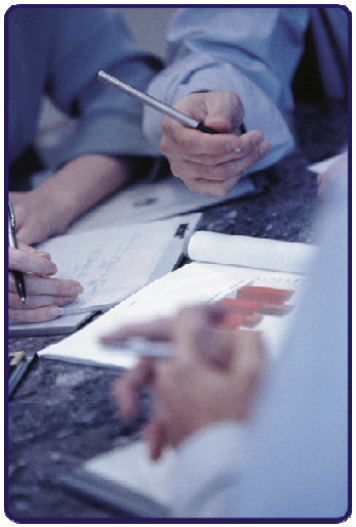
Industrial Mediation
Professional Corporation

Industrial Mediation Professional Corporation
Workplace Safety and Insurance Law for Employers

How to Challenge Questionable WSIB / WCB Claims



No-fault collective liability s.26

- Workers give up the right to sue for their work-related injuries, irrespective of fault, in return for guaranteed compensation for accepted claims.
- Employers, for their part, receive protection from lawsuits in exchange for financing the program through premiums.

Failure to Comply S. 21

Never file a Form 7 as NLT if the worker is not working.

The penalties for an offence under the Act are;

- For individuals, a fine of up to $25,000, or imprisonment for up to 6 months, or both

- For corporations, a fine of up to $100,000.

Case Study-Claims Management

- Facts:
  - 30 year old
  - Hired May 1, 2012-labour
  - Gross $30,000 / yr (with OT) $650/week
  - It was know that worker races motocross on weekends and is sore
  - **May 17, 2015 – mentions to employer that his back is sore – no accident history provided**
    - **“just got worse over the past week”**
  - Seeks medical attention May 27th working dx - low back strain provided history of moving heavy sofa the week before
    - Medically authorized “off work 2 weeks to be re-assessed”
  - What do you do?

Case Study-Claims Management

- 1 week after the employer is notified by WSIB that worker is claiming benefits
  - Requesting that you complete a WSIB Form 7

Three primary questions:

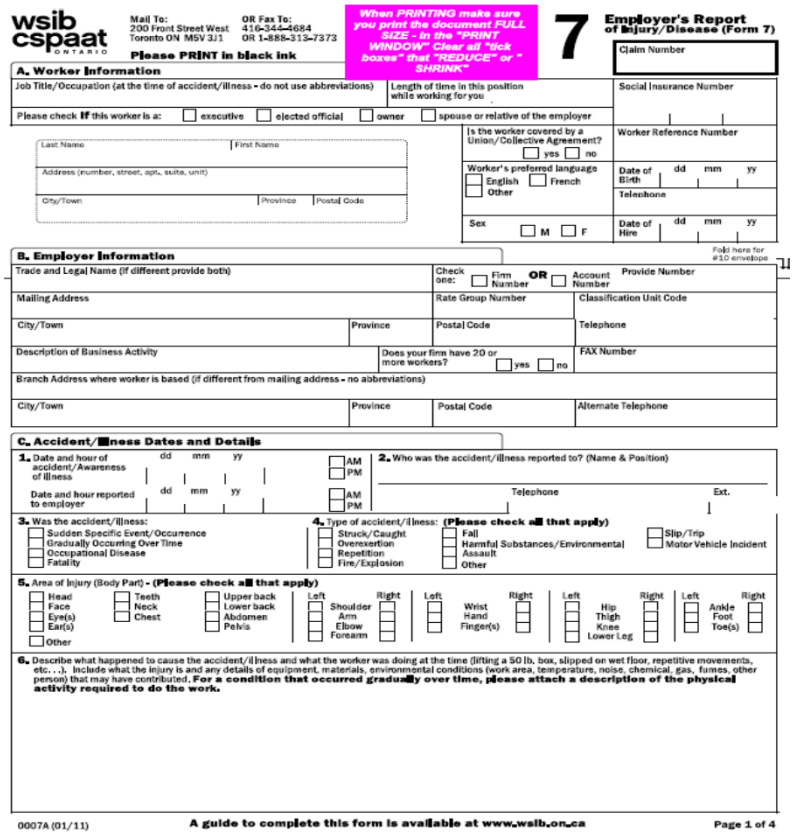
- 1. What are the legal requirements to complete a WSIB Form 7?
- **2. How do I contest it?**
- Can you offer modified work noting the worker was medically authorized off totally?

1. Requirements to Complete

Notice by Employer s. 21

- Seeks medical attention
- Is absent from work
- Requires m/d at less than regular pay
- Requires m/d more than seven calendar days

Obligation to file within 3 days of reporting



wsib cspaat ONTARIO

Mail To: 200 Front Street West Toronto ON M5V 3J1
OR Fax To: 416-344-4684 OR 1-888-313-7373

Please PRINT in black ink

When PRINTING make sure you print the document FULL SIZE - in the "PRINT WINDOW" Clear all "tick boxes" that "REDUCE" or "SHRINK"

7 Employer's Report of Injury/Disease (Form 7)

Claim Number

A. Worker Information

Job Title/Occupation (at the time of accident/illness - do not use abbreviations) | Length of time in this position while working for you | Social Insurance Number

Please check if this worker is a: ☐ executive ☐ elected official ☐ owner ☐ spouse or relative of the employer

Last Name | First Name

Address (number, street, apt., suite, unit)

