MFL Occupational Health Centre submission to the WCB Act Review 2017: medical perspective on WCB's handling of Musculoskeletal Injuries

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The Occupational Health Centre's experience with WCB and Musculoskeletal Work injuries

Introducing the MFL Occupational Health Centre

The MFL Occupational Health Centre (OHC) was established in 1983 to address the needs of Manitoba workers for information, occupational health services and workplace health and safety training. OHC is funded by the Winnipeg Regional Health Authority WRHA as a community health centre with a province-wide mandate to offer low-barrier access to occupational health physician services to working populations of Manitoba, irrespective of workplace organization or union membership. Over time

OHC board governance broadened from solely trade union representation to include immigrant communities that contribute significantly to Manitoba's labour force in unorganized workplaces.

Re. Musculoskeletal Occupational Health at OHC

A core service of the OHC is provision of occupational health physician consultation services for work-related health concerns. Approximately 300 patient clients a year attend the two OHC physicians for a wide range of issues related to work-related injuries, diseases and related conditions for diagnosis, assessment, treatment, management advice and education.

The clinical casework of one of the physicians focuses on work-related musculoskeletal injuries (MSI). Patient clients are referred from a variety of sources: Worker Adviser Office (50%); Family Doctors (10%); Unions (10%), other paralegal advocate appeals (10%), informal community networks and self-referral (20%)(estimated). They seek advice about a musculoskeletal health problem or injury related to work and for medical evaluation; for half the clientele the main reason is their WCB claim, which they want to appeal or take issue with. This typical takes place at a late stage in the claims process, many are on social assistance, disability pension or now depend on others (20%).

The focus varies case by case but may include: providing medical- legal report on specific or general issues, evaluating prospects for recovery, function and employment, recommended treatment options, advice on self-care to mitigate ongoing problems, and counselling. Typical case work up consists of reviewing the worker's account of their work history, job duties, the injury(ies) sustained and subsequent developments, as well as a review of the WCB claim file and other medical documentation.

This submission is based on the accumulated 20 year experience of the OHC physician with more than 1500 MSI WCB claimants[1]. Over this time period more than half the trade unions that used to assist in members' no longer do WCB claim appeals due to budget constraints and increasingly complex task involved, a significant contraction of advocacy in the province. The OHC client profile has also trended significantly to fewer union members attending, 40% down to 20%, with many more clients from immigrant communities seeking assistance.

The submission fully acknowledges that the patient population is skewed towards poor outcomes of the work injury / WCB / health care / recovery continuum. It disproportionately represents those with limited personal resources, self-care skills and coping strategies. The vantage point, unique in Manitoba, is relevant to critical evaluation of 'Workers Compensation Board (WCB) practice, whether it accords with principles of the Act, and as the Review committee seeks "current with emerging trends

[1] Based on 80 per year x 20 years = 1600

in injury and illness, the most up-to-date health and safety knowledge, and medical practices".

The OHCs concentrated experience with frustrated WCB claimants highlight how complex claims are poorly handled by WCB, but these claimants also present challenges to health care providers HCP- the family doc, specialist and the allied health treatment provider- as well as employers, legal advocates and the workers' families. This requires a broader understanding of the dynamics of health care funding and delivery in the province.

MSI and WCB: from the vantage point of unsuccessful claims experience

Almost all (90%) of OHC's patients with MSIs have significant ongoing pain and functional impairments from a work injury. Together, their stories describe problems with multiple, interconnected issues. Most 60-70% relate a negative experience with their WCB claim(s), which has been disallowed (not accepted for various reasons), or closed without recovery- they can't resume life at work or home like before. Often treatments have ceased, WCB process stalls, leading to eventual claim closure. Ongoing musculoskeletal pain flare ups with activities is typical, and with ongoing symptoms, impairments or difficulty resuming work and employment is common. A significant proportion (1/4 to 1/3) are no longer employed; they are on or seeking social assistance, and / or Canada Disability Pension for income support. Complex WCB MSI claims: common problems, issues and patterns

Informed by the clinical experience at the OHC, this section focuses on the experience of complex MSI injured workers as WCB claimants. For this purpose a complex WCB claim is defined as one where post-injury recovery does not progress by the expected time course, barriers and problems reduce treatment benefits, or complicate plans for return to work. Complexity also relates to the fragmentation of information, decision-making and communication dysfunction that arises across multiple actors in the process.

