The Role of the Primary Care Physician in Timely Return to Work

In 1994, the Ontario Medical Association passed the “OMA Position Paper in Support of Timely Return to Work and the Role of the Primary Care Physician.” Subsequently, provincial associations and the Canadian Medical Association have followed suit in an attempt to articulate the role and responsibilities of the physician within return-to-work programs, and to outline a process that meets the need of patients.

Over the past decade, various iterations of timely return-to-work (TRTW) programs have been introduced across Ontario in an effort to improve recovery, productivity, reduce rising absenteeism costs, and assist employers in meeting their obligations to accommodate their employees. During this period, insurers, employers and physicians have gained a more sophisticated understanding of the benefits of early return to work and the best practices in the area. However, there is growing concern among physicians over the collision between the increasing demands for third party services and patient access to quality, routine care.

From a human resources perspective, the administrative aspect of return to work has significant implications for wait times and other physician shortage-related issues. Moreover, there is a sense that the system is not working for patients, and that physicians have lost control over their ability to manage the increasing requests for services.

Within this context, the OMA has revisited its position paper and, in the following pages, articulates some of the ongoing issues within the field of timely return to work, and attempts to offer solutions that will enable successful timely return-to-work programs for patients, employers and physicians.

This paper outlines:
1. Current issues in the field of timely return to work related to:
   a. The Increasing Demand for Physician Services.
   b. The Patient-Physician Relationship.
   c. The Employee-Employer Relationship.
   d. Patient Consent.
   e. Training and Liability and Third Party Requests for Service.
2. A proposed model for successful TTRW.
3. The role of the employer and employee in TTRW.
4. The obligations of the attending/treating physician in TTRW.
5. The role of the return-to-work coordinators in TTRW.

Overview of Current Issues

a. Increasing Demand for Service

Returning an employee/patient to work following or during a period of disability has become an issue of significant importance. A number of factors have combined to result in more information being requested from physicians about more claims.

The growth in disability benefit claims over the past decade, coupled with a growing recognition of the economic and therapeutic benefits of timely return-to-work programs, has resulted in a significant increase in both the information requested of physicians, and the use of this information by employers, insurers and lawyers.

Employers, disability management companies, and insurers have developed an array of policies and programs to reduce workplace costs and group insurance premiums, manage absenteeism and provide for workplace accommodation.

Between 1996 and 2004, the average worker increased time off from
The Role of the Primary Care Physician in Timely Return to Work: Summary of Recommendations

Third Party Requests for Information

1. We recommend that third party requests for medical information and services be distinctly separated into two streams:
   a. Requests for medical documentation of illness, disease, injury or disability for the purposes of entitlement to disability benefits (as per CPSO) and;
   b. Requests for information and services related to returning a patient to work, such as functional assessments, reviewing job descriptions, consulting with supervisors, workplace interviews, assessing barriers to return to work, prescribing restrictions and modifications to the job (herein collectively referred to as “RTW Services”).

2. We recommend that when a third party requests information for (a) entitlement to disability benefits or (b) returning a patient to work that:
   a. Separate patient consent be obtained for each request for medical information.
   b. Patient consent be considered time-limited and that repeat requests for information fall within a reasonable time of the original receipt of patient consent.

3. We recommend the development of educational sessions to support physicians in understanding their CPSO obligations regarding third party requests and to support those physicians who wish to assume the role of the timely return-to-work co-ordinator.

4. We recommend that patients not be required to assume the costs of third party requests for services related to the certification of disability.

5. We recommend that patients not be required to assume the costs of services related to a timely return-to-work program. The OMA believes that the employer/insurer should assume the cost and payment for the services related to a timely return-to-work program, as well as for the services related to the certification of the disability.
6.2 days per year to 7.5. Simultaneously, expenditures on insurance coverage continued to escalate; in the public sector, the total outlay as a percentage of gross domestic product (GDP) rose from 1.19% in 1990 to 1.23% in 1999. As a result, there has been a steady increase in the number of Canadians acquiring insurance benefits and amounts paid out yearly such that, by 2005, it reached $1.9 billion (see Table 1, p. 30).