City/Town | Province | Postal Code

Is the worker covered by a Union/Collective Agreement? ☐ yes ☐ no

Worker's preferred language ☐ English ☐ French ☐ Other

Sex ☐ M ☐ F

Worker Reference Number

Date of Birth dd mm yy

Telephone

Date of Hire dd mm yy

Fold here for #10 envelope

B. Employer Information

Trade and Legal Name (if different provide both)

Check one: ☐ Firm Number OR ☐ Account Number | Provide Number

Mailing Address | Rate Group Number | Classification Unit Code

City/Town | Province | Postal Code | Telephone

Description of Business Activity | Does your firm have 20 or more workers? ☐ yes ☐ no | FAX Number

Branch Address where worker is based (if different from mailing address - no abbreviations)

City/Town | Province | Postal Code | Alternate Telephone

C. Accident/Illness Dates and Details

1. Date and hour of accident/Awareness of illness dd mm yy ☐ AM ☐ PM

Date and hour reported to employer dd mm yy ☐ AM ☐ PM

2. Who was the accident/illness reported to? (Name & Position)

Telephone | Ext.

3. Was the accident/illness: ☐ Sudden Specific Event/Occurrence ☐ Gradually Occurring Over Time ☐ Occupational Disease ☐ Fatality

4. Type of accident/illness: (Please check all that apply) ☐ Struck/Caught ☐ Overexertion ☐ Repetition ☐ Fire/Explosion ☐ Fall ☐ Harmful Substances/Environmental ☐ Assault ☐ Other ☐ Slip/Trip Motor Vehicle Incident

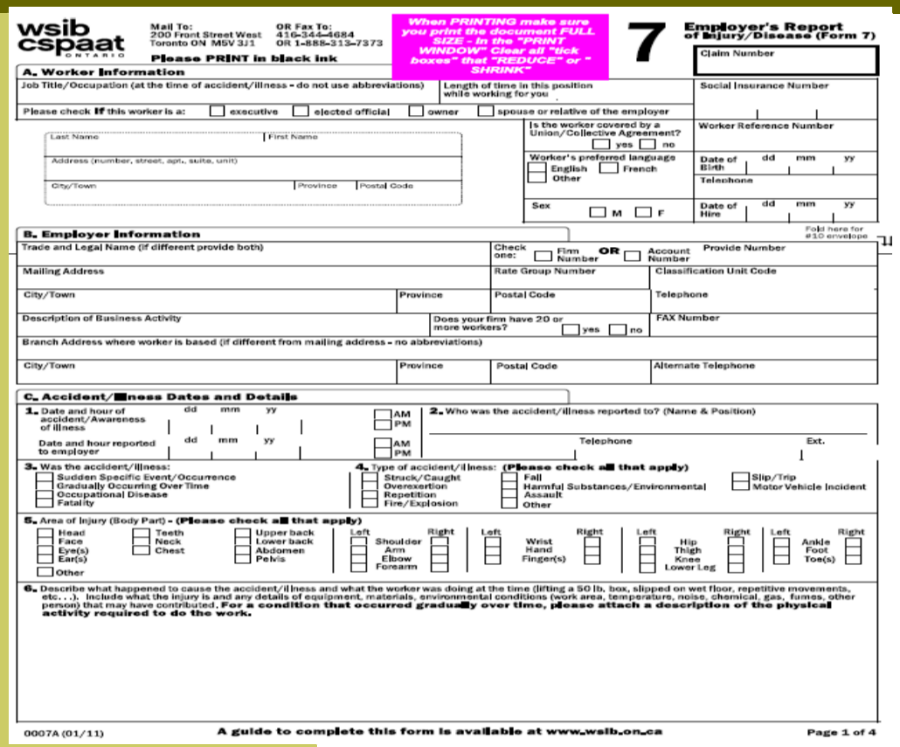
5. Area of Injury (Body Part) - (Please check all that apply)

☐ Head ☐ Face ☐ Eye(s) ☐ Ear(s) ☐ Other ☐ Teeth ☐ Neck ☐ Chest ☐ Upper back ☐ Lower back ☐ Abdomen ☐ Pelvis ☐ Left Shoulder ☐ Arm ☐ Elbow ☐ Forearm ☐ Right ☐ Left ☐ Wrist ☐ Hand ☐ Finger(s) ☐ Right ☐ Left ☐ Hip ☐ Thigh ☐ Knee ☐ Lower Leg ☐ Right ☐ Left ☐ Ankle ☐ Foot ☐ Toe(s) ☐ Right

6. Describe what happened to cause the accident/illness and what the worker was doing at the time (lifting a 50 lb. box, slipped on wet floor, repetitive movements, etc...). Include what the injury is and any details of equipment, materials, environmental conditions (work area, temperature, noise, chemical, gas, fumes, other person) that may have contributed. **For a condition that occurred gradually over time, please attach a description of the physical activity required to do the work.**

0007A (01/11) A guide to complete this form is available at www.wsib.on.ca Page 1 of 4

Requirements to Provide



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7 Employer's Report of Injury/Disease (Form 7)

Please PRINT in black ink

Claim Number

A. Worker Information

Job Title/Occupation (at the time of accident/illness - do not use abbreviations) | Length of time in this position while working for you | Social Insurance Number

