RETURN TO WORK SERVICES

SCHEDULE 2

ASSESSMENT SERVICES

1.00 SERVICE LOCATIONS

1.01 The Contractor's approved Premises for this Schedule are as follows:
a)
b)
c)

2.00 APPLICATION

2.01 Schedules 1, 6 and 7 apply to this Schedule.

3.00 SERVICE OVERVIEW

3.01 Assessment Services are designed to provide assessment options to evaluate the Worker's medical, musculoskeletal, functional, psychosocial, cognitive and employment status in order to triage the Worker into the most appropriate rehabilitation service intervention pathway to facilitate a safe, Sustainable RTW.

3.02 The Services outlined in this schedule will assist Workers and Employers with RTW.

4.00 ADMISSIONS

4.01 Single service referrals allow the Contractor to provide only the Services requested by the CO on the referral. This may include any one or a combination of each of the following:
a) ME;
b) BFCE, CFCE or PSA (in-person or via FIT protocol);
c) RTWPM or RTWPD;
d) Psychological screen; and
e) Additional Assessments such as gait, driving Assessments, ergonomic Assessments, and specialized BI Assessments as specifically requested on the referral form by the CO.

The Contractor will consider the most appropriate form of Service provision, either in-person or through Virtual Care, considering the principles of HCD. If after clinical consideration the Contractor recommends alternate service, CO approval must be provided to move forward.

4.02 When the referral indicates that the CO does not require contact prior to admission on program, the Contractor will consider the Program pre-approved and will admit the Worker to a Program if the Assessment Services indicate it is appropriate pursuant to the Agreement. A new referral for service is not required from the CO.

4.03 The Contractor must advise the CO of the outcome of the Assessment and of all recommendations.

4.04 If clinically indicated and supported through triage, an ME must be performed prior to a BFCE or CFCE.

4.05 The Contractor will contact the Employer to book RTWPMs and RTWPDs.

4.06 The Contractor will successfully communicate a confirmed time and date for the RTWPM, and explain the importance of attending the RTWPM, to the Worker, Employer and/or union Representatives where applicable, and Employer. The Contractor will document all successful communication in this regard.

4.07 If a RTWPM does not proceed for any reason, and the Contractor is unable to provide documentation evidencing the successful communication to all parties, no fee will be payable for the RTWPM, cancellation, or no-show.

4.08 The Contractor will orient the Employer to the RTWPM process during the booking conversation including:

a) Provision of an outline of the components and duration of the RTWPM;
b) Confirmation of Worker job attachment;
c) Confirmation of possible modified RTW accommodation; and
d) Ensuring that the Employer understands which Employer and/or union Representatives should be attending the meeting.

4.09 The Contractor will reasonably facilitate Employer requirements, such as scheduling, to support the success of the RTWPM.

5.00 ASSESSMENT COMPONENTS

5.01 Every Assessment Service must be comprised of the following components:

a) Preparation and orientation;
b) Assessment;
c) Worker education and debrief;
d) RTW plan, as applicable; and
e) Case conference, as applicable.

5.02 The Contractor will review the referral form and Précis Package provided by WCB prior to commencing the Assessment.

5.03 If the Contractor becomes aware that material and relevant documents have not been provided, the Contractor must contact the CO to request that a copy of those documents is provided prior to the Contractor finalizing the Assessment report.

5.04 The results of the Assessment will be discussed with the Worker with an emphasis on what the Worker can do to facilitate the Worker's own rehabilitation and RTW. This will include a discussion of the benefits of early RTW and self-management. The specifics of the discussion, along with specifics of the Worker's response, must be included in the report.

5.05 The Contractor will coordinate integration of the Assessment findings to generate an individualized Worker RTW plan that will be used to focus the discussion at the Assessment case conference.

5.06 The following items are always outside of the scope of this Agreement, and the Contractor may not comment on same:
- a) Compensability of the injury;
- b) Entitlement;
- c) Referrals for IMEs; and
- d) Referrals for MC reviews.

5.07 The Assessment case conference is a discussion between the Contractor and the CO. It may involve the Worker at the discretion of the CO or the Contractor.

5.08 The objective of the Assessment case conference is to review the results of the Assessment, present the draft RTW plan, and finalize that plan to meet the needs of all stakeholders and promote the Worker's safe, Sustainable RTW. The RTW plan must include identification of the Worker's RTW strengths and Barriers, RTW goals, RTW Service interventions, and associated timeframes.

5.09 The Assessment case conference is recommended for all Assessments conducted by the Contractor except for stand-alone MEs or as indicated on the referral form. The case conference should not delay the continuation of the treatment plan.

5.10 If a discussion with the CO is not viable for the Assessment case conference, the Contractor must either leave a voicemail message for, or e-mail, the CO with the update.

5.11 If after the completion of an Assessment there are indications of a BI, TPI and/or CPI, the Contractor will have a case conference with the CO to discuss further Service options.

5.12 The Contractor will document the agreed upon RTW plan as developed at the Assessment case conference in the appropriate report.

6.00 MEDICAL EXAMINATIONS

6.01 The Contractor will evaluate if an MSE is required to safely proceed to other Services. The evaluation will be based on review of Worker information as provided in the referral form and Précis Package. An MSE is indicated, but not limited to, the following circumstances:
- a) Diagnosis not confirmed or needing expedited diagnostics, injections, and consultations;
- b) Lacking medical consensus;
- c) Limited medical on File;
- d) Pending entitlement;
- e) BI Assessment or treatment anticipated; and
- f) Expected contraindications for exercise/rehabilitation.