The injured worker with complex MSI claim encounters various problems at different stages.

With injury

- More than half of the injured work clients are in their 40s to 60s. Older injured workers do not heal from strains and falls as quickly as younger patients, and persistent pain, stiffness and dysfunction is more common.
  Many older workers have prior work injuries or concurrent health issues, musculoskeletal and otherwise. This creates a 'mixed picture': the work injury is the primary source and lead cause of their condition in most cases, but adjudication may disallow the claim or accepts it for a conditional limited period, allowing for initial physiotherapy only.

- For many workers a work injury causing disability threatens family income and future employment prospects can precipitate significant stress leading to catastrophic consequences, particularly for those who lack family and social networks and self-care resources. These secondary problems are often handled ineffectively by the WCB adjudicator case manager, family doc, physiotherapist, a counselling psychologist may assess and support for a brief time.

With medical documentation

- Many injured workers are without a reliable primary care doctors and rely on walk-in clinics. Many turn away patients with work injuries and WCB form completion. This also occurs with surgeons, sport medicine docs and other specialists who decline accepting patients involved with WCB claims. In many cases inadequate medical reporting is the weak link in claim acceptance; many workers recount considerable difficulty getting prompt medical attention and documentation required for initial adjudicators; consequently their claims are thrown out, these are seldom reinstated on appeal
- For many claimants, the initial medical reports provide little or no detail and about the injury event, weakens the claim's viability for acceptance when scrutinized by adjudication.

With work and return to work RTW from MSI injury

- Routine musculoskeletal pain and soreness from demanding work tasks are not allowed as 'injury' by WCB; such work discomfort is very prevalent e.g. in food processing sector and among construction workers with multiple or recurrent injuries. In many cases a flare up from overuse or strain performing routine duties may cause temporary disablement and require treatment, but the injured worker's injury report claim is disallowed because it does not meet the definition of injury event.
- In most MSI work injury cases, the injured worker may be provided a few days' time off, while physiotherapy treatment are arranged, and plans for RTW to modified duties arranged. However, in the narrative of many complex MSI cases, the prompt RTW interfered with the worker's ability to rest and recover, and the degree of pain increases with the premature RTW with function declines, not improves. With optimal timing and the intention of best prospects this should not occur.
- In the case of workers struggling with MSI recovery, RTW simultaneous with their treatment sessions can be at cross-purposes to treatment efforts and goals, particularly in earlier stages, frequently RTW interferes with optimal treatment response because of inadequate attention to rest and recovery.
- Narratives may reveal tensions and workplace dynamics preceding an injury incident with employer or co-workers that impact what is reported and how matters are handled in the workplace. In almost all cases where an employer

disagrees with the claim reported, the claim fails to proceed, and is disallowed or denied on appeal.

With treatment

- Poor quality treatment providers- huge variation – PT little manual attention,
- When active treatment is premature and too active physiotherapy exercising increases pain and symptoms.
- If pain impairments and physical difficulties persist after the initial physiotherapy series, an extension may be allowed. Beyond that, the case manager frequently opts for a work hardening program[2]. Among the OHC clients, most (80%) report significant pain flare up and worsening of symptoms associated with the aggressive demands, which often results in a setback lasting servel weeks or months. Complaining and not participating is taken as non-compliance. On completion, the WCB deems in almost all cases that the worker has recovered and can return to pre-injury duties with no further treatment allowed; appeal is the only recourse.

With WCB

- For many, navigating a WCB claim has been psychologically injurious, over and above dealing with the physical injury. This adds considerable stress and adverse effects to the ordeal. It is important to recognize this as an iatrogenic source of disability, i.e., caused by the claims system when it does not support the person affected, and becomes part of the problem, not the solution .
- Many complex MSI claimants describe unpleasant interactions with the case manager when their injury and pain persist and complicate smooth progression of the RTW plan or winding up treatment. In general there is a wide range of competency and etiquette shown by the pool of case managers. Complaints to Fair Practice Office may lead to assigning a new case manager; some have been though more than half a dozen CMs. In other cases, a more aggressive CM is assigned to bring the claim to conclusion.
- Betrayal and distrust are commonly voiced by workers when the message of the WCB case manager changes from supportive encouragement to pressure to accelerate progress with physiotherapy and work return to work even in the face of increased pain complaints.
- There have been a few dozen cases where multiple insurers are involved in the claim- e.g. the recovery from a work injury on WCB claim is complicated by a motor vehicle accident and an MPI claim. In all such cases attending OHC, the litigation between insurers has stalled coverage for treatments and the worker's plight is doomed to lengthy appeal without resolution. Medical documentation