Please check If this worker is a: executive elected official owner spouse or relative of the employer

Last Name | First Name | Address (number, street, apt., suite, unit) | City/Town | Province | Postal Code

Is the worker covered by a Union/Collective Agreement? yes no | Worker Reference Number

Worker's preferred language: English French Other | Date of Birth dd mm yy | Telephone

Sex: M F | Date of Hire dd mm yy

B. Employer Information

Trade and Legal Name (if different provide both) | Check one: Firm Number OR Account Number | Provide Number

Mailing Address | Rate Group Number | Classification Unit Code

City/Town | Province | Postal Code | Telephone

Description of Business Activity | Does your firm have 20 or more workers? yes no | FAX Number

Branch Address where worker is based (if different from mailing address - no abbreviations)

City/Town | Province | Postal Code | Alternate Telephone

C. Accident/Illness Dates and Details

1. Date and hour of accident/Awareness of illness dd mm yy AM PM
Date and hour reported to employer dd mm yy AM PM

2. Who was the accident/illness reported to? (Name & Position)
Telephone Ext.

3. Was the accident/illness: Sudden Specific Event/Occurrence; Gradually Occurring Over Time; Occupational Disease; Fatality

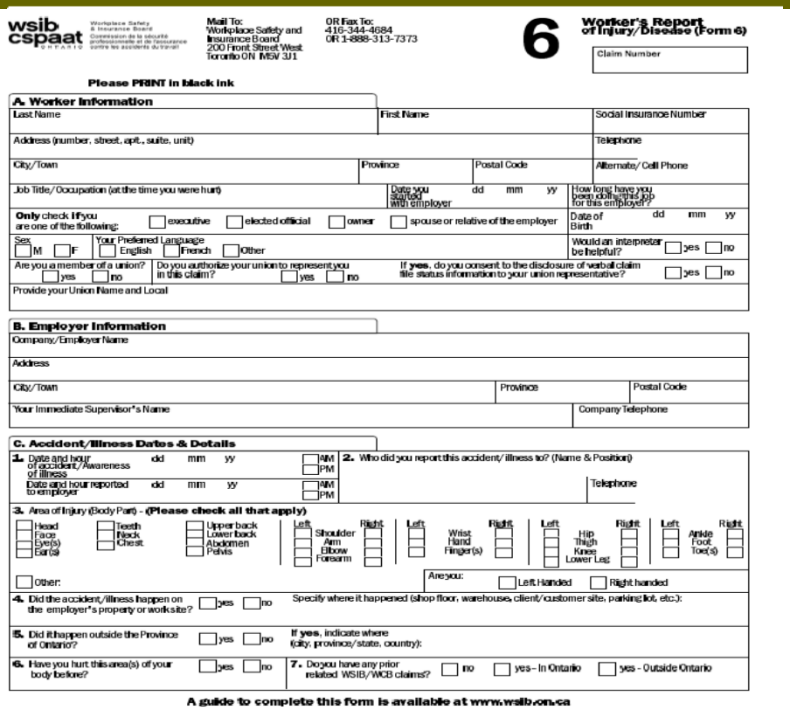
4. Type of accident/illness: (Please check all that apply) Struck/Caught; Overexertion; Repetition; Fire/Explosion; Fall; Harmful Substances/Environmental; Assault; Other; Slip/Trip; Motor Vehicle Incident

5. Area of Injury (Body Part) - (Please check all that apply)
Head, Face, Eye(s), Ear(s), Other; Teeth, Neck, Chest; Upper back, Lower back, Abdomen, Pelvis; Left/Right Shoulder, Arm, Elbow, Forearm; Left/Right Wrist, Hand, Finger(s); Left/Right Hip, Thigh, Knee, Lower Leg; Left/Right Ankle, Foot, Toe(s)

6. Describe what happened to cause the accident/illness and what the worker was doing at the time (lifting a 50 lb. box, slipped on wet floor, repetitive movements, etc. . .). Include what the injury is and any details of equipment, materials, environmental conditions (work area, temperature, noise, chemical, gas, fumes, other person) that may have contributed. **For a condition that occurred gradually over time, please attach a description of the physical activity required to do the work.**

0007A (01/11) A guide to complete this form is available at www.wsib.on.ca Page 1 of 4

The employer shall give a copy of the notice to the worker at the time the notice is given to the Board. S.21 (4)



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Mail To: Workplace Safety and Insurance Board 200 Front Street West Toronto ON M5V 3J1 OR Fax To: 416-344-4684 OR 1-888-313-7373

6 Worker's Report of Injury/Disease (Form 6)

Claim Number

Please PRINT in Black Ink

A. Worker Information

Last Name | First Name | Social Insurance Number

Address (number, street, apt., suite, unit) | Telephone

City/Town | Province | Postal Code | Alternate/Cell Phone

Job Title/Occupation (at the time you were hurt) | Date you started with employer dd mm yy | How long have you been doing this job for this employer?