6.02 Consideration as to the necessity for an MSE being required includes but is not limited to, the following circumstances:

a) The Worker is not job attached and not working (increasing risk of exercise/functional activity contraindications);
b) The Worker is not currently under the care of a GP or in PT treatment (recent medical reporting is not on File);
c) There is no clear entitlement documented on the referral;
d) The Worker is post-surgical, or surgery is pending. (increasing risk of exercise/functional activity contraindications);
e) There is a request for further investigations/consultations.

6.03 In every case, documentation of clinical evaluation to support the decision of whether an MSE is indicated, or not indicated, should be placed on the Worker's File and made available to WCB upon request.

6.04 The ME physician must not have a prior patient relationship with the Worker. The ME physician cannot be the Worker's treating, consulting, or Occupational Injury Service physician prior to the ME.

6.05 SMEs, BMEs, and CSAs must be performed by a WCB approved physician. SMEs must be performed conjunctively by a SME physician and a SME physiotherapist.

6.06 The ME physician will explain the reasons and purpose for Assessment procedures to the Worker as the Service is provided.

6.07 The Service objectives of the ME are to:
a) Educate the Worker as defined in clause 6.09;
b) Confirm the diagnosis;
c) Obtain diagnostic closure;
d) Obtain medical consensus regarding diagnosis and RTW plan interventions;
e) Clarify the Worker's fitness to work from a medical perspective;
f) Minimize work-related disability;
g) Identify residual structural integrity and the magnitude of any impairment including current work restrictions and their duration;
h) Identify the presence and status of any medical conditions which may affect the Worker's rehabilitation and successful RTW; and
i) Identify precautions or contraindications to participation in any further Assessment components.

6.08 For BI MEs, confirming the diagnosis also means that if the Worker presents with symptoms of dizziness, the BI ME physician will provide the most likely diagnosis, including BPPV. The most likely diagnosis must be documented and supported by the rationale used to arrive at the diagnosis, including reference to the use of any tests, investigations, or medical evidence.

6.09 The ME will include a complete history and physical Assessment which includes:
a) A review of relevant past medical, surgical, Assessments, and interventions;
b) A medical Assessment of the Worker's condition;
c) An Assessment of other relevant medical conditions that may impact a successful RTW; and
d) A screen for other medical conditions such as cardiovascular and metabolic risks that may impact the Worker's ability to safely participate in the Assessment.

6.10 The complete history will include detailed information relating to the:
- a) Presenting complaint;
- b) Duration of injury;
- c) Time and mode of onset of injury;
- d) History of relevant injuries;
- e) Site, radiation, quality and severity of pain;
- f) Precipitating and relieving factors;
- g) Biological risk factors;
- h) Associated features;
- i) Work duties; and
- j) Extracurricular activities.

6.11 The ME physician will initiate an educational dialogue with the Worker including a discussion that includes, but is not limited to, the following:
- a) The concept of hurt versus harm, the Worker's diagnosis and prognosis for full recovery, the concept of gradually increasing activity level, and any medical precautions or contraindications;
- b) Activity goals and the benefit of setting activity goals;
- c) The benefit of early RTW with modified duties and duration of modified duties;
- d) Expected RTW date with full duties;
- e) Reasonable recovery expectations;
- f) Self-management; and
- g) Removal of fear surrounding pain, including shoulder and back pain, as applicable.

6.12 The ME physician will review psychosocial barriers during the interview to identify beliefs and behaviours that are counter-productive to recovery and the RTW process.

6.13 The Contractor will ensure that a minimum of twenty (20) minutes of direct time is spent with the Worker to complete all of the ME components.

6.14 The ME physician will confirm the diagnosis and obtain diagnostic and medical consensus by doing the following:
- a) Identifying the need for any necessary investigations and medical interventions required to facilitate diagnosis confirmation and the RTW plan; and
- b) Notifying the CO of any recommended medical coordination activities at the Assessment case conference and in the applicable ME reports.

6.15 The ME physician will identify the impact of the medical coordination activities on the RTW plan, and minimize delays caused by medical coordination activities.

6.16 The ME physician will provide clinical interpretation of findings.

6.17 The Contractor will ensure that the diagnostic testing results are submitted to the CO, and to any relevant treating physician.

6.18 The ME physician will complete the prescribed ME Addendum Reports, as applicable. The Addendum Report will:
- a) Document the medical coordination findings;
- b) Provide recommendations; and
- c) Update the RTW plan, if applicable.

6.19 The ME physician will make best efforts to obtain medical consensus by doing the following:

a) Educating the Worker about the Worker's clinical diagnosis by reviewing objective medical evidence that supports the RTW plan and rehabilitation process;
b) Facilitating Worker and treating physician understanding, and acceptance, of the RTW plan; and
c) Generating medical agreement among treating physicians or identified health care providers where contradictory medical information exists on the Worker's File.

6.20 The ME physician will communicate with the treating physician as required.

6.21 The ME physician will make a determination as to whether the Worker is able to safely proceed with the functional Assessment.

6.22 The Contractor will inform the CO of any Assessment changes.

6.23 In the event that further Assessments are cancelled due to safety issues, the Contractor will complete the Assessment report and outline follow-up recommendations.

6.24 The results of the ME will be communicated to all clinicians responsible for conducting any further Assessment components. The ME physician may not make a recommendation for a Program without consultation of the functional Assessor after a BFCE has been completed.

