February 2003 Update 2003 – 1

TO: HOLDERS OF THE *REHABILITATION SERVICES AND CLAIMS MANUAL* – VOLUME I

This update of the *Rehabilitation Services and Claims Manual* contains amendments to the *Manual* approved by the Board of Directors since update 2002-7.

This amendment includes consequential amendments to reflect the changes in governance at the Board. A list of policies amended has been included as part of the package.

If you have any questions regarding receipt of this update or the *Rehabilitation Services and Claims Manual*, please call Publications and Video Distribution at 1-866-271-4879.

DOUGLAS ENNS
Chair, Board of Directors

Attachments

POLICIES AMENDED – Update 2003 – 1

Chapter 1	2.00	Workers' Compensation Board
	2.10	Jurisdiction over Claims Adjudication
	Notes	
Chapter 2	4.00	Exemptions and Exclusions from Coverage
Chapter 4	26.03	Recognition by Regulation of General Application
	26.70	Occupational Diseases Standing Committee (ODSC) **(Deleted)**
	Notes	
Chapter 10	83.21	Position Prior to August 10, 1992 **(Deleted)**
Chapter 12	96.10	Policy of the Board of Directors

TABLE OF CONTENTS

CHAPTER 4 — COMPENSATION FOR OCCUPATIONAL DISEASE

CHAPTER 6 — PERMANENT DISABILITY AWARDS

CHAPTER 7 — PROTECTION OF AND DEDUCTIONS FROM BENEFITS

CHAPTER 8 — COMPENSATION ON THE DEATH OF A WORKER

CHAPTER 11 — VOCATIONAL REHABILITATION SERVICES

CHAPTER 12— CLAIMS PROCEDURES

#1.20 The Conditions under which Compensation is Payable

Not all injuries or diseases are compensable. The *Act* prescribes the type of injuries (3) and diseases (4) and the circumstances in which they are compensable. (5) Thus, for example, in the case of injuries, compensation is limited to personal injuries arising out of and in the course of employment. (6)

#1.30 The Type and Amount of Compensation

There are a variety of types of compensation provided under the *Act*:

1. payments to compensate the injured worker for loss of earnings caused by a temporary disability; (7)

2. permanent disability awards for actual or estimated loss of earnings; (8)

3. pensions to dependants for loss of support by a deceased worker; (9)

4. health care benefits; (10)

5. rehabilitation assistance. (11)

#1.40 Charging of Claims Costs

The cost of compensation is normally charged to the employer rate group to which the worker's employer belongs. The cost may also affect the employer's experience rating. There are special provisions which relieve the rate group and/or the employer in certain situations. (12)

#2.00 WORKERS' COMPENSATION BOARD

The Workers' Compensation Board is a corporation set up under the *Act* to administer the provisions of the *Act*. (13) The *Act* defines the word "Board" as the Workers' Compensation Board. (14) The use of the word "Board" throughout this *Manual* means the Workers' Compensation Board.

The Board of Directors of the Workers' Compensation Board sets and revises as necessary the policies of the Board, including policies respecting compensation, assessment, rehabilitation and occupational health and safety. The Board of Directors also sets and supervises the direction of the Board.

EFFECTIVE DATE: February 11, 2003 (as to deletion of references to the Appeal Division and the former Governors)
APPLICATION: Not applicable.

#2.10 Jurisdiction over Claims Adjudication

The Board has exclusive jurisdiction to inquire into, hear, and determine all matters and questions of fact and law arising under the *Act*, and the action or decision of the Board thereon is final and conclusive and is not open to review in any Court. (17) Thus, the Board has sole jurisdiction over the adjudication of claims for compensation under the *Act*.

EFFECTIVE DATE: February 11, 2003 (as to deletion of references to the Appeal Division and the former Governors)
APPLICATION: Not applicable.

NOTES

(1) Chapter 2

(2) Chapter 8

(3) Chapter 3

(4) Chapter 4

(5) Chapters 3 and 4

(6) Chapter 3

(7) Chapter 5

(8) Chapter 6

(9) Chapter 8

(10) Chapter 10

(11) Chapter 11

(12) Chapter 17

(13) S.1 S.80

(14) S.1

~~(15) S.81~~ **DELETED**

~~(16) S.82~~ **DELETED**

(17) S.96(1)

~~(18) Chapter 12~~ **DELETED**

~~(19) Chapter 13~~ **DELETED**

CHAPTER 2

WORKERS AND EMPLOYERS COVERED BY THE ACT

#3.00 INTRODUCTION

Section 2(1) of the *Workers Compensation Act* states as follows:

> "This Part applies to all employers, as employers, and all workers in British Columbia except employers or workers exempted by order of the board. "

The employers and workers who are covered and those who are exempted are the subject of this chapter. Prior to January 1, 1994, coverage was limited to certain listed industries.

The Act does not apply to workers of the Federal Government of Canada. However, by Section 4(2) of the *Government Employees Compensation Act*, an "employee" who is usually employed in this province is given the same rights to compensation as workers under the provincial *Workers Compensation Act*. The persons considered "employees" are dealt with in this chapter.

#4.00 EXEMPTIONS AND EXCLUSIONS FROM COVERAGE

The criteria for the exemption of employers or workers may be found in the policy in Item AP1-2-1 of the *Assessment Manual* along with general exemptions which are described in detail. The policy in Item AP1-2-1 also recognizes that some workers and employers are excluded from coverage under the *Act* as a matter of constitutional law or because they have no attachment to B.C. industry.

EFFECTIVE DATE: February 11, 2003 (as to deletion of references to the former Governors)
APPLICATION: Not applicable.

#5.00 COVERAGE OF WORKERS

It is a well established principle of workers' compensation that where an employer comes within the scope of the Act, all workers of that employer are covered for compensation. The coverage is not limited to those engaged in the manual part of the operation. Thus, in a wholesale establishment, for example, workers' compensation coverage extends to clerical and bookkeeping staff, and to corporate presidents, as well as those engaged in the receiving, handling, storage and transmission of goods. All of these functions are part of wholesaling.

This position is not changed where an employer divides up the manual and clerical parts of his operation and attaches a separate corporate identity to each. Nor does it depend on whether the clerical and manual staff are employed by affiliated corporations. The result would be the same if there were no corporate affiliation.