Only check if you are one of the following: executive elected official owner spouse or relative of the employer | Date of Birth dd mm yy

Sex: M F | Your Preferred Language: English French Other | Would an interpreter be helpful? yes no

Are you a member of a union? yes no | Do you authorize your union to represent you in this claim? yes no | If yes, do you consent to the disclosure of verbal claim file status information to your union representative? yes no

Provide your Union Name and Local

B. Employer Information

Company/Employer Name

Address

City/Town | Province | Postal Code

Your Immediate Supervisor's Name | Company Telephone

C. Accident/Illness Dates & Details

1. Date and hour of accident/Awareness of illness dd mm yy AM PM
Date and hour reported to employer dd mm yy AM PM

2. Who did you report this accident/illness to? (Name & Position) | Telephone

3. Area of Injury (Body Part) - (Please check all that apply)
Head, Face, Eye(s), Ear(s); Teeth, Neck, Chest; Upper back, Lower back, Abdomen, Pelvis; Left/Right Shoulder, Arm, Elbow, Forearm; Left/Right Wrist, Hand, Finger(s); Left/Right Hip, Thigh, Knee, Lower Leg; Left/Right Ankle, Foot, Toe(s); Other:

Are you: Left Handed Right handed

4. Did the accident/illness happen on the employer's property or worksite? yes no | Specify where it happened (shop floor, warehouse, client/customer site, parking lot, etc.):

5. Did it happen outside the Province of Ontario? yes no | If yes, indicate where (city, province/state, country):

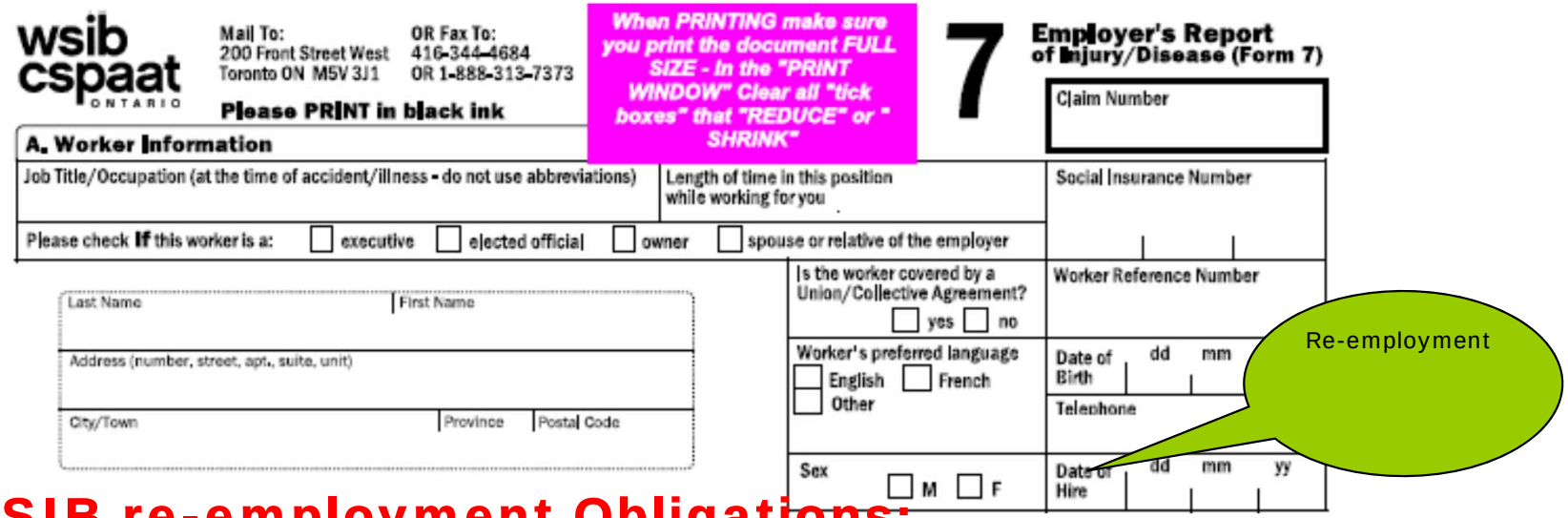
6. Have you hurt this area(s) of your body before? yes no

7. Do you have any prior related WSIB/WCB claims? no yes - In Ontario yes - Outside Ontario

A guide to complete this form is available at www.wsib.on.ca

The claimant shall give a copy of his or her claim to the worker's employer at the time the claim is given to the Board. S.22 (7)

2. Contesting Claim
Key Consideration: Date of Hire



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7 Employer's Report of Injury/Disease (Form 7)

Claim Number

A. Worker Information

Job Title/Occupation (at the time of accident/illness - do not use abbreviations)

Length of time in this position while working for you

Social Insurance Number

Please check If this worker is a: ☐ executive ☐ elected official ☐ owner ☐ spouse or relative of the employer

Last Name | First Name

Address (number, street, apt., suite, unit)

City/Town | Province | Postal Code

Is the worker covered by a Union/Collective Agreement? ☐ yes ☐ no

Worker Reference Number

Worker's preferred language ☐ English ☐ French ☐ Other

Date of Birth dd mm

Telephone

Sex ☐ M ☐ F

Date of Hire dd mm yy

Re-employment

WSIB re-employment Obligations:

1. Employed for at least one year before the date of injury, and
2. The employer regularly employs 20 or more workers

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Re-employment Penalty s. 41 (13)

Failure to comply:

(a) **levy a penalty on the employer not exceeding the amount of the worker's net average earnings for the year preceding the injury; and**

(b) make payments to the worker.

Educate frontline staff is key.

Duration of Requirements

- Obligation to re-employ continues until the earliest of;
  1. Two years from the date of injury.
  2. One year after the worker is fit for essential duties (pre-injury).
  3. The date the worker reaches age 65.

Re-employment – Presumption (6 months)

- When a worker is terminated WSIB presumes that the employer has not fulfilled the re-employment obligation

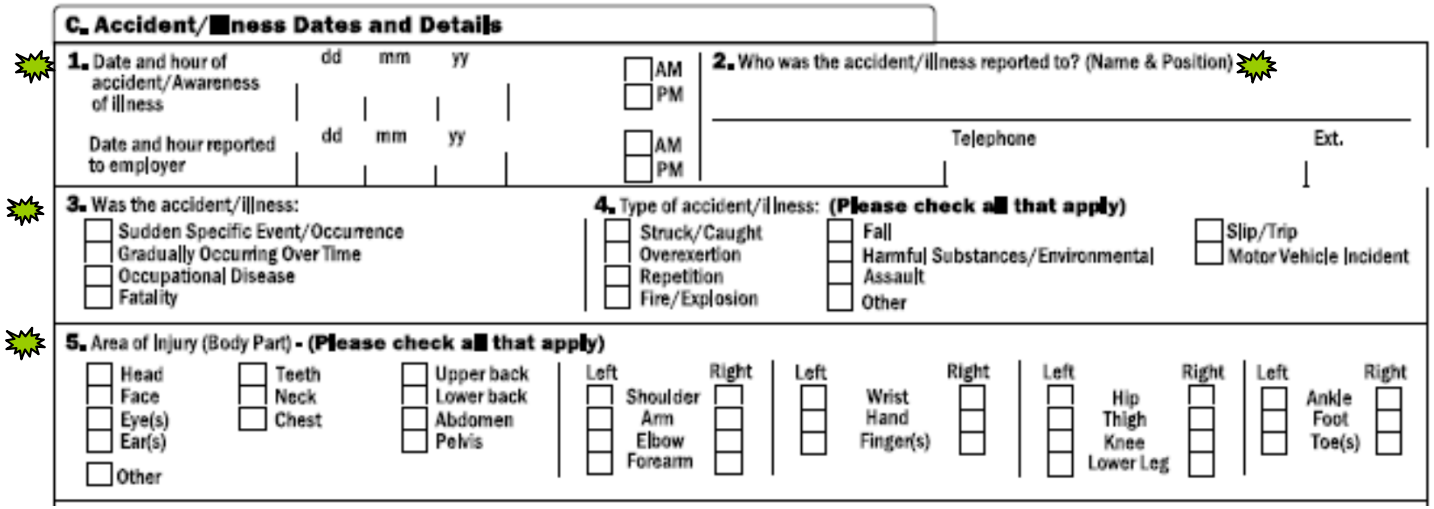
- Employers can rebut the presumption by showing that the termination was not caused in any part by the work-related injury or disease (and related absences from work), treatment for the work-related injury or disease, or the claim for benefits

Documentation is key

Key Consideration: Accident date

Sudden Specific vs.

Gradually disablement



C. Accident/Illness Dates and Details

1. Date and hour of accident/Awareness of illness — dd mm yy — ☐ AM ☐ PM

Date and hour reported to employer — dd mm yy — ☐ AM ☐ PM

2. Who was the accident/illness reported to? (Name & Position)

Telephone Ext.

3. Was the accident/illness:
- ☐ Sudden Specific Event/Occurrence
- ☐ Gradually Occurring Over Time
- ☐ Occupational Disease
- ☐ Fatality

4. Type of accident/illness: **(Please check all that apply)**
- ☐ Struck/Caught
- ☐ Overexertion
- ☐ Repetition
- ☐ Fire/Explosion
- ☐ Fall
- ☐ Harmful Substances/Environmental
- ☐ Assault
- ☐ Other
- ☐ Slip/Trip
- ☐ Motor Vehicle Incident

5. Area of Injury (Body Part) - **(Please check all that apply)**
- ☐ Head
- ☐ Face
- ☐ Eye(s)
- ☐ Ear(s)
- ☐ Other
- ☐ Teeth
- ☐ Neck
- ☐ Chest
- ☐ Upper back
- ☐ Lower back
- ☐ Abdomen
- ☐ Pelvis
- Left ☐ Shoulder ☐ Arm ☐ Elbow ☐ Forearm — Right ☐
- Left ☐ Wrist ☐ Hand ☐ Finger(s) — Right ☐
- Left ☐ Hip ☐ Thigh ☐ Knee ☐ Lower Leg — Right ☐
- Left ☐ Ankle ☐ Foot ☐ Toe(s) — Right ☐

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Key Consideration: Be specific

6. Describe what happened to cause the accident/illness and what the worker was doing at the time (lifting a 50 lb. box, slipped on wet floor, repetitive movements, etc...). Include what the injury is and any details of equipment, materials, environmental conditions (work area, temperature, noise, chemical, gas, fumes, other person) that may have contributed. **For a condition that occurred gradually over time, please attach a description of the physical activity required to do the work.**

Use terms like “workers states” that….

Investigate and document. Obtain written statement(s).
-worker
-co worker
-supervisor (driver)

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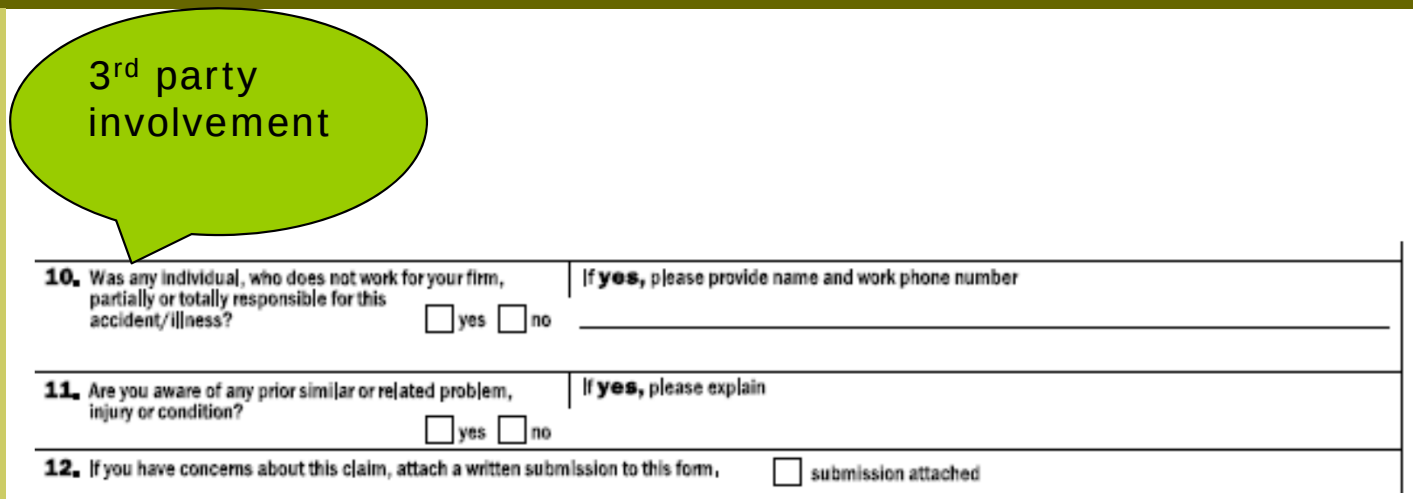
Key Considerations: Accident Details



10. Transfer of cost to another employer – negligence
11. Obtain during your investigation – pre existing (S.I.E.F.)
12. **If no immediates = Challenge the claim**

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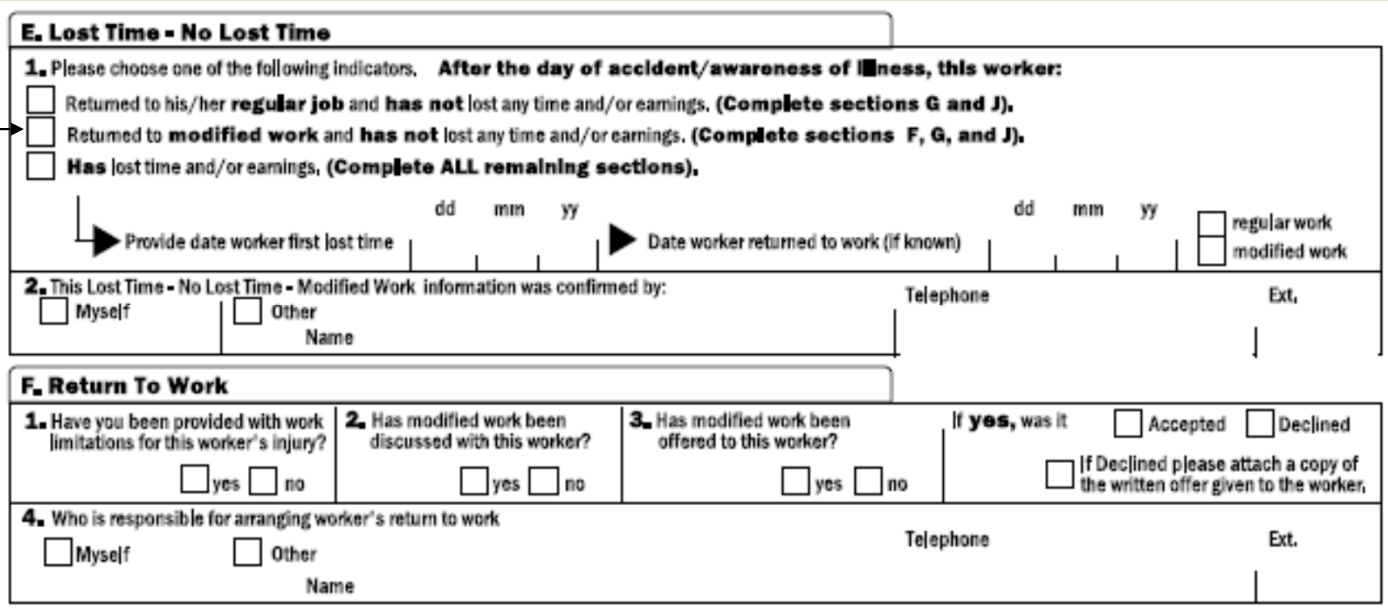
Key Consideration: LTI vs. NLT

If medial is sought then:

1. Offer temporary modified duties (written offer)
2. Provide worker with WSIB Functional Abilities Form (FAF)



E. Lost Time - No Lost Time

1. Please choose one of the following indicators. **After the day of accident/awareness of illness, this worker:**

- ☐ Returned to his/her **regular job** and **has not** lost any time and/or earnings. **(Complete sections G and J).**
- ☐ Returned to **modified work** and **has not** lost any time and/or earnings. **(Complete sections F, G, and J).**
- ☐ **Has** lost time and/or earnings, **(Complete ALL remaining sections).**

Provide date worker first lost time — dd mm yy

Date worker returned to work (if known) — dd mm yy — ☐ regular work ☐ modified work

2. This Lost Time - No Lost Time - Modified Work information was confirmed by:

☐ Myself ☐ Other — Name — Telephone — Ext.

F. Return To Work

1. Have you been provided with work limitations for this worker's injury? ☐ yes ☐ no

2. Has modified work been discussed with this worker? ☐ yes ☐ no

3. Has modified work been offered to this worker? ☐ yes ☐ no

If **yes,** was it ☐ Accepted ☐ Declined

☐ If Declined please attach a copy of the written offer given to the worker.

4. Who is responsible for arranging worker's return to work

☐ Myself ☐ Other — Name — Telephone — Ext.

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Documentation is Critical!!

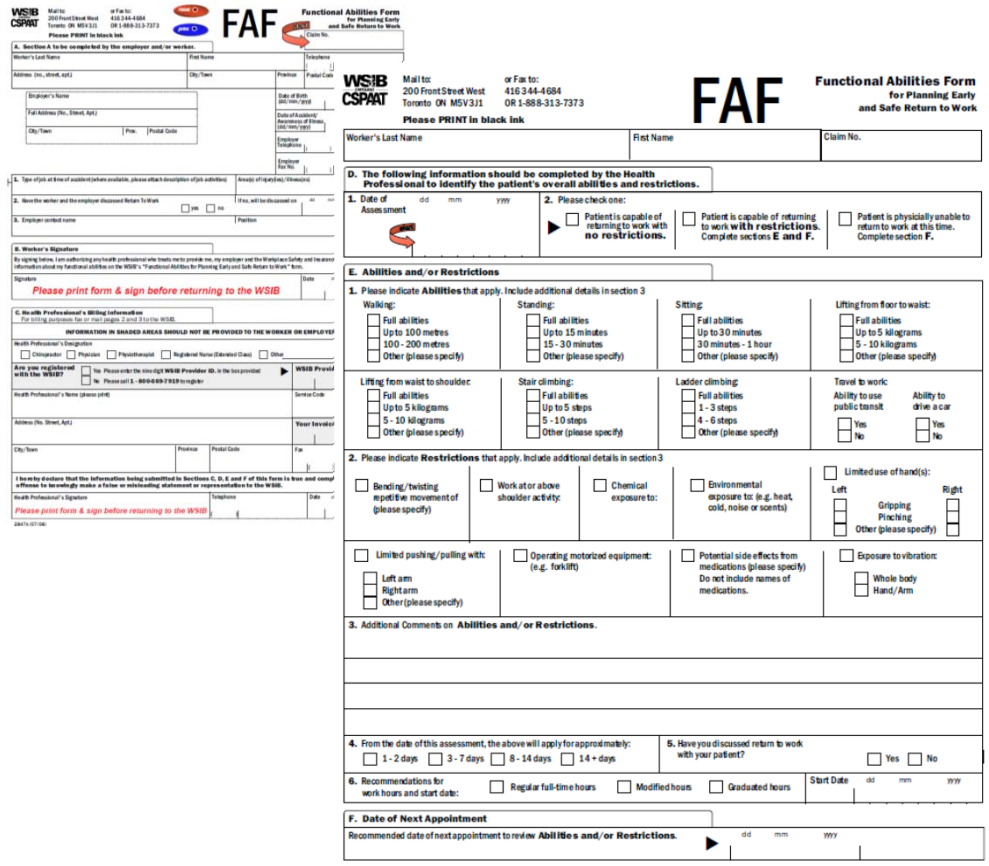
- Form 7 (most important document employer will ever complete!)
  - Worker's Statement of Fact
  - Witness Statement of Fact
  - Write your objection with clear facts
    - Review all the information before submitting
    - Retain confirmation slip
  - Request written decision letter
- Time is critical
  - Have a plan in place (time sensitive)

Objecting to a WSIB Decision

- Section 120 of the *Workplace Safety & Insurance Act* indicates:
  - You have up to 30 days to object to a WSIB decision about
    - Return to Work (RTW) or
    - Work Transition (WT) issues,
    - including re-employment decisions.
  - You have up to 6 months to object to any other WSIB decision

3. Offer of modified Work
WSIB Functional Abilities Form (FAF)

- Will contain
  - Medical/functional restrictions/abilities
  - Indicate regular duties, modified duties, lost time
  - Work schedule, full days, reduced hours etc.
  - How long restrictions in place



WSIB CSPAAT

Mail to: 200 Front Street West Toronto ON M5V 3J1
or Fax to: 416 344-4684 OR 1-888-313-7373

Please PRINT in black ink

FAF Functional Abilities Form for Planning Early and Safe Return to Work

Worker's Last Name | First Name | Claim No.