6.25 The Contractor will utilize the following principles when delivering MEs:

a) Most Workers with back injuries get better without medical intervention;
b) Diagnostic interventions play a supportive role to the clinical examination. However, the clinical examination is widely recognized to be the most important piece of information to properly assess a back Worker. Therefore, the diagnostic investigations should support the clinical examination and support the hypothesis generated by the clinical examination. The correlation between examination and observed pathology should be high;
c) Diagnostic testing will not be recommended simply to rule out other pathology which is naturally absent in most cases;
d) The best rehabilitation approach is early return to normal activity, and the Contractor will therefore encourage the Worker to return to safe activity through prompt implementation of modified duties;
e) The principal risk factors for chronicity of pain, including back and shoulder pain, are psychosocial in nature;
f) Avoidance of activity for fear of aggravating pain, or fear of worsening the pathology, is a significant cause of disability, the Contractor will therefore strive to reduce fear, and avoidance, of activity through hurt versus harm education;
g) The Contractor will engage RTW as the key rehabilitation intervention process rather than clarifying symptomology through multiple health care interventions where this will not assist with safe rehabilitation; and
h) One of the best indicators of a RTW outcome is the Worker's expectation of recovery. The Contractor will, therefore, provide education to the Worker with

regards to safe and Sustainable RTW by promoting positive expectations of recovery.

7.00 CALLS TO TREATING PHYSICIANS

7.01 The ME physician will call the Worker's treating physician in the following situations:
- a) Disagreement on diagnosis, treatment, or fitness to work;
- b) Change in treating physician's treatment plan;
- c) Where the ME physician has concerns regarding the Worker's safety or well-being, such as drug misuse or cardiac concerns;
- d) Where the treating physician has requested a call;
- e) Where the treating physician has made a request for the ME directly;
- f) Where the CO has requested the ME physician to call the treating physician; and
- g) Worker clearly disagrees with the examiner's conclusions and advice.

7.02 If any of the above situations apply the Contractor will make at least one (1) meaningful attempt to schedule a conversation between the ME physician and the Worker's treating physician prior to the ME report submission timeframe.

7.03 The objective of the conversation is to communicate information related to the ME results, and to seek consensus on the RTW plan. The content of the discussion will be documented on the Treating Physician Contact Memo, which must be attached to the relevant ME report.

7.04 Unsuccessful attempts to contact the Worker's treating physician by telephone will be documented within the relevant ME report including the date and time of the call attempt.

8.00 MEDICAL COORDINATION

8.01 Medical coordination is the coordination and interpretation of diagnostic services required to complete ME deliverables.

8.02 The ME physician will coordinate delivery of medical coordination Services.

8.03 All referrals for external investigations and consultations for Workers must be made within WCB Authorized Provider Network at rates and terms determined by HCS unless the Contractor obtains prior approval from the HCC.

8.04 If there is any doubt, the Contractor will confirm with the HCC whether a provider is a WCB Authorized Provider.

8.05 The Contractor will use reasonable efforts to inform the CO of the timeframe to complete all medical coordination Services.

8.06 Medical coordination Services which do not qualify for medical coordination fees include:
- a) Blood work;
- b) VSC consultations;
- c) Interventions provided directly by the Contractor;
- d) Clinical triage Service interventions such as physiotherapy and Programs;

e) Injections;
f) Specialized fitness tests; and
g) Specialist consultations.

9.00 VISITING SPECIALIST CLINICS

9.01 The Contractor will follow all requirements for referrals for ShSRs and SSRs.

9.02 In order for a ME physician to make a referral to VSC for a knee, back or shoulder injury, MRI must have been completed within the last six (6) months, the report for which must be on file.

9.03 The VSC exists to provide consultations and surgical services for work-related injuries. Therefore, the recommendation to VSC will be based upon a high probability of a need for surgical intervention and the recommendation must indicate this.

9.04 The VSC cannot be used to bolster an opinion already established by clinical examination and diagnostic testing.

10.00 BASIC FUNCTIONAL CAPACITY EVALUATION

10.01 The purpose of a BFCE is to provide a baseline evaluation that assesses the Worker's ability to perform injury related CJD. The BFCE is commonly used to determine the need for further rehabilitation during the early stages of a claim. This Assessment is generally geared towards commenting on the need for further treatment.

10.02 The objectives of the BFCE are to:
a) Identify the Worker's current functional status in relation to the Worker's pre-accident level;
b) Assess the Worker's function on vocationally related tasks that are the CJD of the pre-accident occupation or vocational direction;
c) Provide a baseline of the Worker's current functional abilities;
d) Identify the need for a Program;
e) Educate the Worker regarding the RTW process; and
f) Identify any significant RTW barriers such as workplace issues and psychosocial issues.

10.03 The BFCE is comprised of five (5) main components:
a) Worker interview;
b) Musculoskeletal assessment;
c) Functional testing;
d) Job description questionnaires if a PDA is not available or RTWPM has not been completed; and
e) Psychosocial screen.

10.04 An interview with the Worker will be conducted to obtain background medical, psychosocial, and vocational history, current perceived functional status including activities of daily living, recreational activities, and current vocational status.

10.05 The Contractor will explain the reasons and purpose for Assessment procedures, including the maximum effort and safety aspect of BFCE protocols, to the Worker as the Service is conducted.

10.06 A musculoskeletal assessment will be conducted to clarify the Worker's physical status and implications on function including the following, where appropriate:

a) Muscle strength;
b) Range of motion;
c) Pain and irritability status;
d) Ligamentous and joint stability;
e) Special clinical tests, as indicated;
f) Gait;
g) Posture and balance;
h) Coordination;
i) Functional implications of clinical findings; and
j) Precautions and contraindications.