[2] There are 150-250 billings for Work Hardening each year, 80% of which are run by five provider businesses [[redacted] WCB, personal communication]

that chronicles the function and symptoms before and after the injury events to determine 'predominate cause' are tedious and are seldom successful.

Worthy of highlight is the recent Qualitative Research by Dr [redacted] and team at the Institute for Work and Health (IWH, Toronto) titled *"The role of health-care providers in the workers' compensation system and return-to-work process: Final Report"* (December 2016)[3] WCB Manitoba is to be commended for supporting such important research. The qualitative study used ground theory methods to understand health-care providers' (HCP) experience with workers' compensation boards in four Canadian provinces (B.C., Manitoba, Ontario and Newfoundland / Labrador) with interview 131. HCP interviews were conducted with 59 GPs, 19 allied health-care providers and 19 specialists; 20 of the 97 interviews were in Manitoba. In addition 34 case managers were interviewed about their interactions with HCPs in the Return to Work RTW process, WCB Manitoba was well represented. The study found that, *while most health-care providers did not encounter significant problems with WCB and the RTW process when patients had visible, acute physical injuries supported by clear "objective" evidence,*

> *"health-care providers faced challenges when they encountered patients with multiple injuries, gradual-onset or complex illnesses, chronic pain and mental health conditions. In these circumstances, many HCPs experienced the workers' compensation system as opaque and confusing, with little clarity about their role in it. When health-care practitioners dealt with injuries that were complex, the views of case managers and health-care providers were sometimes misaligned with respect to the timing and appropriateness of RTW. Forms and recovery guidelines were viewed as ill-suited to these conditions, and communication difficulties between case managers and health-care providers made it difficult to convey important information needed for decision-making and effective RTW planning. In the absence of regular and effective communication, internal medical consultants were used to help case managers with medical decision-making. For treating health-care providers, however, this practice contributes to their further alienation from the workers' compensation system. Administrative hurdles, disagreements about medical decisions and lack of role clarity impeded the meaningful engagement of health-care providers in RTW. In turn, this resulted in challenges for injured workers, as well as inefficiencies in the workers' compensation system.* [Kosny et al, 2016]

Work injuries in Manitoba and WCB Claims management: what does WCB claims data show?[4]

From WCB's most recent administrative claims data (2010-2016) musculoskeletal Injuries (MSI) is the largest class of injury type[5] and comprises 62% of all time loss

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[3] http://www.ciwa.ca/wp-content/uploads/2016/12/Final-report-HCP-study-Kosny-et-al-Dec-14-2016.pdf

[4] Sincere thanks for assistance and analysis by [redacted]

injuries[6], an average of 9,200 per year. When those MSI claims are open longer than 8 weeks, WCB re-assigns these injured workers to a case manager; this occurs for 37% or 2712 per year, 226 per month (100 in Winnipeg) [7]. By one year post-injury, approximagte 1200 per year remain open (13%), that is 100 each month (40 in Winnipeg). The longer the claim is active, the higher the costs.

The WCB claim cost category of greatest magnitude is wage compensation, $27 million a year (60% of overall WCB MSI claims costs, an average of $46 million dollars annually, based on 2010-2016 data), for 8800 MSI claims a year, an average of $3,116 per claimant. The Return To Work RTW imperative is the principal way an employer can reduce compensation costs. MSI injuries contribute disproportionately to longer more costly claims.

Treatment costs[8] of $15 million a year are 32% of claim costs, an average of $1619 per MSI claim ($9341 per year), Physiotherapy alone is $4,728,571 for 99,142 visits each year; 182 work-hardening billings per year.

By way of contrast, the WCB expenses for MSI claims related to permanent disability or injury assessment are substantially smaller. Vocational rehabilitation costsw are about $2.8 million a year (6% of overall claim costs), paid to an average of 65 claimants per year ($43,250 per case).