Traditionally, physicians have been asked to supply health information about a patient’s illness/injury in order to establish eligibility for benefits and provide a reasonable estimate of a return-to-work date. Increasingly, there is a blurring of the lines between the provision of forms and reports related to benefit entitlement, and requests for services and information related to a patient’s ability to return to work — a major contributor to the growth in demand for physician services.

It is now common for information requested at the initial visit to include requests for documentation and services not only for the eligibility of disability benefits, but also requests for documents and services such as the completion of a Functional Abilities Form (FAF), detailing subjective symptoms and objective findings, response to treatment, and information on mental and/or cardiac functionality, among others. Most often, there is no offer of financial remuneration by the requesting third party.

For the average physician, providing information to deal with complex issues in the workplace, and to establish the eligibility of insurance benefits — often when devoid of any information regarding job description or of a specific insurer’s definition of disability — can be daunting. Moreover, this information is often requested very early in the patient’s disabling condition, frequently before full investigation and diagnosis have been completed, and almost always before outcomes to treatment and rehabilitation are assessed.

The burden of third party requests for information has become so great that it may contribute to a family physician’s decision to change careers, or retire early from practice. Results from the Canadian Medical Association’s National Physician Survey indicate that between 1997 and 2004, physician time spent on indirect patient care increased by 18%. The majority of physician paperwork relates to disability benefits. In Ontario, general practitioners now spend an average of 11.5 hours per week completing forms and providing reports.

In a recent study examining the administrative burden experienced by Ontario’s physicians, 62% of respondents indicated that insurance requests are burdensome or very burdensome. Similarly, a study from the United Kingdom found that 93% of general practitioners report that administrative paperwork had either a “moderate influence” or “great influence” on their retirement decision. This trend extends across Organization for Economic Co-operation and Development (OECD) nations.

b. Patient-Physician Relationship

Following a significant disease or injury to a patient, treating physicians strive to achieve the goal of returning the patient to as close a degree of functionality as the patient was capable of achieving prior to his or her disability.

For most physicians, functionality refers to the activities of daily living that allow a person to enjoy a healthy, independent lifestyle with the ability to be self-supportive. In a return-to-work context, functionality is expanded to encompass the specific job restrictions and limitations of the employee/patient.

Effectively returning an employee/patient to work following a disability is a highly complicated process, and requires co-operation from employee, employer, insurer and healthcare provider in order to ensure that the process does not cause further harm. From the family physician’s perspective, although part of a continuum, returning a patient to optimum functionality, and returning an employee to work, are separate processes.

In some instances, physician engagement in the timely return-to-work process can cause significant conflict with a patient. Most often, this occurs when the patient does not feel that he or she is able to return to work, and the employer/insurer has requested a physician report detailing when and how this can take place.

The potential for conflict is heightened when employers/insurers receive information that they consider inadequate, and deny or delay the provision of benefits; when employers and insurers require repeat services and the patient has to assume the costs; and/or when employers blame doctors for delays in approval, thereby pitting patient against physician.

Physicians, patients and employers regularly confront a scenario where the patient feels that he or she cannot return to work, the employer suspects that the physician is inappropriately certifying disability, and the physician feels that the employer is not truly willing or interested in accommodating the employee.

One of the principal barriers identified by physicians in return-to-work programs is a perceived lack of support from the employer. M.K. Schweigert, et al. examined physician perception of return-to-work barriers in Ontario and found that the most often cited was a lack of accommodated/modified work opportunities.

Conversely, employers and insurers have conveyed a similar frustration with the return-to-work process and the role of the attending physician. Physicians are perceived as reluctant participants in the process, often unwilling to understand the needs of employers and the workplace, and too often willing to inappropriately certify disability.

c. Employee-Employer Relationship

The economic and therapeutic value of TRTW programs is now widely accepted. Research indicates that
employees who are presented with modified return-to-work opportunities prior to complete recovery are twice as likely to return to work as those who are not, and TRTW programs can reduce the number of work days lost by half. The evidence suggests that there is strong correlation between the length of absence and the likelihood of the patient ever returning.

Moreover, there is growing recognition that the critical factor in successful return-to-work programs is the active participation of the employer and employee. This is reflected in a recent review of disability management policies across seven advanced industrial nations by the OECD, and its principal recommendation that policy-makers need to engender “a culture of mutual obligation” between employers and employees in the disability management process.

