.60	8.51	10.64	100.00

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Survey select number of referrals selected by strata

The SURVEYSELECT Procedure

Selection Method	Simple Random Sampling
Strata Variable	Referral_Reason1

Input Data Set	REFERRALS_POST90S
Random Number Seed	123321
Number of Strata	6
Total Sample Size	22
Output Data Set	REPLACEMENT_REFERRALS

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Quality check of number selected by strata from the file to be sent to the review team

The FREQ Procedure

	Referral_Reason1			
Referral_Reason1	Frequency	Percent	Cumulative Frequency	Cumulative Percent
COM	4	18.18	4	18.18
FA	2	9.09	6	27.27
MEDN	4	18.18	10	45.45
MEDO	10	45.45	20	90.91
Psych	1	4.55	21	95.45
TR	1	4.55	22	100.00

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Step 3 – sample selection – replacement 2

A number of 8 (7+1 security file) claims were received to be replaced. The 7 fell under the category "Not Reviewed-Not Referred to MC" (no memos on file). Since the 8 claims accounted for 11 referrals in the population, a total number of 11 referrals were generated.

To sample the 8 claims the following steps were taken:

1. From the total population exclude all pre-1990 claims and also the claims sampled the first time and second time (the 22)
2. Determine the strata the 11 referrals came from

3. Use PROC SURVEYSELECT to randomly select the 11 referrals
4. Once sample is selected confirm strata allocation

Number of claims in each strata to be replaced because of no memos

The FREQ Procedure

Referral_Reason1				
Referral_Reason1	Frequency	Percent	Cumulative Frequency	Cumulative Percent
COM	2	18.18	2	18.18
MEDN	2	18.18	4	36.36
MEDO	2	18.18	6	54.55
Psych	5	45.45	11	100.00

Page Break

Survey select number of referrals selected by strata - no memos for MC referral

The SURVEYSELECT Procedure

Selection Method	Simple Random Sampling
Strata Variable	Referral_Reason1

Input Data Set	REFERRALS_POST90S2
Random Number Seed	876
Number of Strata	4
Total Sample Size	11
Output Data Set	REPLACEMENT_REFERRALS_NOMEMOS

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Check to see if the selected referrals are from the right strata

The FREQ Procedure

Referral_Reason1				
Referral_Reason1	Frequency	Percent	Cumulative Frequency	Cumulative Percent
COM	2	18.18	2	18.18
MEDN	2	18.18	4	36.36
MEDO	2	18.18	6	54.55
Psych	5	45.45	11	100.00

Step 4 – back up sample selection

The steps above were repeated to construct a backup sample in case more referrals needed to be replaced.

Page Break

Randomly Select referrals for replacement of other claims that may not be possible to audit

The SURVEYSELECT Procedure

Selection Method	Simple Random Sampling
Strata Variable	Referral_Reason1

Input Data Set	REFERRALS_POST90S3
Random Number Seed	876
Number of Strata	6
Total Sample Size	80
Output Data Set	BACKUP_FOR_REPLACEMENT

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Back up referrals in case there is need to replace more

The FREQ Procedure

Referral_Reason1				
Referral_Reason1	**Frequency**	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
COM	20	25.00	20	25.00
FA	10	12.50	30	37.50
MEDN	10	12.50	40	50.00
MEDO	10	12.50	50	62.50
Psych	20	25.00	70	87.50
TR	10	12.50	80	100.00

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