Permanent partial impairment PPI awards paid total around $600,000 per year (1.2% total costs), paid out to an average of 141 claimants each year (around $4,000 per case). In many cases PPI awards are halved by blaming / attributing partial causation of the worker's impairment to a pre-existing condition. In many cases the pre-existing diagnosis is extracted from a radiographic report without clinical correlation; there are frequent cases when there is no evidence that the putative pre-existing condition was symptomatic before the workplace accident. *This is a significant departure from the founding principles of worker's compensation, the so-called thin-skull principle, which says workers cannot be discriminated against because of a pre-existing condition that had no physical impact on them before an accident.*

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[5] Musculoskeletal injuries, or MSIs, are injuries to or disorders of the muscles, tendons, ligaments, joints, nerves, blood vessels or related soft tissue including sprains, strains and inflammation. as classified by the diagnoses recorded on the WCB injury report M total of 9,274 MSIs time loss injuries in 2015, 61.9% of all time loss injuries. Reference: 2006-2015 Manitoba Workplace Injury Statistics Report p2

[6] Manitoba Workplace Injury Statistics Report 2006-2015, in 2015

[7] Data provided January 2017 to MFLOHC by [redacted] [Appendix 1]

[8] physician reports, surgery, counselling, physiotherapy, medications, work hardening, etc.

It is important to note that PPI awards are based on algorithms that account for loss of joint movement, or loss of limb only; the PPI system does not allow for consideration of the most frequent long-standing consequences of a MSI: pain, weakness and poor function. Consequently MSI claim expenses from treatment and medication coverage costs are subject to the prerogative of WCB Case Manager and Medical Advisor to re-consider; typically there is significant attenuation after the first year. In the OHC experience it is very rare indeed that a WCB claimant has indefinite coverage, such as approval for 'maintenance' treatments. In most cases, the reality of disabling pain from a work injury is not factored into WCB's costing of future impairments.

WCB's approach to complex MSI claims management and treatment

Re. WCB case management and the role of WCB Medical Advisor

The WCB Medical Advisor can expedite a radiographic procedure or surgical referral as they so choose, or if requested. WCB maintains that the position that its role is not to direct care or provide treatments to injured workers with claims; this is left to the treating physician to direct and supervise. However WCB case managers determine what treatments are covered and when claims get wrapped up in close consultation with WCB Medical Advisors. There is close interplay between the case manager and the Medical Advisor team. Based on 2010-2016 claims data, an yearly average of 27,229 Medical Advisor opinions were sought by case managers, consulting a pool of 61 different medical advisors[9].

The costs of the WCB compensation system are contained by prioritizing return to work to limit wage loss compensation costs, and by limiting treatment coverage when the injury claim does not resolve within expected time frames for reasonable recovery.

Re. Presumptive recovery from work injury ends WCB responsibility; ongoing problems are shifted to a putative 'pre-existing condition'

Eventually a WCB claim usually ends up with no more time loss or treatments costs by its case manager requesting a Medical Advisor's opinion, *in most cases without direct contact with the injured worker or physical examination*. It is the Medical Advisor's consultation that determines the rationale and language used to justify disallowing treatments or closing the file. Typical wording is that "ongoing complaints are no longer associated with the incident injury, from which you have recovered" Oftentimes, the persistence of pain may be attributed to a "pre-existing condition" or diagnosis unrelated to the work injury. This is declared presumptively, whether is some truth to this or not; it is deemed and doesn't have to be proven. Frequently the position is reversal of WCB's responsibility to cover treatments, etc. The claimant's sole recourse to object requires formal appeal.

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[9] [redacted], January 2017 personal communication

This practice is perverse to the Meredith principle of 'no fault' compensation: the injury consequences (pain symptoms, and functional impairments) that were formerly acceptable and now with a sleight of hand deemed to be outside WCB responsibility. This is done routinely, often around the one year anniversary of a claim for those complex MSI claims that do not already resolve on their own.