A worker's claim is not prejudiced by the fact that the employer has not complied with the obligation to register with the Board. This is subject to the principles set out in Workers' Compensation Reporter Decision 335 and 20:30:30 of the Assessment Policy Manual.

#6.00 DEFINITIONS OF "WORKER" AND "EMPLOYER

The basic definitions of "worker" and "employer" in Section 1 of the Act are as follows:

> "'Employer' includes every person having in their service under a contract of hiring or apprenticeship, written or oral, express or implied, a person engaged in work in or about an industry;".
>
> "'Worker' includes
> (a) a person who has entered into or works under a contract of service or apprenticeship, written or oral, express or implied, whether by way of manual labour or otherwise;".

Detailed discussions concerning the definitions of worker and employer may be found at 20:10:30 of the Assessment Policy Manual.

#6.10 Nature of Employment Relationship

Where a person contracts with another to provide labour in an industry covered by the *Workers Compensation Act*, the Board considers that the contract may create one of three types of relationship. The persons doing the work may be independent firms, labour contractors, or workers.

Very detailed registration rules concerning independent firms, labour contractors, and workers are outlined at 20:10:30 and 20:30:20 of the Assessment Policy Manual.

#6.20 Voluntary and Other Workers Who Receive No Pay

Usually a "worker" is paid. Therefore, it is not surprising that voluntary or other workers receiving no payment for their work are not generally considered workers under the Act. On the other hand, some workers of this type are expressly included within the

To assist in adjudicating the merits of occupational disease claims, to facilitate efficiency and consistency in the decision-making process and to establish an institutional memory (with the additional benefit of providing the working community with confirmation that the Board is aware that a disease may arise as a result of employment activities), the Act provides a means by which the Board may designate or recognize a disease as an "occupational disease".

There are levels of designation or recognition based on the available medical and scientific evidence and on the Board's experience in dealing with these diseases. The manner in which a disease is designated or recognized is primarily based on the strength of medical and scientific knowledge about the role employment may have in its causation. The following are the various ways in which an occupational disease may be designated or recognized.

#26.01 Recognition by Inclusion in Schedule B

Any disease listed in the first column of Schedule B is by definition designated or recognized as an occupational disease. This is the highest level of designation or recognition.

The Board lists a disease in Schedule B in connection with a described process or industry wherever it is satisfied from the expert medical and scientific advice it receives that there is a substantially greater incidence of the particular disease in a particular employment than there is in the general population. The questions to be addressed include: is the disease common in that particular employment, and not common amongst the general public? Is it something specific to the employment?

Schedule B is set out in Appendix 2. The application of Schedule B is covered in #26.21. The amendment of Schedule B is covered in #26.60.

#26.02 Recognition under Section 6(4)(b)

Section 6(4)(b) provides that:

> ". . . the board may designate or recognize a disease as being a disease peculiar to or characteristic of a particular process, trade or occupation on the terms and conditions and with the limitations the board deems adequate and proper."

This provision gives the Board substantial flexibility in its designation or recognition of an occupational disease other than by listing it in Schedule B.

The Board may designate or recognize a disease as being a disease peculiar to or characteristic of a particular process, trade or occupation with respect to future claims in a broad sense, or it may impose a much more limited

designation or recognition by specifying whatever terms or conditions or limitations it deems appropriate.

For example, the Board has recognized osteoarthritis of the first carpo-metacarpal joint of both thumbs under this section as being applicable to a physiotherapist who was involved in deep frictional massage which placed particular strain on those joints. (1) This recognition is limited to factual situations substantially the same as those that applied to the worker in that decision.

This section may be used to designate or recognize a disease where the expert medical and scientific information is insufficient to cause the Board to include it in Schedule B (with the benefit of the rebuttable presumption that the Act provides), but is sufficient to cause the Board to state for decision-makers (thus establishing an institutional memory) that there is a recognized possibility that the employment contributed to the causation of the disease where the worker was employed in a specific process, trade, or occupation. In these circumstances there is no presumption that this is the case.

#26.03 Recognition by Regulation of General Application

The Board may designate or recognize a disease as an occupational disease "by regulation of general application" (section 1). In these circumstances, the Board designates or recognizes a disease as an occupational disease but without specifying that it is peculiar to or characteristic of a particular process, trade or occupation. The desired institutional memory is thus less specific. The Board has designated or recognized the following as occupational diseases by regulation:

Bronchitis
Campylobacteriosis (Diarrhea caused by Campylobacter)
Carpal Tunnel Syndrome
Chicken Pox
Cubital Tunnel Syndrome
Disablement from Vibrations
Emphysema
Epicondylitis (Lateral and Medial)
Food Poisoning
Giardia Lamblia Infestation
Head Lice (Pediculosis Capitis)
Heart Disease
Herpes Simplex
Hypothenar Hammer Syndrome
Infectious Hepatitis
Legionellosis

Lyme Disease
Meningitis
Mononucleosis
Mumps
Plantar Fasciitis
Radial Tunnel Syndrome
Red Measles (Rubeola)
Ringworm
Rubella
Scabies
Serum Hepatitis
Shigellosis
Staphylococci Infections
Stenosing Tenovaginitis (Trigger Finger)
Streptococci Infections
Thoracic Outlet Syndrome
Toxoplasmosis
Typhoid
Vinyl Chloride Induced Raynaud's Phenomenon
Whooping Cough
Yersiniosis

It is important to distinguish between designation or recognition of an occupational disease under section 6(4)(b) or by regulation of general application, and the addition of a disease to Schedule B under section 6(4)(a). Where the Board concludes that a disease is more likely to occur in connection with a particular employment covered by the Act than elsewhere, it may be added to Schedule B (see policy item #26.01). On the other hand, where the Board concludes that a disease is sometimes due to the nature of a particular employment covered by the Act, but it does not appear that the disease is more likely to occur in connection with that employment than elsewhere (it is not something specific to that employment), the Board may designate or recognize the disease under section 6(4)(b) or by regulation of general application without the rebuttable presumption afforded by inclusion in Schedule B.

Several of the above contagious diseases are not likely to be ". . . due to the nature of any employment in which the worker was employed . . ." except for hospital employees, or workers at other places of medical care.