10.07 For in-person Assessments, the Contractor will utilize a kinesiophysiological approach to elicit and document maximal Worker performance.

10.08 The CO will provide the Contractor with the job demands analysis and job description of the Worker's occupation, if it is available. The BFCE will assess the injury related CJD of that particular position. The Contractor will document job demands in the BFCE Assessment report. Where appropriate, environmental conditions of the worksite will be documented and taken into consideration.

10.09 Injury-related CJD must be obtained by way of RTWPM, PDA, accessing publications such as the National Occupation Classification (NOC), and/or Worker completing the Job Demands Questionnaire (self-report). In all cases, the CJD must be reviewed with the Worker to ensure accuracy of the information obtained.

10.10 The BFCE will assess the Worker's ability to perform the following functional tasks as they relate to the Worker's specific CJD:

a) Manual material handling, lifting through all levels and ranges;
b) One-handed and two-handed carrying;
c) Pushing and pulling;
d) Walking, sitting and standing;
e) Low level and above shoulder level work;
f) Sustained and variable forward trunk flexion;
g) Balance activities;
h) Fine gross motor dexterity and coordination;
i) Grip, pinch, and strength testing;
j) Sensation testing; and
k) Ambulation, gait and general coordination.

10.11 The Contractor must monitor the Worker's cardiovascular response to activity throughout the Assessment. The Contractor will ensure that the Worker's maximal safe heart rate is not exceeded. If the Worker's heart rate passes eighty-five percent (85%) of the Worker's maximum heart rate, the Assessment will stop, and will not resume unless the Worker's heart rate returns to a safe level, and the assessing clinician determines that

there is no ongoing risk to the Worker to resume the Assessment. If the Worker is not able to safely resume the Assessment, the Contractor will prepare and submit an Incident report accordingly.

10.12 The Contractor will conduct psychosocial barrier screening. The objective of psychosocial barrier screening is to identify and document the extent of any potential psychosocial RTW barriers and treatment Service interventions that may be successful in addressing the identified psychosocial barriers.

10.13 The psychosocial barrier screen will be completed using a combination of file review, clinical interview, and standardized questionnaires. It must include the Short Form-36 (SF-36), the Pain Disability Index (PDI), and the Visual Analogue Scale (VAS). It must also include at least one (1) of the following as applicable to the Worker's injuries:

a) The shortened version of the Disability of the Arm, Shoulder and Hand (QuickDASH) for upper extremity injuries;
b) Lower Extremity Functional Scale (LEFS) for lower extremity injury; and
c) Orebro Musculoskeletal Pain Questionnaire (OMPQ) for spinal injuries.

10.14 The psychosocial barrier screen will, at a minimum, assess the following RTW Barriers of the Worker:

a) Perception of expected recovery and RTW;
b) Perceived level of work and life disruption resulting from the compensable injury;
c) Fear of activity, exercise, and RTW;
d) Level of pain related disability and pain intensity resulting from the compensable injury;
e) Level of distress and anxiety resulting from the compensable injury;
f) Any adverse work or family relationships which may impede RTW;
g) Current coping strategies, and if these are likely to have a positive or negative impact on RTW; and
h) Motivation to participate in a Program.

10.15 For a BI BFCE only, the Contractor must also conduct a cognitive functional screen which comments on all applicable cognitive functioning areas including the Worker's:

a) Ability to understand and follow instructions;
b) Ability to remember instructions or ask for them to be repeated multiple times;
c) Ability to attend to the tasks or distractibility;
d) Insight into their current abilities and limitations;
e) Ability to incorporate feedback and response to it;
f) Ability to start a task independently without cueing;
g) Ability to follow task steps as required;
h) Ability to wait until all the task instructions are completed;
i) Speed and control of movements;
j) Recognition of errors or problems; and
k) Safety and judgment during testing.

10.16 The BFCE must be completed within one (1) Day.

11.00 COMPREHENSIVE FUNCTIONAL CAPACITY EVALUATION

11.01 The objective of the CFCE is to determine the Worker's maximal functional abilities and determine work restrictions. It is utilized once a Worker's injury has reached maximum medical improvement in order to determine whether the Worker has any residual restrictions.

11.02 The CFCE will follow the same Service outline, and requirements, as the BFCE.

11.03 The CFCE is completed over a period of two (2) consecutive calendar days. The second Day of the CFCE allows for re-testing for consistency, and for determining how the Worker has been affected by the first Day of the Assessment. Endurance and alternate methods of work will be identified in this Assessment.

11.04 The Contractor cannot make treatment recommendations on the CFCE report. If the Contractor has treatment recommendations, the Contractor will discuss them with the CO. If approved, the Contractor will submit an addendum to the CFCE report detailing the approved treatment recommendations.

12.00 PHYSICAL SUITABILITY ASSESSMENTS

12.01 The PSA is an Assessment that determines the functional status of the Worker, decides if the agreed upon job option identified through RE is suitable with the Worker's current physical abilities, and provides a physical suitability table to be compared to any future job options.

12.02 The objective of the PSA is to determine the Worker's functional status, abilities, physical suitability for job options, and the Worker's ability to work at pre-accident hours.

12.03 The PSA will follow the Service outline of the CFCE.

13.00 RETURN TO WORK PLANNING MEETING

13.01 The RTWPM is a meeting with the Contractor, Employer, Worker, and union, if applicable. The Contractor will make reasonable efforts to conduct the RTWPM at the pre-accident worksite or alternate worksite.