The Ontario Human Rights Commission contends that, under the Ontario Human Rights Code, all workers with disabilities have the right to be accommodated in the workplace. By extension, all employers and unions have a legal duty to provide such accommodation. As a result, employers are modifying their disability and absentee management, both as an economic imperative and in order to meet their duty under the Code, to provide accommodation in the workplace (see Appendix 1, p. 34).

d. Patient Consent for Release of Information

Physicians frequently express concerns about the practice of employers/insurers having patients sign "blanket consents" authorizing the release of information well beyond that which the physician believes to be relevant to the return-to-work or benefits issue at hand. Two issues arise in this context: the requirement to minimize collection, use and disclosure to meet the purpose; and what constitutes a knowledgeable consent.

In Ontario, the rules relating to the collection, use and disclosure of personal health information are addressed in separate legislative regimes for health providers versus employers and insurers. This section will address the privacy provisions as seen from the physician lens.

The Personal Health Information Protection Act (PHIPA) speaks to health information custodians (HICs) about their obligations to protect patients’ privacy. One of the fundamental principles underlying PHIPA is the requirement upon HICs to collect, use and disclose “only as much personal health information as is necessary for the purpose.”

PHIPA addresses issues relating to consent in detail. One of the requirements for a consent to be valid is that it “must be knowledgeable.” The Act then goes on to state that a HIC may generally assume that a statement of consent is valid. There is nothing, however, which prevents a physician from testing this assumption. In the event that it does not appear to the physician that the consent was knowledgeable, he or she may rely upon the provisions of the Act that allow a patient to withdraw consent and to substitute a new (informed) consent.

In addition to the general provisions minimizing the collection, use and disclosure of information in the system and defining consent, PHIPA contains specific provisions to distinguish information-sharing among HICs from the situation where a HIC discloses information to third party “recipients,” such as employers and insurers. When dealing with third party recipients, PHIPA requires a HIC to disclose information only for authorized purposes. In addition, the recipient is prohibited from using or disclosing more of the information than is necessary to meet the purpose.

Again, it should be noted that except for the so-called “recipient rule” discussed above, insurers are not captured by PHIPA. They are governed by the federal privacy statute known as PIPEDA — the Personal Information Protection and Electronic Documents Act. Although the specific rules under PHIPA and PIPEDA vary, they both are predicated on a requirement to limit the collection, use and disclosure of personal information to that which is required for the purpose.

In light of patients’ apparent lack of awareness in this area, it is recommended that separate consents for the disclosure of information be required, and that patients be explicitly informed of the extent of the proposed disclosure and purposes to which the information will be used (e.g., to certify disability or to return the patient to work).

e. Training and Liability

The majority of physicians outside of occupational medicine have not received the appropriate training to participate in return-to-work programs and are thus uncomfortable doing so. In part, this results from the fact that there may be other issues beyond the mere disability itself that have a part to play in returning a disabled person to work. Such issues include workplace stress, difficulties with co-workers, poor performance, demeaning modified work programs, and personal issues, e.g., marital discord, chronic pain and mental disorders. Compounding this issue is research suggesting that there is an increasing complexity in both diagnosing diseases, such as mental illness or stress-related illness, and assessing their implication on work capacity.2

Physician concern about training is compounded when they are asked to perform functional assessments in order to complete a Functional Abilities Form (FAF), and provide services and opinions regarding an employee’s ability to return to work before they have all the evidence on which to draw adequate conclusions. Further, the timing of these requests often requires physicians to provide a speculative response, which is of particular concern when they are asked to sign a statement on forms to the effect that, “I hereby declare that the information submitted is true and complete and I understand that it is an offense to knowingly make a false or misleading statement.”
Timely Return to Work

A Proposed Model for a Successful Return to Safe and Timely Work Program

The literature shows that there are a number of definitions of “Return to Work”, “Timely Return to Work,” and “Safe Return to Work” Programs, but the concept of returning a disabled person to the workplace in some modified manner is addressed universally.

