

POLICY NUMBER: POL-92

Chapter:
CLAIMS

Subject:
HEALTH CARE BENEFITS

Effective Date:
September 26, 2002

Last Update:
May 15, 2025

PURPOSE STATEMENT:

The purpose of this policy is to explain how the Workers Compensation Board determines entitlement to health care benefits for injured workers.

REFERENCE:

Workers Compensation Act R.S.P.E.I. 1988, Cap. W-7.1, Section 1 (1) (r), 18
Workers Compensation Board Policy, POL-64, Health Care Providers – Roles and Responsibilities
Workers Compensation Board Policy, POL-71, Conditions for Entitlement
Workers Compensation Board Policy, POL-160, Decision Making

DEFINITION:

In this policy:

“Chiropractic treatment” means the provision of any professional service usually performed by a chiropractor, and includes the prevention, diagnosis, and treatment of biomechanical disorders of the neuro-musculoskeletal system by methods that include the use of imaging, laboratory and clinical diagnostic procedures; joint manipulation or other manual therapies; exercise and patient education; without the use of prescription drugs or surgery.

“Direct Access Provider” means a health care provider that can be accessed directly for the first assessment of a work-related injury, without pre-approval from the WCB and without a referral

from another health care provider.

“Functional Capacity Evaluation” means a detailed examination and evaluation that objectively measures a worker’s current level of function, primarily within the context of the demands of competitive employment, activities of daily living, or leisure activities.

“Health care benefit,” also referred to as medical aid, means payment for health care services, treatment, medications, equipment, supplies and other supports authorized by the Workers Compensation Board and required as a result of the work-related injury.

“Impairment” means a medically measurable, permanent

- (i) loss of physiological function, anatomical function or anatomical structure, or
- (ii) abnormality of psychological function, physiological function, anatomical function or anatomical structure.

“Massage therapy” means the assessment of the musculoskeletal system of the body and the treatment and prevention of physical dysfunction, injury and pain by manipulation, mobilization and other manual methods to develop, maintain, rehabilitate or augment physical function, relieve pain or promote health.

“Pension” means an award based on a medically assessed disability awarded by the Workers Compensation Board prior to January 1, 1995, and was paid in recognition of a permanent partial or total disability.

“Physiotherapy” means physical therapy practiced in a continuing way to remove, alleviate or prevent movement dysfunction or pain, in a manner that requires the practitioner’s independent exercise of professional knowledge, skill, judgement, and ethical conduct, including, but not limited to: diagnostic assessment; design and conduct of treatment involving exercise, massage, hydrotherapy, heat, sonic, laser and electrical techniques, and other treatment modalities within the scope of practice of the treating physiotherapist; evaluation of progress; patient instruction, research; and educational or preventative measures.

“Plateau in medical recovery” means there is little potential for improvement or any potential changes in the condition are in keeping with the normal fluctuations which can be expected with that kind of injury.

“Return to work” means modified duties, alternate duties or tasks, or ease back, including approved employer-initiated ease backs. Return to work includes transition from light, alternative or modified duties and modified or alternative work.

“Supportive care” means treatment that is therapeutically necessary for workers, who have reached their maximum recovery from a work-related injury, to maintain a maximum level of recovery.

POLICY:

1. The Workers Compensation Board (WCB) will assist workers by paying health care benefits to help them recover, maintain function and reduce the impact of their work-related injury.
2. This policy explains the general principles and criteria for entitlement to health care benefits.

Health Care Benefit Principles

3. The WCB recognizes the importance of timely and appropriate health care in an injured worker's recovery and safe return to work and therefore considers a variety of health care providers to be direct access providers. These health care providers are the first possible point of contact with the health care system following a work-related injury.
 4. Direct access providers are:
 - Physicians
 - Nurse Practitioners
 - Physiotherapists (if approved as a WCB service provider)
 - Chiropractors
 - Psychologists
 - Audiologists
 - Pharmacists
 5. Following assessment of a work-related injury by a health care provider, the WCB is responsible for determining the necessity, type and extent of health care benefits for the treatment of a work-related injury.
 6. Decisions about entitlement to health care benefits are evidence-based and made in accordance with relevant legislation and WCB policies, including WCB policy, POL-160, Decision Making.
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Eligibility Criteria

7. The WCB may approve health care benefits before an initial claim decision is made to assist with timely assessment, treatment and recovery.
8. Generally, to be eligible for health care benefits beyond an initial assessment of a work-related injury:
 - A worker must have an accepted workers compensation claim that meets the conditions set out in WCB policy, POL-71, Conditions for Entitlement.
 - Objective information and evidence must support the need for health care benefits for the work-related injury.
 - The WCB must determine that the health care benefits are reasonable and necessary for the work-related injury.