The authority under the *Act* to designate or recognize a disease under sections 6(4)(a), 6(4)(b) or by regulation of general application rests with the Board of Directors.

EFFECTIVE DATE: February 11, 2003 (as to deletion of reference to the former Governors)
APPLICATION: Not applicable.

#26.04 Recognition by Order Dealing with a Specific Case

The lack of prior designation or recognition by the Board of a disease as an occupational disease by any of the means specified in #26.01, #26.02, or #26.03, does not mean a claim for such disease will not be considered on its merits. Such disease may not have been previously designated or recognized due to weak or a complete absence of medical and scientific information which causally associates such disease with employment. If the merits and justice of an individual claim for such a disease warrant its recognition as an occupational disease, the Board may do so "by order dealing with a specific case" (Section 1).

The effect of such an order is to accept the claim for compensation purposes without establishing an institutional memory for decision-makers or an expectation for others who may suffer from that disease that the disease may be due to the nature of some employment. In other words, the disease will be recognized as an occupational disease limited to the specific facts of that individual claim.

This allows an avenue of recognition for unique, meritous, individual disease claims. As the Board repeatedly encounters such claims for a particular disease, it may determine that a higher level of designation or recognition is warranted for that disease.

An Adjudicator upon investigating an individual claim may find that the condition suffered by the worker is not one listed in the first column of Schedule B, nor is it one which has been previously designated or recognized by the Board as an occupational disease under Section 6(4)(b) or by regulation. If the Adjudicator concludes, after seeking appropriate input from both the worker (or their legal representative) and the employer (if a specific employer is identified) that the facts warrant recognition of the worker's condition as an occupational disease, the Adjudicator will refer the claim with a recommendation to that effect to a panel made up of his or her Client Services Manager, (referred to in this section as the "Manager"), and a Board Medical Advisor (referred to in this section as the "Medical Advisor").

If, however, after seeking such input from the worker and employer, the Adjudicator concludes that the facts do not warrant recognition of the worker's condition as an occupational disease, the Adjudicator will disallow the claim without referring it to the panel, and will notify the worker and employer. This is an appealable decision. The Adjudicator shall provide the Manager with a memorandum advising that the worker's condition is not one previously designated or recognized by the Board as an occupational disease, the nature of the condition, and the Adjudicator's decision to disallow the claim.

doing so. It has the same flexibility in its ability to add to or delete from the descriptions of process or industry set out in the second column.

Claims for all of the diseases in Schedule B will be considered in respect of such disease even if the worker was not employed in the process or industry described opposite to the disease in the second column of Schedule B, but without the benefit of the presumption set out in Section 6(3) of the Act. See #26.22.

#27.00 ACTIVITY-RELATED SOFT TISSUE DISORDERS OF THE LIMBS

The terms “cumulative trauma disorder”, “repetitive strain injury”, “repetitive motion disorder”, “occupational overuse syndrome”, “occupational cerviobrachial disorder”, “hand/arm syndrome”, and others, are broad collective terms used to describe a diverse group of soft tissue disorders which may or may not be caused or aggravated by employment activities. A further term (adopted by the World Health Organization) for such disorders where employment may have a significant causative role is “work-related musculoskeletal disorders” or “WMSDs”. Each of these collective terms can be misleading. They may imply the presence of “repetition” or “trauma” or “motion” or “work-relatedness” where in fact the cause of the disorder may be due in whole or in part to other factors. The common elements of the disorders included in these collective terms are that they are related to physical activity and they affect muscles, tendons, and other soft tissues. This chapter adopts the term “activity-related soft tissue disorder” or “ASTD” to describe this group of disorders which may or may not be caused or aggravated by employment activities. This chapter deals with the compensability of ASTDs affecting the limbs.

ASTDs affecting the limbs are typically characterized by discomfort or persistent pain in muscles, tendons, or other soft tissues, at times accompanied by numbness and tingling and muscle weakness (loss of power), with or without physical manifestations. In terms of causation, they are multifactoral, where work activities and work environment may play a significant role in causing or in aggravating, activating, or accelerating them. Fatigue or minor traumatic injury is often the precursor of an ASTD. Included in ASTDs affecting the limbs are a number of known clinical entities (such as tendinitis, epicondylitis, and carpal tunnel syndrome) and to a significantly lesser extent, ill-defined symptom complexes also described as “unspecified disorders” or “multiple-tissue disorders”. In the absence of a described clinical entity, these unspecified disorders are occasionally referred to in terms of the broad collective terms referred to above.

The soft tissue disorders described by these terms have differing etiologies depending on the anatomical structures affected.

Given the different recognition and treatment that certain of these disorders may receive under the *Workers Compensation Act* and under Board policy, it is normally necessary to identify the involved anatomical structures and to determine the specific diagnosed disorder(s) suffered by the worker.

As with other occupational diseases, the question is: was the worker's ASTD caused or aggravated by his or her employment. In the case of ASTDs the answer to this question may be impacted by the following:

- there may not be a direct cause and effect relationship between some employment activity and the ASTD, rather there is an interaction between a number of factors, occupational and non-occupational, that trigger or impact the process;

- little is known about the interaction of certain factors which may impact the process;

- some cases of an ASTD may be idiopathic (occurring without known cause) where a causal agent cannot be identified;

- many of the risk factors that may trigger the onset of an ASTD are part of everyday life; not all ASTDs are caused or aggravated by work;

- some ASTDs may develop over hours while others develop over years;

- two or more ASTDs may exist simultaneously; a second ASTD may occur as the result of adjusting to or compensating for the first;

- individuals react differently to risk factors; some people are more susceptible to ASTDs than others.

Where the strength of association between an employment activity and a specific ASTD is strong, it may be listed in Schedule B with the benefit of the rebuttable presumption provided for in Section 6(3) of the Act. For all other ASTDs, the decision on causation can only be a judgment one makes in the particular circumstances of the claim by weighing the evidence for and against work-relatedness.

#27.10 ASTDs Recognized by Inclusion in Schedule B

Four such ASTDs are recognized as occupational diseases by inclusion in Schedule B; namely bursitis (#27.11), tendinitis, tenosynovitis (#27.12), and hand-arm vibration syndrome (#27.13).