13.02 The Industry Specialist may attend a RTWPM or RTWPD when there are barriers to RTW and this is documented on the referral form. The Contractor will make reasonable efforts to schedule the RTWPM or RTWPD to coincide with all participants.

13.03 The RTWPM options are a:

a) Full RTWPM for pre-accident CJD and modified work options;
b) RTWPM with Microprocessor Knee Assessment.

13.04 The objectives of the RTWPM are to:

a) Initiate RTW discussion and explore modified and alternate employment options with the Employer;

b) Determine whether there is a need for ergonomic or worksite modifications to facilitate RTW;
c) Determine if there are any RTW Barriers specific to the worksite;
d) Re-establish the Worker and Employer relationship, as required;
e) Measure and document pre-accident CJD, and job tasks;
f) Educate the Employer about the RTWPM, and the rehabilitation process;
g) Educate the Worker about the RTW process; and
h) Develop a formal RTW plan, as applicable.

13.05 Exploring modified and alternate employment options may include:
a) Transitional RTW, which takes place while a Worker is attending Program;
b) GRTW if the Worker is not attending Program; and
c) Alternate positions for temporary, and permanent, solutions, as applicable.

13.06 Ergonomic and worksite modifications considered to facilitate RTW include:
a) Whether simple ergonomic changes can be made to facilitate an early and Sustainable RTW; and
b) Whether there is a need to engage an ergonomist for a more detailed ergonomic Assessment.

13.07 The RTWPM will, at a minimum, include the following components:
a) Meeting with all participating stakeholders together;
b) Job and workstation analysis;
c) Exit meeting with all participating stakeholders together; and
d) Development of a formal RTW plan.

13.08 BI RTWPM will also review and assess the cognitive and psychosocial job demands.

13.09 TPI and CPI RTWPMs will also review and assess the psychosocial job demands and cognitive job demands if the Worker's cognitive function has been impacted by the Worker's psychological condition.

13.10 The meeting with all participating stakeholders together will include an introduction of key participants, a review of the RTWPM process and objectives, Contractor contact information, and an initial discussion about the pre-accident job and modified work options.

13.11 Job and workstation analysis will include objective measurements of key job components, and of CJD. This will include, but is not limited to, the following, as applicable:
a) Weight of objects lifted and carried;
b) Push and pull force;
c) Repetition of manual handling tasks which is either both timed and measured by the Contractor, or when objective measure is not possible, agreed upon between the Employer and Worker with respect to frequency of tasks;
d) Workstation heights, any mismatch between Worker height and workstation height, and whether any mismatch can be resolved with changes;
e) Postures used during work; and
f) Psychosocial and cognitive job demands.

13.12 During the exit meeting with all participating stakeholders together, the Contractor will review all modified work options, ensure there is agreement with the RTW plan, and complete the Offer of Modified Work Form, when applicable, with both the Employer's signature and the Worker's signature.

13.13 The formal RTW plan will include, at a minimum, the start date for RTW, all specific job duties performed including the weights and frequency, things the Worker is to avoid, required breaks, progression of the plan and a feedback mechanism to engage if the plan is not working.

13.14 The Contractor will ensure that the following stakeholders are in attendance and able to participate in the RTWPM:

a) Contractor;
b) Worker;
c) Employer;
d) Workers' union representative, if appointed by the Worker;
e) Industry Specialist, if indicated;
f) Employer's representative, if applicable; and
g) CO, if requested by the CO.

13.15 The Contractor cannot proceed with the RTWPM without the Worker present without prior approval from the HCC. On the date of the Assessment, if all parties, with the exception of the Worker, are in attendance, and the Worker has agreed to attend in the Day(s) prior to the Assessment, the Assessment may proceed at the request of the Employer. The Contractor must document the date confirmation to attend was received from the Worker in the final report.

13.16 The Contractor will explain the reasons for, and purpose of, the RTWPM procedures to the Worker as the procedures take place.

13.17 The Contractor will follow-up with the Employer after the RTWPM in every case where the Employer was non-committal about the availability of modified work during the RTWPM. This follow-up must be completed within the one (1) week following Service delivery. A minimum of two (2) contact attempts are required.

13.18 The Contractor will ensure the Employer has a written documentation of the RTW plan, which can be in the form of a RTW Memo or RTWPM Report where authorized.

13.19 Where the Worker does not attend the RTWPM, the Contractor will make best efforts to discuss the outcome of the Service with the Worker in order to gain consensus prior to finalizing the report. A minimum of two (2) contact attempts are required.

13.20 Consideration to access an Industry Specialist should occur in cases where a RTW was not achievable and/or RTW Barriers were noted.

13.21 A new RTWPM should be completed when there are substantive changes since the previous RTWPM, to analyse a new position, or when there is disagreement regarding the CJD collected in the original RTWPM.

13.22 RTWPM follow-up is appropriate when a RTWPM has been completed in the last ninety (90) days in the following circumstances:

a) The Worker is not attending a Program;
b) The Worker requires a progression on a previously developed RTW plan;
c) Disagreement between Employer and Worker regarding the RTW plan is jeopardizing the plan; or
d) Changes in the work environment are affecting the success of the previous RTW plan.

The RTWPM follow-up reporting should include the RTW Follow-Up Report (C1211) and the RTW Employer Memo (C1016).

14.00 RETURN TO WORK PLANNING DISCUSSION

14.01 A RTWPD between the Employer, Worker and the Contractor may be indicated where a formal RTWPM is not realistic, available, or has been denied.

14.02 The Contractor cannot proceed with the RTWPD without the Worker present without prior HCC approval. On the date of the Assessment, if all parties, with the exception of the Worker, are in attendance, and the Worker has agreed to attend in the Day(s) prior to the Assessment, the Assessment may proceed at the request of the Employer. The Contractor must document the date confirmation to attend was received from the Worker in the final report.

14.03 The CO will provide the following three (3) sets of information in order for the Contractor to complete a RTWPD:
a) A copy of the Employer's PDA for that Worker's position;
b) Confirmation and documentation of modified duties, if any; and
c) Current fitness for work level.

14.04 The RTWPD can be either telephone communication between the Contractor, Worker and the Employer, or a meeting at the Contractor's Premises if the Employer is in agreement.

14.05 The RTWPD will include the following:
a) Review of options for RTW including modified duties or hours;
b) Obtain agreement on pre-accident work duties; and
c) Development and documentation of a RTW plan.

14.06 The RTWPD may not be used for the following purposes:
a) Gathering detailed documentation of the Worker's CJD;
b) Onsite Assessment, development and negotiation of modified work duties; and
c) A comprehensive overview of the Worker's job description.

15.00 WORKSITE VISIT FOR ENTITLEMENT

15.01 A WSV for entitlement is a meeting with the Contractor, Employer and Worker to analyse and document the Worker's pre-accident job demands in furtherance of making claims decisions.

15.02 There will be an initial meeting with all participating stakeholders together, which includes an introduction of key participants and a review of the WSV process.

15.03 Job and workstation analysis will include the objective measurements of key job components and of the CJD. This will include, but is not limited to the following, as applicable:

a) Weight of objects lifted and carried;
b) Push and pull force;
c) Repetition of manual handling tasks which is either both timed and measured by the Contractor; or when objective measure is not possible, agreed upon between the Employer and Worker with respect to frequency of tasks;
d) Workstation heights, any mismatch between Worker height and workstation height, and whether any mismatch can be resolved with changes, as applicable;
e) Postures used during work; and
f) Psychosocial and cognitive job demands.

15.04 During the exit meeting, all participating stakeholders together with the Contractor will review the findings to ensure there is agreement with the findings of the job, and workstation analysis.

15.05 The Contractor cannot proceed with the WSV for entitlement without the Worker present without prior HCC approval. On the date of the Assessment, if all parties, with the exception of the Worker, are in attendance, and the Worker has agreed to attend in the Day(s) prior to the Assessment, the Assessment may proceed at the request of the Employer. The Contractor must document the date confirmation to attend was received from the Worker in the final report.

16.00 COMBINATION RETURN TO WORK ASSESSMENTS

16.01 The Contractor will ensure that the individuals involved in combination Assessment meet to integrate findings prior to the Assessment case conference. All Assessment recommendations will support a consistent RTW plan.

17.00 PSYCHOLOGICAL INJURY SCREENS FOR TPI PROGRAM

17.01 Information gathered from an Assessment may indicate that the Worker would likely benefit from a psychological screen. Relevant information pertains to the:

a) Nature of injury;
b) Psychosocial presentation of the Worker;
c) Protracted recovery; and
d) Diagnostic information and other information on file.

17.02 Nature of the injury may include one or more of the following:

a) Life-threatening or serious injury;
b) Sexual violence;
c) Repeated traumatic emergency response calls;
d) Assault, robbery, motor vehicle accident, or a fall from a significant height;
e) Significant amputation or crush injury;
f) De-gloving or scalping;

g) Significant burn; and
h) Environmental or man-made disaster.

17.03 Indications of a protracted recovery include the following:
a) Recovery beyond what is expected for the physical injury;
b) Multiple admissions, interventions, and investigations;
c) Failed RTW; and
d) Post-traumatic psychiatric history.

17.04 Relevant diagnoses on the file include the following:
a) Acute stress disorder, adjustment disorder, anxiety disorder and depressive disorder;
b) Acute reaction to stress; and
c) Post-traumatic stress disorder.

17.05 Relevant observed symptoms include the following:
a) Fear avoidance behaviours related to RTW;
b) Hyper or hypo arousal level when discussing RTW;
c) Reports of nightmares or flashbacks;
d) Depressive symptoms;
e) Over emphasis on physical complaints;
f) Psychological barriers to RTW or refusal to attend RTWPM;
g) Conflict with Employer, co-workers or WCB;
h) Isolation at home; and
i) Suicidal ideation.

17.06 The Contractor must determine if the Worker would likely benefit from a psychological screen based on current medical and treatment recommendations as provided to the Contractor.

17.07 If a psychological screen is not requested on the original referral form, the Contractor must obtain prior approval from the CO prior to providing the Service.

17.08 Psychological screen assessors must use the Beck Depression Inventory, Beck Anxiety Inventory, and Trauma Symptom Inventory-2 (TSI-2). The psychological screen assessor will exercise reasonable discretion as to what other instruments are required.

18.00 PSYCHOLOGICAL INJURY SCREENS FOR CPI PROGRAM

18.01 Information gathered from an Assessment may indicate that the Worker would likely benefit from a psychological screen. Relevant information pertains to the:
a) Nature of injury;
b) Psychosocial presentation of the Worker;
c) Diagnostic information and other information on file.

18.02 Nature of the injury may include one or more of the following:
a) Bullying in the workplace;
b) Harassment in the workplace;
c) Sexual harassment in the workplace; and/or
d) Ongoing stress in the workplace.

18.03 Relevant diagnoses on the file include the following:
- a) Acute stress disorder, adjustment disorder, anxiety disorder and depressive disorder;
- b) Acute reaction to stress; and
- c) Post-traumatic stress disorder.

18.04 Relevant observed symptoms include the following:
- a) Fear avoidance behaviours related to RTW;
- b) Hyper or hypo arousal level when discussing RTW;
- c) Reports of nightmares or flashbacks;
- d) Depressive symptoms;
- e) Psychological barriers to RTW or refusal to attend RTWPM;
- f) Conflict with Employer, co-workers or WCB.

18.05 The Contractor must determine if the Worker would likely benefit from a psychological screen based on current medical and treatment recommendations as provided to the Contractor.

18.06 If a psychological screen is not requested on the original referral form, the Contractor must obtain prior approval from the CO prior to providing the Service.

18.07 Psychological screen assessors must use the Beck Depression Inventory, Beck Anxiety Inventory, Connor-Davidson Resilience Scale and Maslach Burnout Inventory. The psychological screen assessor will exercise reasonable discretion as to what other instruments are required.

19.00 TRAUMATIC BRAIN INJURY INTAKE & EDUCATION

19.01 The Contractor will review all available clinical information prior to completing a TBI intake interview with the Worker.

19.02 The Contractor will make reasonable efforts to admit a Worker within three (3) Days of receipt of a referral form.

19.03 The objectives of the TBI intake interview are to:
- a) Review accident history;
- b) Review treatment and Services to date;
- c) Review current symptoms;
- d) Provide education about RTW and recovery expectations; and
- e) Determine the need for additional Assessments and Services.

19.04 Where appropriate, and with the Worker's consent, the Worker's family maybe invited to participate in the TBI intake interview. In determining when this is appropriate, the Contractor will consider the Worker's desire for family involvement, and the Worker's mental capacity.

19.05 A NPS may be included in the Assessments if indicated by the TBI, and will:
- a) Review results of any psychological tests performed during the TBI intake session;

b) Review the status and diagnosis of the Worker's injuries;
c) Outline recommendation for RTW, as applicable; and
d) Recommend further Assessments or Services, as applicable.

19.06 Either the psychologist, or neuropsychologist, will communicate findings and recommendations by case conference with the CO.

20.00 BRAIN INJURY NEUROPSYCHOLOGICAL SCREEN

20.01 A NPS must be completed by a neuropsychologist and is used to document possible cognitive difficulties, and to screen for issues that may impact rehabilitation Services and discharge planning.

20.02 The NPS will utilize standardized tests.

20.03 A NPS can be considered as follows:
a) When the Worker has a neuroimaging documented mild-complicated, moderate or severe BI which is less than eight (8) weeks post-acute hospital or inpatient rehabilitation phase, and, in this case, it can be combined with the TBI intake interview; and
b) When the Worker has a mild BI and the CO requests the Assessment to develop a baseline of cognitive function, or as a result of concerns about the validity of the Worker's presentation.

20.04 The neuropsychologist will communicate findings and recommendations with the CO.

21.00 BRAIN INJURY NEUROPSYCHOLOGICAL ASSESSMENT

21.01 A NPA must be completed by a neuropsychologist and can be used for Workers with a documented BI at any point in the rehabilitation process, as determined by the Contractor in consultation with the CO.

21.02 The NPA will utilize standardized tests.

21.03 A NPA can be considered:
a) When the Worker has a neuroimaging documented mild-complicated, moderate or severe BI which is less than eight (8) weeks post-acute hospital or inpatient rehabilitation phase, and in this case, it can be combined with the TBI intake interview;
b) If deemed necessary by the Contractor in consultation with the CO; and
c) If the existing NPA is out of date.

21.04 For Workers with a BI considered to be within the mild range, an NPA may not be provided unless at least two (2) of the criteria below are met:
a) It is greater than three (3) months following date of accident;
b) The Worker had Glasgow Coma Scale (GCS) of less than fifteen (15) following the injury;
c) The Worker experienced a loss of consciousness, or posttraumatic amnesia, greater than one (1) hour;

d) The Worker had, or has, concussive convulsions;
e) The Worker's job requires safety sensitive clearance, such as working from heights, or operating machines;
f) The Worker has medical risk factors for complicated outcomes including being sixty-five (65) years of age or older, having severe associated injuries, or significant comorbid medical or neurological disorders; and
g) The Worker has a prior history of significant BI.

21.05 The Contractor will communicate findings and recommendations by case conference with the CO.

22.00 SPECIALIZED BRAIN INJURY ASSESSMENTS

22.01 All specialized BI Assessments recommended from a BI ME require CO approval.

22.02 Specialized BI Assessments include the following:
a) BPPV physiotherapy Assessment; and
b) Occupational therapy Assessment.

22.03 BPPV physiotherapy Assessments can only be performed when the BI ME physician has requested this Assessment as a result of positive BPPV findings on the BI ME.

22.04 The Contractor must have relevant technology to conduct a BPPV physiotherapy Assessment. This includes video nystagmograph goggles (VNG) to perform the Assessment.

22.05 The occupational therapy Assessment will:
a) Investigate areas of self-care and community living skills, physical, cognitive, and social RTW Barriers that may affect the rehabilitation process;
b) Include paper and pencil exercises, behavioral observations, standardized assessment instruments and functional tasks designed to probe adaptive living skills; and
c) Evaluate overall fitness and conditioning, muscular strength, range of motion, sensations, proprioception, pain complaints, function, tone, balance issues, and coordination issues.