Common to these definitions is an acknowledgment that a timely return-to-work program is a compilation of services required to safely and effectively return an individual to work as soon as possible. There is no common timely return-to-work template that meets all individual needs in all circumstances in all workplaces.

The most appropriate program may involve accommodation in the form of a temporary workload restriction, while in other instances it may be necessary to have the employee perform a completely different job function, or move into part-time employment. Each program should be individually prescribed and should support the reintegration and rehabilitation of a disabled or injured employee back into the workplace. The program should provide temporary or modified work assignments, which take into consideration the employee’s physical and psychological limitations.

As in our 1994 position paper on the subject, the OMA recommends the continued evolution of well-designed, co-ordinated efforts to create workplaces that can promote the safe and timely return of workers, and emphasizes the important contribution in this area made by occupational health physicians.

Successful timely return-to-work programs should embody the following operating principles:

1. The primary responsibility for successful timely return to work lies within the employer-employee relationship.
2. Personal responsibility and the co-operation of the employee are critical.

3. Workplace policies should outline the roles and responsibilities of the stakeholders, i.e., management, the employee, the union, human resource staff, and workplace health-care professionals. All stakeholders should be educated on their responsibilities in order to ensure compliance.
4. Medical restrictions should be matched with the physical and psychological demands of the regular or modified job.
5. Employees participating in a graduated timely return-to-work program should be accommodated without financial loss to the employee.
6. Occupational medicine is recognized and utilized as a referral resource to help with specific case management.
7. The program and policies are subjected to continuous quality improvement.
8. That the role of the timely return-to-work co-ordinator as defined herein is recognized and utilized.

Due to the complexity of the timely return-to-work process, and increasing demands on physicians’ time as outlined previously, we recommend that third party requests for physician services be distinctly separated into two streams:

- Request for medical documentation of illness, disease, injury or disability for the purposes of entitlement to disability benefits (as per College of Physicians and Surgeons of Ontario [CPSO] requirements) and;
- Requests for TRTW Services as defined in the Timely Return-to-Work Services section of this document (see p. 29).

Employee and Employer Role

Employers, in managing disabled employees, are bound to act in a manner that is not discriminatory. To that end, the employer may have to revise a measure already in place, or make arrangements in the workplace to facilitate an employee’s reintegration.

According to the Ontario Human Rights Commission, the accommodation process is a joint endeavour between the employee and employer, both of whom have a responsibility and duty to ensure that accommodation is achieved (see Appendix 1, p. 34).

Patients are responsible for receiving the information they require from their health-care providers to safely re-enter the workplace; to familiarize themselves with their condition in order to bring this information to bear on the modified work opportunities made available from the employer; and to work with the employer to manage the process. Employers are responsible for applying this information to provide modified work options for the patient’s consideration. The employer must ensure that the information offered to the patient and his or her health-care provider about the company’s program and the modified work available in the workplace is, in fact, fully operational. The employer should also provide accommodation in a timely manner, limit information requests to those related to the accommodations process, and assume the cost of any medical information/documentation requests.

The employer and employee have a responsibility to provide the health-care professional (HCP) with enough employment-related information to enable him or her to provide appropriate medical advice and support. It is the employer’s responsibility to provide the HCP with a written job description, identifying the job risks and available work modifications, and to appropriately compensate physicians (per the 2008 Schedule of Fees, available online at: https://www.oma.on.ca/economics/billing/2008sof/menu.htm) for their participation in the TRTW process.

The employer’s approach to the return-to-work process is of critical importance. Some issues, like return to a “toxic” environment, meaning a situation where external factors, such as problems with the supervisor, conflict among workers, perceived or
actual unfair treatment, etc., can only be addressed by the employer directly. Other issues can be effectively managed by the occupational health team on behalf of the employer.

**Physician Role in Timely Return to Work**

In 1994, the OMA suggested a role for the attending physician in the timely return-to-work process, and provided specific recommendations. As outlined above, there has since been a significant change in the landscape affecting timely return to work. There is now a focus on ability rather than disability, and there has been an increased demand for medical information and advice from physicians and other health-care providers concerning patient functionality, restricted work, and modifications to the workplace to help accommodate the disabled patient (see Appendix 2, pp. 35-37).