#27.11 Bursitis

Schedule B lists "Knee bursitis (inflammation of the prepatellar, suprapatellar, or superficial infrapatellar bursa)" and "Shoulder bursitis (inflammation of the subacromial or subdeltoid bursa)" as occupational diseases.

A bursa is a sac-like cavity lined with a slippery synovial tissue. It is typically

found at a site of potential friction between tendons and muscles and a bony prominence lying beneath them. The primary purpose of the bursa is to reduce friction between the tissues. By virtue of its anatomical proximity to less flexible structures, a bursa can become inflamed if it is subjected to excessive friction, rubbing or pressure.

Bursitis is inflammation of a bursa. It is most commonly found in the knee involving the prepatellar or superficial infrapatellar bursa. Bursitis may also be caused by general inflammatory diseases (such as rheumatoid arthritis) or by bacterial infections typically following a puncture wound.

A claim for bursitis attributed to a sudden trauma to the knee (such as kneeling on a protruding object), to a sudden trauma to the shoulder, or for an infection of the bursa due to a penetrating wound, will be treated as an injury and will be adjudicated in accordance with the policies set out in Chapter 3. A claim made by a worker diagnosed with bursitis where no specific trauma or penetrating wound has occurred, will be treated as a disease and will be adjudicated in accordance with the policies set out in Chapter 4.

The following guiding principles apply when interpreting terms in Schedule B in connection with shoulder bursitis (Schedule B item 12(b)) and shoulder tendinitis (Schedule B item 13(b) – also see #27.12).

Frequently repeated abduction or flexion of the shoulder joint

In determining whether a particular work task involves "frequently repeated…abduction or flexion of the shoulder joint" consideration is given to such matters as:

- the frequency of the work cycle for the tasks being performed (how often there is abduction or flexion of the shoulder joint greater than sixty degrees);

- the amount of time during a work cycle that the affected muscle/tendon groups of the shoulder are working compared to the amount of time such tissues have to return to a relaxed or resting state;

- the amount of time between work cycles that the affected muscle/tendon groups of the shoulder have to return to a relaxed or resting state;

- whether other activities are performed between work cycles that require motions or muscle contractions that affect the ability of the affected muscle/tendon groups of the shoulder to return to a relaxed or resting state, and if so whether such activities are repetitive in nature.

Generally, tasks that are considered to involve "frequently repeated… abduction or flexion of the shoulder joint" include:

- ones that involve abduction or flexion of the shoulder joint greater than sixty degrees at least once every thirty seconds; or

- ones that are repeated and where at least 50 percent of the work cycle involves abduction or flexion of the shoulder joint greater than sixty degrees and where the muscle/tendon groups of that shoulder have less than 50 percent of the work cycle to return to a relaxed or resting state.

Whether tasks that involve lower work cycle frequencies or greater periods of rest and recovery time than referred to above involve "frequently repeated…abduction or flexion of the shoulder joint", will require the exercise of judgment based on the circumstances of the individual claim.

Sustained abduction or flexion of the shoulder joint

"Sustained abduction or flexion of the shoulder joint" means that the shoulder joint is held in a static position of abduction or flexion greater than sixty degrees. The greatest pressure is placed on the shoulder bursa when there is between 60 and 120 degrees of abduction or flexion (0 degrees being when the arm is straight down by the side of the torso). The longer the shoulder joint is held in such a static position during the work cycle, and the less time the affected muscle/tendon groups of the shoulder have to return to a relaxed or resting state, the more one is able to conclude that the work involves "sustained abduction or flexion of the shoulder joint". Conversely, the less time the shoulder joint is held in such a static position during the work cycle, and the more time that the affected muscle/tendon groups of the shoulder have to return to a relaxed or resting state, the less one is able to conclude that the work involves "sustained abduction or flexion of the shoulder joint".

Significant component of the employment

Use in Schedule B items 12(b) and 13(b) of the words "where such activity represents a significant component of the employment" means that the worker has been performing work activities involving the described use of the shoulder joint for sufficiently long that it is biologically plausible that the inflammation affecting the shoulder has resulted from the work activities. Employment activities that have involved minimal or trivial use of the shoulder joint do not amount to "a significant component of the employment".

For claims that do not meet the descriptions contained in items 12(a), 12(b) or 13(b) of Schedule B, see #27.20.

#27.12 Tendinitis and Tenosynovitis

Schedule B lists "Hand-wrist tendinitis, tenosynovitis (including deQuervain's tenosynovitis)" and "Shoulder tendinitis" as occupational diseases.

The performance of work often involves positioning and exerting the upper extremities in order to carry out tasks. Tendons carry much of the strain in the performance of certain types of work. If the strain on the tendon is large enough or lasts long enough (resulting in insufficient recovery time), the tendinous tissue may be damaged, leading to an inflammatory response in the tendon or extending to the tendon sheath.

Inflammation of a tendon (tendinitis) and of its synovial sheath (tenosynovitis) may occur at the same time.

Common sites for these inflammations include:

- the shoulder – for example rotator cuff tendinitis, supraspinatus tendinitis (either of which may cause an impingement syndrome), and bicipital tendinitis. Any of these may occasionally lead to frozen shoulder (adhesive capsulitis);

- the hand and wrist – for example deQuervain's tenosynovitis (inflammation affecting the abductor pollicis longus and the extensor pollicis brevis tendons).

Hand-wrist tendinitis/tenosynovitis and shoulder tendinitis may result from sudden strain placed on the tendons (such as where the tendon is suddenly contracted or stretched with sufficient force to cause immediate damage). Such a claim will be treated as an injury and will be adjudicated in accordance with the policies set out in Chapter 3. A claim made by a worker diagnosed with hand-wrist tendinitis/tenosynovitis or with shoulder tendinitis where no specific event or trauma, or series of events or traumas, has occurred, will be treated as a disease and will be adjudicated in accordance with the policies set out in Chapter 4.

Hand-wrist tendinitis or tenosynovitis

The following guiding principles apply when interpreting terms in Schedule B in connection with hand-wrist tendinitis/tenosynovitis (Schedule B item 13(a)).