23.00 TRIAGE OPTIONS

23.01 The Assessment Report will recommend one of the following triage intervention options:
a) No interventions required;
b) RTW Program;
c) RE on either an integrated or stand-alone basis;
d) Single Service intervention;
e) Community Services;
f) Brain injury Assessments including BI ME, TBI intake, NPS and NPA;
g) Further medical Services; or
h) Other interventions, as required.

23.02 A BI Program can only be recommended following BI Assessments, including, at a minimum, both a BI ME and TBI intake Assessment.

23.03 A PCR Program can only be recommended following PCR Triage.

24.00 TRIAGE PATHWAYS

24.01 Triage pathways were developed for each standard RTW Program based on a comprehensive review of the initial Assessment results of Workers going onto each Program (see Appendix B). Triage pathways assist with the clinical decision-making process, but do not replace clinical reasoning.

24.02 The Contractor will use triage pathways prescribed by this Agreement for non-BI Services.

24.03 When recommending a BI Program, the Contractor will use the BI triage model to determine which Program group the Worker will attend.

24.04 The SME physician and the SME physiotherapist will jointly triage the Worker into one of seven possible treatment streams. Those streams are:

Stream	Description
1	Education and RTW
2A	Education and continue community PT
2B	Education and RTW program
3	Education, RTW program and RTW
4A	Education, imaging, RTW program and RTW
4B	Education, imaging, surgical consult through VSC, and RTWPM
4C	Education, imaging and surgical consult through VSC, RTWPM, surgery, surgical rehabilitation and RTW

24.05 When a SME Addendum Report is submitted, the SME physician, and the SME physiotherapist, will triage the Worker into the recommended treatment stream. If the stream includes a Program, the Contractor must obtain CO approval unless pre-approved on referral form.

25.00 STAFFING

25.01 The Assessment team should have the following staff, at a minimum:

a) ME Physician;
b) Physiotherapist;
c) Occupational therapist;
d) Exercise therapist or kinesiologist;
e) Psychologist, if providing psychological Screens or BI Assessments; and
f) Neuropsychologist, if providing BI Assessments.

25.02 The BFCE, CFCE, RTWPM and RTWPD may only be conducted by the following types of clinicians:

a) Physiotherapist;
b) Occupational therapist; and

c) Exercise therapist or kinesiologist with experience in musculoskeletal and functional Assessments.

25.03 The following Assessments must always be provided by a fully registered psychologist who is a WCB authorized provider of the Service in question:
a) Psychological screen; and
b) TBI Intake Interview.

25.04 NPSs and NPAs must be conducted by a neuropsychologist.

25.05 BPPV physiotherapy Assessments must be conducted by a physiotherapist licensed to practice in Alberta, with training on vestibular Assessments. Provisionally registered physiotherapists are not eligible to perform this Service.

26.00 MEDICAL EXAMINATION STAFFING

26.01 MEs must be performed by a physician certified as a Fellow of the Royal College of Physicians and Surgeons of Canada or a Physician who holds a Certificate of the Canadian College of Family Physicians.

26.02 BI MEs must be performed by a physician with appropriate training and experience to deliver a ME for the Worker with a BI.

26.03 WCB will maintain a roster of approved ME physicians, and only those physicians are entitled to provide the applicable Service.

26.04 WCB may unilaterally and, at its sole discretion, set the criteria for the selection of ME physicians. The criteria may be amended at any time by WCB.

26.05 WCB may, at its sole discretion, bar any physician from providing Services should WCB determine that they do not meet the criteria.

26.06 WCB will, at its sole discretion, determine the need to add additional SME & BME physicians to the approved roster. If WCB determines that such a need exists, WCB will communicate the application process for the addition of SME & BME physicians.

26.07 BME,SME, and CSA physicians are required to:
a) Participate in a mandatory orientation session provided by WCB prior to providing any Service;
b) Shadow an approved ME physician of the same type of ME for a minimum of two (2) such MEs prior to independently providing such Services; and
c) Participate in a yearly continuing education workshop as specified by WCB for SMEs and BMEs only.

26.08 WCB is not responsible for travel and related costs associated with participating in the workshop or mandatory orientation sessions.

27.00 MEDICAL EXAMINATION QUALITY ASSURANCE

27.01 The Contractor must assign a “Medical Director” who is responsible for:

a) Ensuring that all MEs conducted at the Contractor’s site meet quality expectations as outlined in the Agreement;
b) Fostering best practice interventions among ME physicians;
c) Acting as the key contact for WCB in relation to Service issues and maintain responsibility for resolving said issues;
d) Training and mentoring new medical examiners; and
e) Ensuring that all ME reporting meets standards prescribed in this Agreement, and coordinate report quality audits as applicable.

27.02 Fostering best practice interventions among ME physicians will include, but is not limited to:

a) Awareness of the most recent literature and research, in particular as it relates to backs for BMEs and shoulders for SMEs;
b) Peer-review and feedback; and
c) Tracking and monitoring RTW and diagnostic referral patterns to ensure appropriate utilization of secondary Services.

27.03 The Medical Director will coordinate quarterly quality reports summarizing the results of at least five (5) audits per ME physician per type per quarter on the appropriate ME Report Quality Assurance Data Collection Sheet.

27.04 WCB will monitor processes and outcomes on a continuous basis. If outcomes fall below Service expectations as outlined in this Agreement, the Medical Director and ME physician will be required to participate in quality improvement initiatives including Service evaluation, action planning, and follow-up.

27.05 The Contractor will participate in report audit inter-rater reliability exercises, as and when directed by HCS.