Prior injuries , involving the same anatomic region, are raised as confounders by adjudication. This occurs even when such 'pre-existing' condition is clearly work-related, e.g. a prior work injuries recognized by WCB: a prior work injury is, not uncommonly, the reason for not allowing the claim; this requires formal appeal to argue against the WCB position. Or the injured worker must re-submit for a recurrence of the prior injury which, after weeks of delay, is seldom allowed. The legalistic hair-splitting is frustrating for both work and their treating physician

Re. ideological opposition to myofascial pain disorder

Repeatedly the Medical Adviser's opinion is prejudicial to diagnostic, evaluation and treatment approaches that are based on **considerable clinical** evidence and scientific basis for pain and dysfunction of myofascial origin- i.e., from muscles and their related fibro-connective tissues of tendons and fascia. It is very common that e.g. a wrist injury may lead to shoulder muscle strain, or walking on a painful foot can lead to back and hip girdle muscle pain-- from muscle substitution patterns compensating for injury related weakness, or with chronic patterns of guarding that develop when repetitive work tasks aggravate injury-related musculoskeletal pain and endurance intolerance. When this common syndrome or pattern is documented and explained, the MA opinion refutes it by stating that pain is subjective and there is no pathoanatomical entity, relying on classical orthopaedic terminology that pre-dates a large body of manual therapeutics and growing neuromuscular evidence on the physiology of pain. In keeping with this conservative position, it is standard WCB practice that remedial massage therapy is seldom authorized, and that physiotherapy treatment outside the localized injured area (not above the elbow for a hand injury) is routinely discouraged by WCB. This limitations run counter to evidence-based guidelines for judicious and appropriate treatment in many cases.

Re. Appeal system has perverse effects

The only recourse for many workers with complex MSI is to appeal denied claims, for which the process is onerous, adversarial and leads to further delays. This frequently adds insult to injury, when the language used to close the claim or deny coverage is

From a medical perspective there may be merit to their patient's plight, but the MD is sceptical that their input and advocacy will lead to successful outcome. **M**any claimants find doctors unwilling to devote the time and effort to document their patient's to the degree necessary for a reasonable appeal hearing.

What is the data on WCB disability and recovery outcomes?

Several years ago WCB sent out follow up surveys to claimants- to enquire at 6 months and 1 years post claim- whether they are working or seeking health care for the work injury. This practice has been discontinued with no reporting of lessons learned[10]. Beyond the administrative claims data of an active claim file, WCB does not know, nor does it attempt to find out, what are the medium and long term consequences of a work injury- if the injured worker continues sustain employment. Or, when there is post-injury unemployment , what is the frequency and cost burden of reliance on social assistance, disability pension, and government services in health care, including pharmaceutical use, and social services.

Moving toward Solutions: **It's time to measure outcomes of WCB**

While direct costs of WCB are well-known, the indirect costs associated with WCB case management are poorly understood and a matter of much conjecture. There are of course costs are borne by the injured worker and their family. But, importantly for this Review of WCB, WCB disallows a claim for legitimate work injuries[11], or deems a claimant recovered when he remains disabled and in need of health care it falls to the province's 'safety net' of health care system, income assistance programs, and social services, to cover WCB's shortcomings. *It is the responsibility of good government to develop data collection systems and analysis to guide planning health care, social services, income support programs.*

Recommendation #1: Link WCB claims administrative data with the Manitoba Population Research Data Repository to measure and track outcomes of Work injuries and the WCB claim experience

One strong recommendation to the WCA Legislative Review Committee is to advance WCB's limited ability to analyse outcomes of work injury and case management by linking WCB claims data with provincial data repository maintained by the Manitoba Centre for Health Policy MCHP at the University of Manitoba[12]. MCHP acts as a steward of the information in the Repository for a wide variety of research and policy purposes. For WCB outcomes, it can track downstream employment, social assistance, health care utilization, and medication use in WCB claimants with sub-analysis of different claimant types and stages.

What is the employment status change within one year, 3 years after a WCB injury claim? With this powerful resource unique to Manitoba, the Repository can provide valuable insights and answers, such as determining the population attributable

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[10] personal communication [redacted]

[11] In 2010-2016 period, WCB disallowed 49,967 claims: common reasons entered include: failure / delay in reporting (7,210), insufficent information (26,823), not in course of employment (2,946)

[12] http://www.umanitoba.ca/faculties/health_sciences/medicine/units/chs/departmental_units/mchp/resources/repository/index.html

risk of employment change, disability, pain medication use, health care utilization from work injuries and the (in)effectiveness of WCB case management and treatment model.

Recommendation #2 Treatment of complex MSIs: time for a new approach?

WCB leaves the selection of therapy provider to the treating physician, who in many cases has little / no experience to guide the injured worker to the better therapist. There is wide variability in quality and skill level among physiotherapists and other allied health professionals, particularly when serving complex MSI patients with multiple challenges. This contributes to significant treatment ineffectiveness throughout the WCB system. It is of high concern that more than 55,000 physiotherapy billings are processed annually, worth $5 million, without quality control and incentives for superior treatment outcomes. WCB does not track provide incentives for higher quality care and performance of physiotherapist and treatment providers. Consequently there is a significant and valid criticism among skilled practitioners.

Complex WCB claims management- is there a better way?

Under the present WCB treatment model of MSI claim longer than 8 weeks; treatment recommended by the GP, is allowed or not by the case manager's in consultation with the Medical Advisor; early return to work RTW is a priority.

When, however, a worker's recovery from injury does not progress well by 8 or 10 weeks post-injury it is important to assess complexity, to identify and address factors limiting progress. At this stage, the main effort should be improving the best prospects of recovery, irrespective of mixed picture (work injury, versus pre-existing condition). For many workers the work injury can be catastrophic mentally or physically, at home or at work, and sequelae.

A more holistic, integrated, myofascially-informed, multi-disciplinary treatment model would be preferable and more responsive. A team model would allow for judicious input of various skills sets, for example: social work, non-pharmacologic pain management approaches, self-care skills e.g restorative yoga, mindfulness stress reduction.

The above treatment model could be trialed with WCB claimants at this stage who are screened for complexity issues that could be addressed by the team approach (e.g. poor social or psychological coping; MSK pain worsens with physiotherapy treatment or RTW; poor pain control and/or pain management skills).

Each month in Winnipeg there are more than 100 new injured workers on WCB whose MSI claims are at 8 weeks post-injury. These numbers are large enough to undertake a randomized control trial (RCT) of the integrated treatment approach versus standard WCB approach to treatment. The sample size for the RCT should be powerful enough to detect e.g. a 20% difference in treatment outcomes. The study arm would

supervised by the team coordinator rather than the WCB case manager for a period of e.g. 6-8 weeks. During this time, RTW may be paused to optimize treatment effectiveness. The treatment and controls arms of the RCT would have follow up outcome evaluation for comparison. If the RCT finds significantly improved treatment effectiveness, this would have many diverse, positive benefits for many parties interconnected by WCB: the injured worker and family, employers, the medical providers, WCB staff, etc.

WCB's RWIP program may be an appropriate funder to undertake the study. This recommendation is consistent with mandate of the WCA Review Committee to to ensure that the Workers Compensation Board of Manitoba (WCB) is current with emerging trends in injury and illness, the most up-to-date health and safety knowledge, and medical practices.

Recommendation #3: Manitoba medical community needs a voice in realigning WCB claim practices

Apart from submitting reports and some input on a case-by-case basis in their patient's WCB claims, the physician community is out of the loop and with no communication channel to present concerns with the WCB. There is considerable dissatisfaction among treating doctor that their opinion and recommendations are secondary to, and often overruled by, the opinion of the WCB Medical Advisor. The medical community's association Doctors Manitoba do not have standing committees to hear concerns and represent the voice of physicians , primary care and specialist, with WCB: this should be corrected.

The same concern is frequently voiced by OHC patients who recount their GP's frustration about not being consulted and their opinion discounted in important decisions. Of particular concern is that WCB Medical Advisors are indemnified by by physicians' provincial licensing body, the College of Physicians and Surgeons of Manitoba (CPSM) against formal complaints by WCB claimants who strongly object to their authority to decide upon their claim status without any doctor-patient encounter. This runs counter ethical principles that are fundamental to medical practice and is a further cause for alienation of the medical community from WCB.

References

1. Agnieszka Kosny, Marni Lifshen, Sabrina Tonima, Basak Yanar, Elizabeth Russell, Ellen MacEachen, Barb Neis, Mieke Koehoorn, Dorcas Beaton, Andrea Furlan, and Juliette Cooper, *"The role of health-care providers in the workers' compensation system and return-to-work process: Final Report"* (December 2016) Institute for Work and Health (IWH, Toronto)