Frequently repeated

In determining whether a particular work task involves "frequently repeated" motions or muscle contractions, consideration is given to such matters as:

- the frequency of the work cycle for the tasks being performed (the number of times the same motion or muscle contraction is performed within a specified period);

- the amount of time during a work cycle that the affected muscle/tendon groups are working compared to the amount of time such tissues have to return to a relaxed or resting state;

- the amount of time between work cycles where the affected muscle/tendon groups are able to return to a relaxed or resting state;

- whether other activities are performed between work cycles that cause stresses to be placed on the affected muscle/tendon groups that affect the ability of those tissues to return to a relaxed or resting state, and if so whether such activities are repetitive in nature.

A worker who is performing the same work task(s) again and again without interruption or rest between, is likely required to perform "frequently repeated motions or muscle contractions".

Generally, tasks (that place strain on the affected tendon(s)) that are considered to involve “frequently repeated motions or muscle contractions” include:

- ones that are repeated at least once every 30 seconds; or

- ones that are repeated and where at least 50 percent of the work cycle is spent performing the same motions or muscle contractions and where the affected muscle/tendon groups have less than 50 percent of the work cycle to return to a relaxed or resting state.

Whether tasks that involve lower work cycle frequencies or greater periods of rest and recovery time than referred to above involve “frequently repeated motions or muscle contractions”, will require the exercise of judgment based on the circumstances of the individual claim.

Significant flexion, extension, ulnar deviation or radial deviation

“Significant flexion, extension, ulnar deviation or radial deviation of the affected hand or wrist” means:

- moving (or holding) the hand or wrist in greater than 25 degrees of flexion, or
- moving (or holding) the hand or wrist in greater than 25 degrees of extension, or
- moving (or holding) the hand or wrist in greater than 10 degrees of ulnar deviation, or
- moving (or holding) the hand or wrist in greater than 10 degrees of radial deviation.

Forceful exertion

“Forceful exertion” of the muscles utilized in handling or moving tools or other objects means that the muscles and tendons which are used are loaded to a significant proportion of the maximum mechanical limit of those tissues. This limit will vary depending on factors such as the size, strength, and fitness level of the individual performing the work.

In determining whether the worker has been engaged in “forceful exertion of the muscles utilized”, consideration is given to such matters as:

- the weight of the tool or work object;
- the manner in which the tool or work object is moved (pushed, pulled, carried, lifted, lowered, gripped, pinched etc);

Notes

(1) Decision No. 231, 3 W.C.R. 87
(2) Decision No. 3, 1 W.C.R. 11
(3) S.6(1)(a)
(4) Decision No. 99, 2 W.C.R. 15
(5) Decision No. 205, 3 W.C.R. 16
(~~6) ODSC Charter, 8 W.C.R. 135~~ **Deleted**
(7) Decision No. 207, 3 W.C.R. 21
(8) An agreement entered into pursuant to Section 8.1 of the Act may supersede
(9) S.6(10)
(10) Decision No. 232, 3 W.C.R. 91
(11) Decision No. 267, 3 W.C.R. 188
(12) See #93.24
(13) See Chapter 6
(14) See #13.20 and #22.33-34
(15) Decision No. 348, 5 W.C.R. 127
(16) Decision No. 102, 2 W.C.R. 25
(17) *Government Employees Compensation Act*, S.8(1)(a)

reach an agreement with the worker regarding the accommodation to be selected and the amount the Board is prepared to approve as a reimbursement.

In addition to accommodation costs, the worker will be paid a full or partial per diem meal allowance as follows:

Date	Breakfast	Lunch	Dinner	Per Day
January 1, 1999 - December 31, 1999	$9.23	$11.38	$19.57	$40.20
January 1, 2000 - December 31, 2000	9.44	11.64	20.02	41.13
January 1, 2001 - December 31, 2001	9.71	11.96	20.57	42.27
January 1, 2002 - December 31, 2002	9.89	12.19	20.96	43.04

If required, earlier figures may be obtained by contacting the Board.

The above meal rates also apply where a worker has to buy meals while engaged on a journey for which the Board is paying expenses.

Where board and/or room is included in a treatment or vocational rehabilitation program, it will be paid at cost.

The rate of subsistence in Richmond when claimants or other persons eligible for admission to the Board's Rehabilitation Residence choose not to stay there is as follows:

Date	Amount Per Day
January 1, 1999 - December 31, 1999	$16.31
January 1, 2000 - December 31, 2000	16.68
January 1, 2001 - December 31, 2001	17.14
January 1, 2002 - December 31, 2002	17.47

If required, earlier figures may be obtained by contacting the Board.

After January 1, 1993, the meal allowance, and the subsistence rate paid to workers who choose not to stay at the Residence, will be adjusted on January 1 of each year. The Consumer Price Index ratio determined under Section 25 of the *Workers Compensation Act* for January 1 and the previous July 1 will be used (see #51.00).

The rules set out above apply equally to family members or other persons travelling with or visiting an injured worker. The Board may, however, pay the cost of hotel accommodation for such a person close to the hospital where the worker is located even though there is accommodation available at the Residence. This would normally be limited to situations where the worker's condition is considered to be life threatening.

#84.00 REHABILITATION RESIDENCE

The Board's Rehabilitation Residence is located at 6951 Westminster Highway, Richmond, British Columbia.

#84.10 Eligibility For Admittance

As the Rehabilitation Residence is a self-care unit, the residents must normally be able to function by themselves, handle their own hygiene and keep their rooms tidy. Six rooms have however been modified for claimants who are paraplegics or suffer severe walking disabilities. These persons must be self-sufficient to the degree that, with or without the assistance of an authorized travelling companion, they could stay in an hotel.

The eligibility of claimants from outside the province for admission to the Rehabilitation Residence is the same as claimants from within the province.

The following categories for Residence admission eligibility have been established.

#84.11 Rehabilitation Centre Treatment

Any claimant who normally resides outside the Lower Mainland area and is taking treatment at the Board's Rehabilitation Centre is entitled to stay in the Residence. Injured workers who live in the Lower Mainland area, but for medical reasons might appropriately be admitted to the Residence, may be admitted at the discretion of the Claims Adjudicator where the Rehabilitation Centre Physician agrees. Discharge from the Rehabilitation Centre generally terminates Residence eligibility. The Residence staff has discretion to extend the stay a few days if travel connections prevent an immediate return home.