The clinical role of the patient’s personal family physician (attending physician) is still patient-centred, and remains to:
1. Provide medical treatment in order to achieve optimum functionality and discuss with the patient anticipated recovery and healing times early in the course of treatment.
2. Support and encourage the patient to participate in a timely return-to-work program.
3. Provide medical report(s) as per the College of Physicians and Surgeons of Ontario requirements.
4. Accept overall responsibility for the patient’s medical care.
5. Request and help co-ordinate appropriate auxiliary treatment and rehabilitation services.
6. Protect the patient’s medical confidentiality.

In Ontario, the attending or treating physician has several distinct considerations when dealing with an injured or ill patient where they require time off work, and possibly a timely return-to-work program:

- The patient may have a Workplace Safety & Insurance Board (WSIB) claim, in which case treatment and TRTW service provision would fall under The Workplace Safety and Insurance Act. The reader is referred to the WSIB policy entitled, “Injury/Illness and Return to Work/Function” (see Appendix 3, p. 38).
- The attending or treating physician has an obligation to provide medically necessary services to the patient during the course of the clinical investigations and treatment of the specific illness or injury that is preventing the patient from attending work or causing the patient to seek accommodation in the workplace. These clinically medically necessary services must be billed to the provincial health plan (OHIP) under the Health Insurance Act.
- The attending or treating physician has an obligation to provide accurate and timely objective medical information for the entitlement of eligibility for insurance benefits as per CPSO requirements. The provision of such a report is an uninsured service and may be charged to the requesting third party or to the patient.
- The attending or treating physician should provide accurate and timely objective medical information for the purposes of TRTW. This information should highlight duration of illness, expectations for recovery, and work capability, where known. The provision of such a report is an uninsured service, and may be charged to the requesting third party or to the patient.
- The attending physician needs to consider whether he or she will play a role as TRTW co-ordinator when requested by the employer/employee or the other third party.

**CPSO Obligations**

In the case of third party insurance benefits, physicians are commonly requested to provide objective medical information. This is most readily done from documented and reproducible clinical findings from examination of the employee/patient. A treating physician is under an obligation to provide a medical report when requested by, or on behalf of, a patient. The CPSO Third Party Reports Policy (#8-02) requires physicians to provide medical reports to third parties “within 60 days of request”, unless other arrangements are made. If additional time is required to prepare an appropriate report, due to complexity or other appropriate reasons, this should be discussed with the third party.”

Physicians are required to report information they have within their knowledge or within their medical chart. Hence, if a third party other than WSIB, for example, sends a request for a functional ability assessment (FAF) to a physician and the physician knows the answers, he or she is obliged to provide the information. If the physician does not know the answers to some questions, he or she can reply “I do not know,” and is not obliged to perform tests or provide a service to find the answer.

**Timely Return-to-Work Co-ordinator**

Many aspects of the TRTW process require special training and a workplace knowledge, and as a result, many physicians may prefer to use the expertise of other health-care professionals for this purpose.

The attending or treating physician is not obliged to perform TRTW services, and should not provide such services if they are beyond the physician’s training and expertise. The attending physician should advise the employer/employee whether he or she agrees to provide such TRTW services beyond the provision of limited, objective, medical information — and if not, the physician should provide the employer/employee with the names of other health-care professionals in the local area who do provide such services. If the attending or treating physician has the requisite training and expertise to provide TRTW services, and elects to assume
the role of TRIW co-ordinator, he or she should advise the employer that such services are uninsured, and enter into a written agreement with the employer regarding the terms under which the physician will provide such services (see Appendix 2, pp. 35-37).

The Role of the Timely Return-to-Work Co-ordinator
Regardless of whether the physician assumes the role and provides the services, works with other health-care professionals in a collaborative manner, or refers the employee to another health-care professional to oversee the TRTW of the employee, there appears to be a role for either the physician or another health-care professional to assume the role of TRIW co-ordinator.

The TRIW co-ordinator assumes the primary responsibility for compiling medical information together with the employee’s workplace and job functions information, which may include a formal ergonomic assessment, if appropriate, and provides advice concerning the limitations, restrictions and modifications that may be necessary to accommodate the employee in a timely return-to-work program. This role might also include a review of the workplace policies and collective agreements to which the employee may have agreed, and/or a detailed review of the pre-morbid work history (e.g., chronic absenteeism, difficulty with co-workers). The co-ordinator should periodically review the prescribed program and suggest modifications until the patient eventually assumes his or her previous full-duty status, or is working in a modified manner that has been agreed upon, which may involve changes to role, hours, etc.

Physicians taking on the role of timely return-to-work co-ordinator should explain to the patient that they have taken on this role. It should be further explained to the patient that the physician has assumed obligations to report health information to the patient’s employer or insurer. Clear consent should be provided by the patient for this to occur, and should help to provide clarity with respect to the potential for conflict.

The TRIW co-ordinator will need to have access to local medical specialty services, especially where it comes to the management of emotional/mental health issues and chronic pain, as these areas both represent significant challenges where it comes to workplace reintegration.

Where an attending physician refers the patient to another health-care professional, including a medical specialist, then the receiving care provider should agree to assume care. In the event that the purpose of the referral is for the specialist or other health-care provider to co-ordinate a timely return-to-work program, then the parties should fully understand the purpose of the referral and their appropriate roles.

Timely Return-to-Work Services
The TRIW co-ordinator is a health-care professional who works with the employer and the employee/patient to assist in developing and overseeing a timely return-to-work program that is individualized to the employee, and meets the requirements of the employer. Regardless of who assumes the role — physician or alternate health-care provider — any combination of the following timely return-to-work services may be required for the patient in an individualized return-to-work program.

1. Co-ordinator identifies employee/patient’s ability to return to work with workplace restrictions and/or limitations:
   • Specific and objective limitations.
   • Specialized equipment requirements.
   • Duty day/work/hour limitations.
   • The time period for restrictions is required.
   • Report/form of capabilities sent to employer and physician.

2. Co-ordinator may need to reach an understanding of possible non-medical barriers to return through one or more of the following:
   • Patient/supervisor interviews.
   • Family interviews.

• Psychological/social factors.

3. If, after the above steps, the employee/patient is not able to return to work, the co-ordinator may need to advise the employer that one or more of the following multidisciplinary assessments may be necessary:
   • Job demand analysis evaluations.
   • Job site analysis.
   • Functional capacity evaluation.
   • Psychological assessment.

4. If, after the above steps, the employee/patient is not able to return to work, the employee/patient may require the following rehabilitation to be co-ordinated:
   • Physical/occupational therapy.
   • Work conditioning.
   • Work hardening.

5. If the employee/patient has achieved maximum medical improvement, if the employee/patient cannot perform “essential tasks” of assigned job, or if the employer cannot “reasonably accommodate” the employee/patient, then the employee/patient may need to consider another form of employment and re-education, and vocational rehabilitation may be required.

Billing for Third Party Services
It should be noted that while physicians have an obligation to provide a report to a third party when requested by the patient to do so, the provision of such a report is an uninsured service and may be charged to the requesting third party or the patient. (Note: although such reports may be charged to either the third party or the patient, it is recommended that the third party requester bear the costs.)

If the physician assumes the role of the timely return-to-work co-ordinator for the provision of services associated with a timely return-to-work program for the individual employee, then the physician should bill the requesting third party according to the OMA 2009 Physician’s Guide to Third Party and Other Uninsured Services (available online at: https://www.oma.org/Economics/billing/ThirdParty
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Guide, or, alternatively, to a negotiated rate agreed to by the physician and the requesting third party. The OMA believes that the third party should be responsible for remunerating the physician for the provision of any of the timely return-to-work services listed above.

Workplace Safety & Insurance Board
It should be noted that the processes outlined above are applicable to those circumstances where the employee/patient may be receiving benefits from a third party private insurance plan, and do not apply to any patient of a physician who has been injured at work, or has a work-related disease, for which the patient is receiving WSIB benefits and treatments provided through the WSIB claims procedure.

In the province of Ontario, the responsibilities of attending physicians and other health-care providers when providing clinical assessments and treatment to a patient who is receiving WSIB benefits through a legitimate claim are governed by the Workplace Safety and Insurance Act (see Appendix 3, p. 38).

Disability Income Insurance in Ontario
Table 1 below shows a steady increase in the numbers of Canadians acquiring insurance benefits, and an increase in the amounts paid out yearly. These trends are illustrative of the need for cost-containment; as costs for benefits rise, there is an increase in yearly premiums passed back to the individual or to group disability plans.

The cumulative effect of increased costs and absenteeism are causing a situation that has a ripple-down effect on physicians, as increased demand for documentation and services accompanies the pressure for cost containment.

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- OMA Clinical Sections: Chronic Pain Physicians, General and Family Practice, Occupational and Environmental Medicine, Orthopedic Surgery, Physical Medicine and Rehabilitation, Psychiatry.

Selected References
2. Organization for Economic Co-operation and Development. Transforming disability into ability: policies to promote work and income security for disabled people. Paris,

| Table 1: Disability Income Insurance in Ontario |
|--------|-------|-------|-------|-------|-------|
| # of individuals covered (000s) | 2001 | 2002 | 2003 | 2004 | 2005 |
| Long term | 3,600 | 3,900 | 4,000 | 4,200 | 5,000 |
| Short term | 1,200 | 1,400 | 1,500 | 1,800 | 1,900 |
| Totals | 3,600 | 3,900 | 4,000 | 4,200 | 5,000 |
| Benefits paid ($millions) |       |       |       |       |       |
| Long term | $1,310 | $1,410 | $1,450 | $1,410 | $1,510 |
| Short term | 330 | 340 | 330 | 330 | 400 |
| Total Paid | 1,640 | 1,750 | 1,780 | 1,740 | 1,910 |

Persons with short-term disability (STD) coverage are already included in the number of people with long-term disability (LTD) coverage, as most people with STD coverage also have LTD coverage.
Timely Return to Work


(discontinued on p. 34)

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Appendix 1
The Human Rights Commission (Ontario) Policy and Guidelines
on Disability and the Duty to Accommodate

“The person with a disability is required to:
• Advise the accommodation provider of the disability (although the accommodation provider does not generally have the right to know what the disability is);
• Make her or his needs known to the best of his or her ability, preferably in writing, in order that the person responsible for accommodation may make the requested accommodation;
• Answer questions or provide information regarding relevant restrictions or limitations, including information from health care professionals, where appropriate, and as needed;
• Participate in discussions regarding possible accommodation solutions;
• Co-operate with any experts whose assistance is required to manage the accommodation process or when information is required that is unavailable to the person with a disability;
• Meet agreed-upon performance and job standards once accommodation is provided;
• Work with the accommodation provider on an ongoing basis to manage the accommodation process; and
• Discuss his or her disability only with persons who need to know. This may include the supervisor, a union representative or human rights staff.

The employer is required to:
• Accept the employee’s request for accommodation in good faith, unless there are legitimate reasons for acting otherwise;
• Obtain expert opinion or advice where needed;
• Take an active role in ensuring that alternative approaches and possible accommodation solutions are investigated, and canvass various forms of possible accommodation and alternative solutions, as part of the duty to accommodate;
• Keep a record of the accommodation request and action taken;
• Maintain confidentiality;
• Limit requests for information to those reasonably related to the nature of the limitation or restriction so as to be able to respond to the accommodation request;
• Grant accommodation requests in a timely manner, to the point of undue hardship, even when the request for accommodation does not use any specific formal language; and
• Bear the cost of any required medical information or documentation. The employer should pay for example, doctors’ notes and letters setting out accommodation needs.
• Take an active role as partners in the accommodation process;
• Share joint responsibility with the employer to facilitate accommodation; and
• Support accommodation measures irrespective of collective agreements, unless to do so would create undue hardship.

Unions and professional associations are required to:
• Take an active role as partners in the accommodation process;
• Share joint responsibility with the employer to facilitate accommodation; and
• Support accommodation measures irrespective of collective agreements, unless to do so would create undue hardship.”

Appendix 2
Proposed Overview of Health-Care Professional Role and Co-ordinator Role in the Timely Return-to-Work Process

Step 1: Initial Encounter with Physician or Other Health-Care Professional

Employee experiences injury/illness requiring physician assessment.

Requires time off work?

- No → Patient returns to full-time regular work or stays at work.
- Yes → As per CPSO policy, the physician may need to provide a medical report for the eligibility of benefits and deal with it as a third party request.

Step 2: Determination of Need for a Timely Return-to-Work Program

Employer/employee discuss a return-to-work plan.

Work plan implemented?

- Yes → Patient returns to work. Employer possibly utilizing in-house medical/RHP assistance or EHP.
- No → RTW process is initiated and more information is required. May require referral to an occupational medicine specialist.

(continued on p. 36)
Appendix 2 (con’t from p. 35)

Step 3: Timely Return-to-Work Program to be Designed for Patient

- Physician continues to provide clinical care/a treatment plan, i.e. medication and rehabilitation.
- Physician or employer, with patient’s agreement, refers patient to other medical or allied health professional to act as the TRTW co-ordinator.

Timely Return-to-Work Co-ordinator Role
(Suggested Services Template)

Co-ordinator identifies patient’s ability to return to work with workplace restrictions and/or limitations:
- Specific and objective limitations
- Specialized equipment requirements
- Duty day/work/hour limitations
- Time period for restrictions is required
- Report/form of capabilities sent to employer and physician negotiates with employer regarding compensation for completion of the above.

Able to RTW after specified time period?

Yes ➔ Return to work full duty.

No ➔ Co-ordinator must reach an understanding of possible non-medical barriers to return through one or more of the following:
- Patient/ supervisor interviews
- Family interviews
- Psychological/social factors

Able to RTW after specified time period?

Yes ➔ Return to work full duty.

No ➔ (continued on p. 37)
Appendix 2 (con’t from p. 36)

Co-ordinator should consider requesting one or more of the following multidisciplinary assessments:
• Job demand analysis evaluation
• Job site analysis
• Functional capacity evaluation
• Psychological assessment

Able to RTW after specified time period?  
Yes → Return to work full duty.

No → Patient may require rehabilitation:
• Physical/occupational therapy
• Work conditioning
• Work hardening

Yes → Patient returns to assigned job, as modified.

No → If patient has achieved maximum medical improvement, if patient cannot perform “essential tasks” of assigned job, if employer cannot “reasonably accommodate” the patient:
• Patient may need to consider another form of employment and re-education and vocation rehabilitation may be required.
Appendix 3
Workplace Safety & Insurance Board Reporting Requirement

Many physicians are uncertain as to when it is appropriate to submit initial reporting forms to the Workplace Safety & Insurance Board (the “Board”), and under what circumstances the Board may request additional information related to a patient.

The Board has the ability to request any information it feels necessary in order to process claims under its insurance plan. Section 37 (1) of the Workplace Safety and Insurance Act states:

“Every health care practitioner who provides health care to a worker claiming benefits under the insurance plan or who is consulted with respect to his or her health care shall promptly give the Board such information relating the worker as the Board may require.”

This Section provides the Board with a broad authority to demand the delivery of information. If a physician treats an injured worker who wishes to make a claim under the insurance plan, he or she must promptly give the Board the information that it requests. The Board has indicated that after an initial visit relating to a claim, it will request that the information of that visit to be sent by way of a “Physician’s First Report” form (Form 8).

After the initial visit, the Board may continue to request information regarding the treatment of the patient. In most circumstances, the patient’s situation will dictate how the information is reported.

For example, if the physician who conducted the initial report continues to treat the patient, he or she will most likely be required to complete a “Physician’s Progress Report” (Form 26) to update the Board with information regarding the treatment that has been provided, or if the claiming patient has been referred to a specialist, the specialist must complete a “Consultation Report” form.

There are, however, circumstances where the Board may request additional information, separate from the information provided on the reporting forms.

Most physicians who receive a request of this nature find it to be a nuisance. However, Section 37 (1) of the Act provides the Board with a substantially broad power that allows it to demand “any information” relating to a claiming patient that it “may require.” Therefore, it is not unusual for the Board to demand a copy of the entire medical history of a patient.

The Board may opt to use this power in instances where it would like proof that the treatment provided is wholly work-related, and not treatment for an injury that was either aggravated by a workplace incident, or not at all related to the workplace.