Rehabilitation Services

9. Rehabilitation services will promote the principle of functional or psychological restoration and will focus on injury recovery to enable a worker to remain at work or to return to work in a safe and timely manner.
10. The WCB recognizes rehabilitation services as an acceptable form of health care when it is provided by a licensed health care provider as set out in POL-64, Health Care Providers – Roles and Responsibilities.
11. The WCB recognizes massage therapy as an acceptable form of rehabilitation when it is:
 - Recommended by a direct access provider and is provided by a licensed massage therapist recognized as a health care provider by the WCB as set out in POL-64, Health Care Providers – Roles and Responsibilities.
 - Provided in conjunction with a treatment or conditioning program.
12. The WCB recognizes that education is an important component of rehabilitation and expects the treating provider to provide education to an injured worker on the following:
 - Appropriate care and treatment goals.
 - Self-management to include a home exercise program.
 - Prevention of re-injury.

- Benefits of remaining at work or safe and timely return to work.

Assessments to Support Return to Work / Stay at Work

Functional Scan/Fit For Work/Functional Job Analysis

13. The following types of functional assessments may be used to provide objective measurements of functional ability for a worker:
- **Functional scan** - a functional assessment that provides objective measurement of a worker's current functional abilities and compares it to their pre-injury job demands.
 - **Fit for work assessment** - a combination of a physical examination, a functional scan and a pain/activity questionnaire. The purpose is to provide clinical recommendations for rehabilitation programs that assist with return to work.
 - **Functional job analysis** - an objective assessment at the workplace involving both a worker and employer that identifies functional elements and measures the physical or cognitive demands of the essential duties of the position.

Functional Capacity Evaluation

14. A Functional Capacity Evaluation quantifies safe functional abilities and is a pivotal resource for return to work, job placement decisions and disability evaluation.
15. The worker, and where appropriate, the employer, are expected to attend a case conference following completion of the Functional Capacity Evaluation to discuss the findings and return to work options.

The results of a Functional Capacity Evaluation can be used for the purpose of return to work, stay at work or case planning for up to a period of one (1) year following the post-Functional Capacity Evaluation case conference.

16. These assessments must be pre-approved by the WCB and conducted by a service provider approved by the WCB to perform functional assessments. The WCB may use one or more of these assessments to develop or adjust a return to work or stay at work plan.

Supportive Care

17. Health care benefits are typically provided until a worker has recovered or reached a plateau in their medical recovery. For work-related injuries that have resulted in an impairment, the WCB may provide supportive health care benefits to assist the worker to maintain function and quality of life.
18. Supportive care treatment may be appropriate to enable a worker to maintain function at a maximum level of recovery.

The WCB will approve payment of supportive care treatment where a worker:

- Has an impairment or is awaiting an impairment assessment as a result of a work-related injury.
- Is a pre-1995 pensioner.

Generally, supportive care treatment includes up to one initial assessment and twelve chiropractic, physiotherapy, massage therapy or psychological care treatments in a twelve-month period.

Worker Responsibilities

19. Worker roles and responsibilities are set out in WCB policies, POL-76, Worker Role in Recovery and Return to Work.

Payment and Reimbursement

20. Fees and payments for health care are determined by the WCB and are based on reasonable costs.
21. Health care providers must bill the WCB directly for all costs related to the work-related injury. They are not permitted to charge a worker extra fees above those paid by the WCB or charge workers directly for services provided.

WCB policy, POL-64, Health Care Providers – Roles and Responsibilities lists criteria that health care providers must meet to be recognized by and registered as a service provider with the WCB and their reporting and invoicing requirements.

22. If a worker is required to pay for health care expenses, such as treatments, medications

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and supplies, the WCB will reimburse the worker if the expense is reasonable and necessary. The worker must submit an expense claim with receipts, if applicable, within six months from the date of the expense.

Duration of Health Care Benefits

23. Treatment approval decisions are based on credible, evidence-based guidelines for the type of work-related injury or illness, as accepted by the broad scientific and medical community (e.g. Official Disability Guidelines, Reed Group MD Guidelines, etc.). WCB will advise the service provider and the worker about the treatment approval.
24. Health care benefits will continue for as long as the WCB considers it necessary in the recovery or maintenance of a work-related injury.

HISTORY:

May 15, 2025 – Amended to reflect addition of psychologists, audiologists, and pharmacists to list of direct access providers; updated descriptions of functional scan, fit for work assessment and functional job analysis to better reflect current assessment methods and criteria.

January 2023 – Amended to incorporate content from POL-25, POL-26 and POL-158; addition of definition and information relating to Direct Access Providers.

July 30, 2021 - Non-substantive changes for clarification, including guiding principles, eligibility criteria, and payment and duration of benefits, under the revised title Health Care Benefits - General Principles (formerly *Medical Aid*).

April 25, 2013 – Amended to move the section on hospital room amenities to this policy from POL-33, “Hospital Room Amenities”, which has been rescinded.

June 23, 2011 – On April 28, 2011 the Board of Directors approved that the section on “out-of-province” be moved into this policy upon final approval of the amended POL-64, “Health Care Providers” policy.

June 24, 2008 - The policy was updated as a result of the 60 month policy review process. A section on expedited medical aid was added to the policy.

Board of Directors Approval Date: September 26, 2002