From time to time a Rehabilitation Centre patient is discharged to await further acute care in a hospital or a medical specialist consultation. This waiting period should be done at home rather than in the Residence unless the wait for the next service is known to be less than one week. This guideline is subject to the Adjudicator's discretion if:

1. the costs of travel are high;

2. the consequences of missing an important appointment are too great; or

3. travel arrangements are difficult.

For the purpose of this chapter, the Lower Mainland area extends to and includes Vancouver, Richmond, Delta, Surrey, New Westminster, Coquitlam, Port Coquitlam, Burnaby, North and West Vancouver, Deep Cove, Port Moody, White Rock, Haney, Maple Ridge, Whalley, Langley, and up to the eastern municipal boundaries of Abbotsford and Mission. It also includes all settlements and small villages, etc. inside this area.

#84.12 Medical Consultation or Disability Evaluation

Injured workers can be admitted to the Board's Rehabilitation Residence for short stays when they have been sent to Richmond for a medical consultation or a permanent disability evaluation. A claimant should not be kept in the Residence any longer than five days for a medical examination unless the next medical visit is already scheduled. If the next medical visit is more than 10 days from the last visit, the claimant should return home to await the consultation.

This guideline is subject to the Adjudicator's discretion on the same grounds as are set out in #84.11.

Where a claimant involved in an appeal to a Medical Review Panel is entitled to subsistence in accordance with #100.13 Residence accommodation may be provided instead.

#84.13 Rehabilitation Programs

Claimants brought to Richmond by a Rehabilitation Consultant are eligible for accommodation in the Board's Rehabilitation Residence in the situations set out below.

A. Rehabilitation Centre Vocational Assessment Programs

   A claimant may be admitted to the Rehabilitation Centre for vocational evaluation, functional appraisal, and physical evaluation assessment as a rehabilitation procedure. In some instances, the worker may not be taking treatment other than in the industrial shops. The Rehabilitation Consultant can have such a worker admitted to the Board's Rehabilitation Residence.

B. Training and Education Programs

   Claimants from outside the Lower Mainland area who have been placed in training positions or educational programs may be authorized to stay in the Board's Rehabilitation Residence by the Rehabilitation Consultant. The maximum length of stay is normally one month but extensions may be authorized by a Director, Claims or a delegate.

#84.14 Rehabilitation Residence Filled

Where all the rooms at the Board's Rehabilitation Residence are filled, the Board provides hotel accommodation for claimants who would otherwise be eligible for admission. The practice set out in #83.20 is followed.

Claimants are allowed a maximum of two local telephone calls per day as part of their hotel account. No responsibility is accepted for long distance calls.

#84.20 Right of Eligible Workers to Choose Own Accommodation

Patients are allowed a free choice as to whether they wish to stay at the Board's Rehabilitation Residence or stay elsewhere. Where it is the opinion of the treating doctor that residence elsewhere would be detrimental to the health of the patient, the patient will be advised to stay at the Residence and be informed of the medical opinion. But the patient will still be allowed the choice.

Where a patient who is eligible for accommodation at the Residence chooses to stay elsewhere (otherwise than at home), the subsistence allowance set out in #83.20 is payable.

Patients who live outside the Lower Mainland area, (29) but within the Fraser Valley, who come to the Rehabilitation Centre for treatment daily, will be offered accommodation at the Residence. If they elect not to accept that accommodation, they will be offered their actual travel expenses up to a maximum equal to the rate of subsistence payable under #83.20 to a worker who is eligible to stay in the Residence but chooses not to do so. The use of automobiles will be permitted where it is unreasonable to expect the patient to use public transport.

Patients are not allowed to park campers or trailers on the Board's premises while attending the Rehabilitation Centre for the purpose of accommodating themselves or their families. The vehicle should be parked at a recognized trailer park and the claimant will receive the appropriate subsistence allowance if he or she chooses to live there.

#84.30 Visits to and from Home

The eligibility of spouses, relatives, or companions of workers to receive subsistence and stay at the Board's Rehabilitation Residence is dealt with at #83.11.

No accommodation at the Residence will normally be offered to anyone under 16 unless a patient.

Where a spouse, relative, or other companion is not eligible for accommodation at the Residence under the guideline set out in #83.11, they will still be able to obtain accommodation by paying the current rate.

Where the Board is not paying for a spouse etc. to visit the patient in Richmond, (30) the Board will pay for one home visit every three weeks by the patient in accordance with the principles set out in #83.12.

#84.40 Conduct of Worker at the Rehabilitation Residence

The Residence Manager has the responsibility for judging the conduct of claimants in the Residence. Disregard of the regulations of the Residence and caution against repetition can lead to loss of Residence privileges. This is a decision of the Manager in consultation with the Director, Technical Services. The worker may still, however, be entitled to a subsistence allowance.

#84A.00 HOMEMAKERS SERVICES

The Board provides homemakers' services for cases involving a single parent or, in families with two parents, when one parent is incapable of maintaining the home and family due to illness or other reasons.

Normally, in such circumstances, arrangements have been made by the worker to look after home and family with live-in housekeepers/babysitters, daycare centres or other family or community resources while the worker is away on the job. It is assumed that the same or similar arrangements would continue as an ongoing personal responsibility even though the worker is attending treatment for an industrial injury or undergoing a vocational rehabilitation program rather than being at work.

Homemakers' services may also be provided to workers where the seriousness of the injury would otherwise require hospitalization.

The Board does, however, recognize cases in which the provision of homemakers' services on a temporary basis should be considered, particularly in

instances where a worker is away overnight. The Board will pay for such services under appropriate circumstances.
The criteria for the payment of a homemakers' service will be:

1. no suitable arrangements can be made with the family, friends, or through the use of community resources;
2. the decision for treatment outside the claimant's home environment should be a decision with which the Board is in agreement;
3. the rates paid for such service will not be in excess of reasonable community rates; and
4. in cases of emergency when the spouse escorts a seriously injured worker who must be transported immediately to another health care facility, thereby leaving the home and family unattended.

Homemakers' services are considered a health care benefit expense where the costs incurred are the result of treatment. Where the homemakers' services relate to a vocational rehabilitation program, the costs will be part of Vocational Rehabilitation Services. In all cases, the Vocational Rehabilitation Consultant is responsible for the investigation of the worker's circumstances and ongoing monitoring.

The allowance will normally be paid to the claimant.