D. The following information should be completed by the Health Professional to identify the patient's overall abilities and restrictions.

1. Date of Assessment (dd mm yyyy)

2. Please check one:
- ☐ Patient is capable of returning to work with **no restrictions.**
- ☐ Patient is capable of returning to work **with restrictions.** Complete sections **E and F.**
- ☐ Patient is physically unable to return to work at this time. Complete section **F.**

E. Abilities and/or Restrictions

1. Please indicate **Abilities** that apply. Include additional details in section 3

Walking:	Standing:	Sitting:	Lifting from floor to waist:
☐ Full abilities ☐ Up to 100 metres ☐ 100 - 200 metres ☐ Other (please specify)	☐ Full abilities ☐ Up to 15 minutes ☐ 15 - 30 minutes ☐ Other (please specify)	☐ Full abilities ☐ Up to 30 minutes ☐ 30 minutes - 1 hour ☐ Other (please specify)	☐ Full abilities ☐ Up to 5 kilograms ☐ 5 - 10 kilograms ☐ Other (please specify)

Lifting from waist to shoulder:	Stair climbing:	Ladder climbing:	Travel to work:
☐ Full abilities ☐ Up to 5 kilograms ☐ 5 - 10 kilograms ☐ Other (please specify)	☐ Full abilities ☐ Up to 5 steps ☐ 5 - 10 steps ☐ Other (please specify)	☐ Full abilities ☐ 1 - 3 steps ☐ 4 - 6 steps ☐ Other (please specify)	Ability to use public transit: ☐ Yes ☐ No Ability to drive a car: ☐ Yes ☐ No

2. Please indicate **Restrictions** that apply. Include additional details in section 3

☐ Bending/twisting repetitive movement of (please specify)	☐ Work at or above shoulder activity:	☐ Chemical exposure to:	☐ Environmental exposure to: (e.g. heat, cold, noise or scents)	☐ Limited use of hand(s): Left / Right: ☐ Gripping ☐ Pinching ☐ Other (please specify)
☐ Limited pushing/pulling with: ☐ Left arm ☐ Right arm ☐ Other (please specify)	☐ Operating motorized equipment: (e.g. forklift)	☐ Potential side effects from medications (please specify) Do not include names of medications.	☐ Exposure to vibration: ☐ Whole body ☐ Hand/Arm	

3. Additional Comments on **Abilities and/or Restrictions.**

4. From the date of this assessment, the above will apply for approximately: ☐ 1 - 2 days ☐ 3 - 7 days ☐ 8 - 14 days ☐ 14 + days

5. Have you discussed return to work with your patient? ☐ Yes ☐ No

6. Recommendations for work hours and start date: ☐ Regular full-time hours ☐ Modified hours ☐ Graduated hours — Start Date (dd mm yyyy)

F. Date of Next Appointment

Recommended date of next appointment to review **Abilities and/or Restrictions.** (dd mm yyyy)

WSIB –Functional Abilities Form

D. The following information should be completed by the Health Professional to identify the patient's overall abilities and restrictions.

1. Date of Assessment dd mm yyyy

Start >

2. Please check one:

- ☐ Patient is capable of returning to work with **no restrictions.**
- ☐ Patient is capable of returning to work **with restrictions.** Complete sections **E and F.**
- ☐ Patient is physically unable to return to work at this time. Complete section **F.**

E. Abilities and/or Restrictions

1. Please indicate **Abilities** that apply. Include additional details in section 3

Walking:
- ☐ Full abilities
- ☐ Up to 100 metres
- ☐ 100 - 200 metres
- ☐ Other (please specify)

Standing:
- ☐ Full abilities
- ☐ Up to 15 minutes
- ☐ 15 - 30 minutes
- ☐ Other (please specify)

Sitting:
- ☐ Full abilities
- ☐ Up to 30 minutes
- ☐ 30 minutes - 1 hour
- ☐ Other (please specify)

Lifting from floor to waist:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ Other (please specify)

Lifting from waist to shoulder:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ Other (please specify)

Stair climbing:
- ☐ Full abilities
- ☐ Up to 5 steps
- ☐ 5 - 10 steps
- ☐ Other (please specify)

Ladder climbing:
- ☐ Full abilities
- ☐ 1 - 3 steps
- ☐ 4 - 6 steps
- ☐ Other (please specify)

Travel to work:

Ability to use public transit
- ☐ yes
- ☐ no

Ability to drive a car
- ☐ yes
- ☐ no

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Suitable work offer-components

Key concepts

- Clearly state what work is being offered
- The nature of the work (duties tasks)
- Hours of work
- Associated pay with the job
- Location of modified duties
- Expectations to maintain regular contract

Human Rights and Return-to-Work

Key Concepts:

- Imposes human rights obligation on employers,
- Post injury jobs to be considered suitable must;
  - consider both work related and non-work related disabilities/impairments
- non-work related disabilities must also be considered

Therefore, you need to understand your Human Rights Obligations!

What is the legal authority to impose HR obligation within WSIA?

THANK YOU

- Follow-up questions / comments? Please contact Greg Sathmary via e-mail at:
  - gsathmary@industrialmediation.com

Or

- 613-260-0600 Toll Free 1-800-660-3554

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