NOTES

(1) S.6(1); See #26.30
(2) See #75.11
(3) See #78.22
(4) S.1
(5) S.56; See #95.00
(6) S.56(2); See #78.00
(7) S.56(4)
(8) S.21(2)
(9) See #78.20
(10) See #74.60
(11) See #77.00
(12) See #78.20
(13) See #73.10
(14) See Chapter 16
(15) S.21(9)
(16) S.21(6)
(17) S.21(6)
(18) See #22.11
(19) S.21(6)
(20) S.21(6)
(21) See #80.00
(22) Decision 324
(23) See #74.00 for the difference between “physician” and “qualified practitioner”
(24) See #48.40
(25) S.21(3)
(26) S.21(1)
(27) See #71.21
(28) See #84.10
(29) See #84.11
(30) See#83.11

#95.31 Payment of Wage-Loss without Medical Reports

Wage-loss compensation is normally paid on the basis of medical evidence supporting a disability. This medical evidence is usually in the form of a signed medical report from a physician or a qualified practitioner.

Exceptions can be made in cases of short-term disability where the worker receives brief treatment from a first aid attendant or a hospital emergency department. If the circumstances are in all other respects acceptable, and the facts support the conclusion that the lay-off was a result of the injury, then wage-loss compensation may be paid. Normally, benefits should not be paid for periods of disability exceeding three days or in any case of occupational disease unless supported by proper medical evidence.

Exceptions can also be made in cases of longer term disability. Where there is evidence to support the existence of a disability, but there has been no receipt of a medical report and where the claim has been adjudicated and accepted, a first payment should be processed on the claim. Moreover, there must be some discretion to depart from the principle that wage-loss benefits are to be paid only on medical confirmation of disability. That confirmation may appear at the time the disability begins, some time during the disability or, in some cases, after it has ceased. The question is always whether the claimant was disabled. The best evidence of that disability is almost always medical evidence, but on some occasions, evidence from the claimant or from other sources may be sufficient to establish the existence and continuation of the disability.

In summary, if there is acceptable evidence of disability, and that evidence is clearly documented, wage-loss benefits can be paid in the absence of medical reports although these will, in almost all cases, be the most acceptable evidence.

Reports from Red Cross Outpost nurses can be considered as medical reports if no doctor is in the area.

#95.40 Obligation to Advise and Assist Worker

The physician or qualified practitioner must give all reasonable and necessary information, advice, and assistance to the injured worker and the worker's dependants in making application for compensation, and in furnishing in connection with it the required certificates and proofs, without charge to the worker. (21)

#96.00 THE ADJUDICATION OF COMPENSATION CLAIMS

Section 96(1) of the Act provides that "The board has exclusive jurisdiction to inquire into, hear and determine all matters and questions of fact and law arising under this Part, and the action or decision of the board on them is final and

conclusive and is not open to question or review in any court, and proceedings by or before the board must not be restrained by injunction, prohibition or other process or proceeding in any court or be removable by certiorari or otherwise into any court, and an action must not be maintained or brought against a governor, officer, appeal commissioner or employee of the board in respect of an act, omission or decision done or made in the belief that it was within the jurisdiction of the board; and, without restricting the generality of the foregoing, the board has exclusive jurisdiction to inquire into, hear and determine

(a) the question whether an injury has arisen out of or in the course of an employment within the scope of this Part;
(b) the existence and degree of disability by reason of an injury;
(c) the permanence of disability by reason of an injury;
(d) the degree of diminution of earning capacity by reason of an injury;
(e) the amount of average earnings of a worker, whether paid in cash or board or lodging or other form of remuneration, . . . for purposes of payment of compensation;
(f) the existence, for the purpose of this Part, of the relationship of a member of the family of a worker as defined by this Act;
(g) the existence of dependency;
(h) whether an industry or a part, branch or department of an industry is within the scope of this Part, . . .;
(i) whether a worker in an industry within the scope of this Part is within the scope of this Part and entitled to compensation under it; and
(j) whether a person is a worker, a subcontractor, a contractor or an employer within the meaning of this Part."

#96.10 Policy of the Board of Directors

Section 82 provides that the Board of Directors must set and revise as necessary the policies of the Board of Directors, including policies respecting compensation, assessment, rehabilitation, and occupational health and safety. While Board officers and the Workers' Compensation Appeal Tribunal ("WCAT") may make decisions on individual cases, only the Board of Directors has the authority and responsibility to set the policies of the Board.

As of February 11, 2003, the policies of the Board of Directors consist of the following:

(a) The statements contained under the heading "Policy" in the *Assessment Manual;*
(b) The *Occupational Safety and Health Division Policy and Procedure Manual*;
(c) The statements contained under the heading "Policy" in the *Prevention Manual;*
(d) The *Rehabilitation Services & Claims Manual* Volume I and Volume II, except statements under the headings "Background" and

"Practice" and explanatory material at the end of each Item appearing in the new manual format;

(e) The *Classification and Rate List*, as approved annually by the Board of Directors;

(f) *Workers' Compensation Reporter* Decisions No. 1 – 423 not retired prior to February 11, 2003; and

(g) Policy decisions of the former Governors and the former Panel of Administrators still in effect immediately before February 11, 2003.

After February 11, 2003, the policies of the Board of Directors consist of the documents listed above, amendments to policy in the four policy manuals, any new or replacement manuals issued by the Board of Directors, any documents published by the Board that are adopted by the Board of Directors as policies of the Board of Directors, and all decisions of the Board of Directors declared to be policy decisions.

In the event of a conflict between policy in a manual identified in (a), (b), (c), or (d) above, and policy in *Workers' Compensation Reporter* Decisions No. 1-423, policy in the manual is paramount.

In the event of any other conflict between policies of the Board of Directors:

(a) if the policies were approved by the Board of Directors on the same date, the policy most consistent with the *Act* or Regulations is paramount.

(b) if the policies were approved on different dates, the most recently approved policy is paramount.

The policies of the Board of Directors are published in print. The policies may also be published through an accessible electronic medium or in some other fashion that allows the public easy access to the policies of the Board of Directors.

The Chair of the Board of Directors supervises the publication of the *Workers' Compensation Reporter.* It will include decisions of the Board of Directors and selected decisions of WCAT. It may also include key decisions of the Courts on matters affecting the interpretation and administration of the *Act* or other matters of interest to the community.

WCAT decisions do not become policy of the Board of Directors by virtue of having been published in the *Workers' Compensation Reporter*. WCAT decisions are published in the *Reporter* to provide guidance on the interpretation of the *Act*, the Regulations and Board policies, practices and procedures.

The Board is not bound to follow legal precedent; its decision shall be given according to the merits and justice of the case. (22)

In the adjudication of individual claims, the Board is not "bound" by either internal policy directives or by external authorities in the field of compensation, at least not in the sense of the word "bound" as understood at common law. However, in issuing internal directives, the Board gives general indications of how it will act when certain circumstances come before it. When these circumstances arise, the applicable directive will normally be followed. It is recognized that there is an infinite variety of circumstances that can arise and that it is not possible to lay down in advance policies to finally determine every conceivable situation. Furthermore, there is the obligation on the Board to decide each case in accordance with its merits and justice and the right of individual persons affected under the rules of natural justice to present argument and evidence on their own behalf. Therefore, regard must always be had to the particular circumstances of each claim to determine whether an existing policy should be applied or whether there are grounds for a change in or departure from a policy. There will also be situations arising from time to time which are not covered by existing policy.

Board officers making decisions on claims are generally required to follow Board policies which are applicable to a claim before them. If they feel that a change in, or departure from a policy would be desirable, or they can find no applicable policy, they may refer the matter, with the approval of their Manager, to the Director of their department or the Director's delegate. They are required to exercise discretion in referring such matters to their Director when the practical implications are nominal and the "policy" issue effects only an extremely small number of potential future claims. If it is an unusual situation that is unlikely to occur again, or the administrative costs of reviewing the matter far outweigh the dollars on the claim, it is not considered that a referral for policy direction is necessary. This does not apply however when there is a serious concern over a small claim which represents a broad issue of policy, or over a large claim in financial terms which represent a relatively small issue of policy.

EFFECTIVE DATE: February 11, 2003 (as to references to Board of Directors policies)
APPLICATION: Not applicable.

#96.20 Claims Officers and Claims Adjudicators

A Claims Officer or Claims Adjudicator determines whether compensation is payable. They will decide, for instance, whether a claimant was employed in an industry under Part 1 of the Act, whether a personal injury was suffered arising out of and in the course of employment, or whether the claimant is suffering from an occupational disease which is due to the nature of the employment.

Following acceptance of a claim, the Claims Officer or Claims Adjudicator determines the amount and duration of compensation to be paid for temporary disability.

In a case of death, the Claims Adjudicator decides whether the death is compensable and whether the members of the worker's family are dependants and entitled to compensation.

The term "compensation" here includes, among other things, health care benefits, transportation and subsistence. For administrative purposes, and with the approval from the Claims Adjudicator or Claims Officer, Payment Clerks and other authorized staff may return to workers, with an explanatory letter, items such as transportation receipts, drug accounts, etc. which do not appear to qualify for payment on a claim. This is an interim measure only to the extent that, should a worker disagree, the Claims Adjudicator or Claims Officer must make a formal decision which, if negative, is appealable.

It is the responsibility of Claims Adjudicators and Claims Officers to determine whether a worker's claim should be referred to the Disability Awards Department for review and possible pension evaluation. This decision is generally made on the basis of information supplied by a treating physician, qualified practitioner, consulting specialist or the injured worker. Treating physicians and qualified practitioners are required to send periodic reports to the Board outlining the worker's condition. These reports include a question which asks specifically whether there will be any permanent disability resulting from the injury.

To ensure consistent referrals of all cases where there is a potential permanent disability, the Claims Adjudicator or Claims Officer is required to refer the claim to the Disability Awards Department for further evaluation where any of the following guidelines apply:

1. Where a medical report indicates that a permanent disability exists or that there is a possibility a permanent disability exists.

2. Where a worker indicates there is a permanent disability as a result of the compensable injury, or states there is an inability to return to employment as a consequence of the injury.

3. Where there is any other indication of a permanent disability or potential permanent disability.

If there is any doubt about the existence of a permanent disability, these claims are referred to the Disability Awards Department for final consideration. Claims Adjudicators and Claims Officers, however, are expected to exercise discretion and common sense in deciding whether to refer a worker's claim to the Disability Awards Department. Once a decision is made to refer a claim to the Disability Awards Department, it is up to the Claims Adjudicator or Claims Officer to clearly delineate by memo the status of the claim and to confirm what conditions have been accepted.

#96.21 Interim Adjudication

An interim decision to allow a claim will be made when the following conditions are all present:

1. The worker appears to be currently disabled from work.
2. On the evidence at present available, it appears probable that the worker is suffering from a compensable injury or occupational disease, or at least it appears that the possibilities are evenly balanced.
3. There is some significant delay in obtaining the best evidence to arrive at a conclusion on the validity of the claim, and the Claims Adjudicator is unable to avoid that delay.
4. The worker is not causing the delay.
5. The delay appears to be causing an interruption of income. For example, the case is not one in which the worker is still being paid by the employer or another source.
6. The claim is not a third party one. (23)

The above criteria apply whether or not the claim is protested by the employer.

Where a claim is allowed on an interim basis, the following rules will apply:

1. Wage-loss benefits will be commenced, with an explanation to the claimant, employer and attending physician.

2. Payments of wage-loss benefits under the interim decision will commence as of the date when the Adjudicator makes the interim decision. Arrears of wage-loss benefits for any time period prior to that date will not be paid until the final decision on the validity of the claim, except that the Adjudicator may pay such arrears on an interim decision to the extent that this may be necessary to avoid hardship.

3. The Adjudicator will proceed to obtain the best evidence to reach a final conclusion on the claim as soon as possible.

4. Health care benefit bills will not be paid under an interim decision. Where a claim has been accepted on an interim adjudication basis and there has been a request for surgery, it will be handled in the same manner as with other claims that have yet to be formally adjudicated. In such cases, the patient and physician should proceed privately, pending a final decision on the claim. This principle also applies with respect to other medical referrals, with the exception of a consultation with a specialist which may be paid on an investigation basis.

5. Where payments have been commenced on an interim basis, and the final decision is to disallow the claim, then: